AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)

Report of Reference Committee on Amendments to Constitution and Bylaws

William C. Reha, MD, MBA, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 2 – New Specialty Organizations Representation in the House of Delegates
2. Board of Trustees Report 33 – Specialty Society Representation in the House of Delegates - Five-Year Review
3. Council on Ethical and Judicial Affairs Report 1 – Competence, Self-Assessment and Self-Awareness
4. Council on Ethical and Judicial Affairs Report 2 – Physician Assisted Suicide
5. Council on Ethical and Judicial Affairs Report 3 – CEJA's Sunset Review of 2009 House Policies
6. Resolution 003 – Conforming Sex and Gender Designation in Government IDs and Other Documents
7. Resolution 006 – Use of Person-Centered Language
8. Resolution 009 – References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment
9. Resolution 014 – Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations
10. Resolution 018 – Support for Requiring Investigations into Deaths of Children in Foster Care
11. Resolution 021 – Health, In All Its Dimensions, Is A Basic Human Right
12. Resolution 023 – Distribution and Display of Human Trafficking Aid Information in Public Places
13. Resolution 024 – Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings
14. Resolution 025 – Gender Equity in Hospital Medical Staff Bylaws
15. Resolution 026 – Restrictive Covenants of Large Health Care Systems
16. Resolution 027 – Model Legislation for "Mature Minor" Consent to Vaccinations

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

17. Resolution 004 – Reimbursement for Care of Practice Partner Relatives
18. Resolution 005 – Right for Gamete Preservation Therapies
19. Resolution 007 – Delegation of Informed Consent
20. Resolution 008 – Preventing Anti-Transgender Violence
21. Resolution 011 – Mature Minor Consent to Vaccinations
22. Resolution 012 – Improving Body Donation Regulation
23. Resolution 013 – Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court
24. Resolution 015 – Opposing Mandated Reporting of People Who Question Their Gender Identity

25. Resolution 016 – Sexual and Gender Minority Populations in Medical Research

RECOMMENDED FOR REFERRAL

26. Board of Trustees Report 26 – Research Handling of De-Identified Patient Information
27. Council on Constitution & Bylaws Report 1 – Clarification to the Bylaws: Delegate Representation, Registration and Credentialing
28. Resolution 001 – Opposing Attorney Presence at and/or Recording of Independent Medical Examinations
29. Resolution 010 – Covenants not to Compete
30. Resolution 017 – National Guidelines for Guardianship
31. Resolution 019 – Opposition to Requirements for Gender-Based Medical Treatments for Athletes
32. Resolution 022 – Opposition to Involuntary Civil Commitment for Substance Use Disorder

RECOMMENDED FOR NOT ADOPTION

33. Resolution 002 – Addressing Existential Suffering in End-of-Life Care
34. Resolution 020 – CEJA Opinion E-5.7

(1) BOARD OF TRUSTEES REPORT 2 – NEW SPECIALTY ORGANIZATIONS REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 2 be adopted and the remainder of the report be filed.

Board of Trustees Report 2 recommends that our AMA grant representation in the House of Delegates to the American Academy of Sleep Medicine and the American Society of Cytopathology. The report outlines the criteria National Medical Specialty Societies must meet to be granted representation to the House, and confirms that these societies have met these criteria.

The only testimony heard on Board of Trustees Report 02 was given by the authors. Your Reference Committee recommends that Board of Trustees Report 2 be adopted.

(2) BOARD OF TRUSTEES REPORT 33 – SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES - FIVE-YEAR REVIEW

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 33 be adopted and the remainder of the report be filed.

Board of Trustees Report 33 recommends that the American Association of Gynecologic Laparoscopists, American Academy of Cosmetic Surgery, American Association for Thoracic Surgery, American Association of Plastic Surgeons, American Association of Public Health Physicians, American College of Allergy, Asthma and Immunology, American Society for Metabolic and Bariatric Surgery, and the Society of Laparoendoscopic Surgeons retain representation in the American Medical Association House of Delegates. The report also recommends that, having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.50, the American Society for Aesthetic Plastic Surgery, American Society of Interventional Pain Physicians, Association of University Radiologists, Infectious Diseases Society of America and the International Society for the Advancement of Spine Surgery be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership.

The only testimony heard on Board of Trustees Report 33 was given by the authors. Your Reference Committee recommends that Board of Trustees Report 2 be adopted.

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

RECOMMENDATION:

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

Council on Ethical and Judicial Affairs Report 1 examines physicians' ethical responsibility of commitment to competence as one that encompasses more than knowledge and skill. This responsibility requires that physicians understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context, and that they need to recognize when they are and when they are not able to provide appropriate care for the patient in front of them. Hence, it is important for physicians to practice informed self-assessment that leads to self-awareness of their own ability to practice safely "in the moment." The report proposes guidance to this end.

Your Reference Committee heard concerns regarding circumstances in which physicians no longer possess the self-awareness to accurately assess their own competence, such as in the case of impairment (e.g. in the case of dementia). Testimony argued that impaired physicians should not be considered to be acting unethically. Other testimony suggested that the recommendations as written in the current version of this report successfully address that concern. While your Reference Committee is sensitive to these concerns, its judgment is that these issues are duly addressed both by section (f) in the recommendations of this report and Opinion E-9.3.2 "Physician Responsibilities to Impaired Colleagues". Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 01 be adopted as written.

(4) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 2 – PHYSICIAN ASSISTED SUICIDE

RECOMMENDATION:

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

Council on Ethical and Judicial Affairs Report 2 responds to Resolution 15-A-15, "Study Aid-in-Dying as End-of-Life Option," and Resolution 14- A-17, "The Need to Distinguish between 'Physician-Assisted Suicide' and 'Aid in Dying'." Resolution 15-A-15 asks that CEJA study medical aid-in-dying and make a recommendation regarding the AMA taking a neutral stance; Resolution 14-A-17 asks that the AMA define and clearly distinguish "physician assisted suicide" and "aid in dying" for use in all AMA policy and position statements. This report holds that the terms 'aid in dying' and 'physician-assisted suicide' reflect different ethical perspectives. The Council finds "physician assisted suicide" to be the most precise term and urges that it be used by the AMA. Importantly, the report

explains that there are irreducible differences in moral perspectives regarding the issue of physician-assisted suicide, such that both sides share common commitment to "compassion and respect for human dignity and rights," (see Principle I of the AMA Principles of Medical Ethics) but draw different moral conclusions from these shared commitments. The report considers the risks of unintended consequences of physician-assisted suicide, noting that there is debate about the available data. The report argues that where physician-assisted suicide is legal, safeguards can and should be improved to mitigate risk. The report further notes that too often physicians and patients do not have the conversations they should about death and dying and that physicians should be skillful in engaging in these difficult conversations and knowledgeable about the options available to terminally ill patients. The report concludes that in existing opinions on physician-assisted suicide and the exercise of conscience, the *Code of Medical Ethics* offers sufficient guidance to support physicians and the patients they serve in making well-considered, mutually respectful decisions about legally available options for care at the end of life while respecting the intimacy of a patient-physician relationship. Thus, the report recommends that the *Code* not be amended, and that Resolutions 15-A-16 and 14-A-17 not be adopted.

Your Reference Committee heard extensive testimony regarding Council on Ethical and Judicial Affairs Report 2. Your Reference Committee heard concerns that maintaining the AMA's current opposition to physician-assisted suicide would not be a true reflection of the analysis contained in the report. However, testimony offered a great deal of support for the acceptance of CEJA's report and keeping the current *Code* unchanged. Your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 02 be adopted.

(5) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 3 – CEJA'S SUNSET REVIEW OF 2009 HOUSE POLICIES

RECOMMENDATION:

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

Council on Ethical and Judicial Affairs Report 3 presents the annual sunset report of House policies. This report reviewed House policies from 2009 and recommends that the policies listed in the Appendix of this report be acted upon in the manner indicated.

Testimony was offered against the reaffirmation of H-140.952, "Physician Assisted Suicide" in light of the fact that Council on Ethical and Judicial Affairs Report 02 on the same topic has not yet been adopted by the House. However, your Reference Committee believes that not reaffirming the existing policy would constitute a significant change in policy, and therefore agrees with the Council's recommendation to reaffirm H-140.952, "Physician Assisted Suicide". Other speakers noted that multiple reaffirmed, consolidated, or otherwise maintained policies reviewed in this sunset report use only male pronouns. Your Reference Committee urges that the language in these policies be editorially updated

by AMA staff since CEJA reports cannot be amended, and recommends that CEJA Report 03 be adopted.

(6) RESOLUTION 003 – CONFORMING SEX AND GENDER DESIGNATION IN GOVERNMENT IDS AND OTHER DOCUMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 008 be adopted.

Resolution 003 asks that our AMA modify Policy H-65.967, "Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients," to address change of sex designation on government documents and other forms of government identification. Currently, policy H-65.967 advocates for the removal of barriers to change the sex designation on an individual's birth certificate. This resolution asks our AMA to modify the policy to support every individual's right to determine their gender identity and sex designation on other government documents and forms of government identification. Additionally, Resolution 003 asks our AMA to support policies that allow a sex designation or change of designation on all government IDs to reflect an individual's gender identity, as reported by the individual and without need for verification by a medical professional, and policies that include an undesignated or nonbinary gender option for government records and forms of government-issued identification in addition to "male" and "female." The resolution also asks that our AMA support efforts to ensure that the sex designation on an individual's government-issued documents and IDs does not hinder access to medically appropriate care or other social services in accordance with that individual's needs.

Your Reference Committee heard testimony in almost unanimous support of the resolution. Limited testimony was offered for referral, suggesting that there may be unintended security issues if government identification reflected something other than the gender identified at birth. However, significant testimony noted that individuals in the transgender community face harassment due to inappropriate gender markers on various forms of identification, and this resolution would be in line with laws passed in several states. It was also noted that the World Health Organization has recently moved forward changes that being transgender or gender non-binary is not a disorder. Your Reference Committee recommends that Resolution 003 be adopted.

(7) RESOLUTION 006 – USE OF PERSON-CENTERED LANGUAGE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 006 be adopted.

Resolution 006 asks that our AMA encourage the use of person-centered language, a style of communication in which the person is listed first followed by descriptive terms such as a disease state (e.g., "a person with schizophrenia" rather than "a schizophrenic").

Your Reference Committee heard testimony that unanimously supported the resolution. Speakers noted that no person should be described by their disease state, and that stigmatizing language should be avoided. Speakers suggested that the use of person-centered language could be effective in eliminating biases that may impact patient care. Your Reference Committee therefore recommends that Resolution 006 be adopted.

(8) RESOLUTION 009 – REFERENCES TO TERMS AND LANGUAGE IN POLICIES ADOPTED TO PROTECT POPULATIONS FROM DISCRIMINATION AND HARASSMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 009 be adopted.

Resolution 009 asks that our AMA undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not, and research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment. The resolution asks that the preliminary study results be presented to the Minority Affairs Section, the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment. The resolution asks for a report with the study results and recommendations within 18 months.

Limited testimony was offered in support of the resolution, and your Reference Committee recommends that Resolution 009 be adopted.

(9) RESOLUTION 014 – DISCLOSURE OF FUNDING SOURCES AND INDUSTRY TIES OF PROFESSIONAL MEDICAL ASSOCIATIONS AND PATIENT ADVOCACY ORGANIZATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 014 be adopted.

Resolution 014 asks that our AMA support guidelines for members of the Federation of Medicine and patient advocacy organizations to disclose donations, sponsorships, and other financial transactions by industry and commercial stakeholders.

Your Reference Committee heard general positive testimony regarding Resolution 014. Your Reference Committee recommends that Resolution 014 be adopted.

(10) RESOLUTION 018 – SUPPORT FOR REQUIRING INVESTIGATIONS INTO DEATHS OF CHILDREN IN FOSTER CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 018 be adopted.

Resolution 018 asks our AMA to support legislation requiring investigations into the deaths of children in the foster care system that occur while the child is in the foster care system.

Your Reference Committee heard testimony in unanimous support of Resolution 018. An amendment was offered to stipulate that autopsies should be performed after investigations, as abuse is sometimes not visible externally, however your Reference Committee believes that the medical examiner or coroner should make this determination in order to avoid autopsies on children whose cause of death is known. Your Reference Committee recommends that Resolution 018 be adopted.

(11) RESOLUTION 021 – HEALTH, IN ALL ITS DIMENSIONS, IS A BASIC HUMAN RIGHT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 021 be adopted.

Resolution 021 asks that our AMA acknowledge that enjoyment of the highest attainable standard of health, in all its dimensions, including health care, is a basic human right, and that the provision of health care services, as well as optimizing the social determinants of health, is an ethical obligation of a civil society.

Your Reference Committee heard testimony in strong support of Resolution 021. Speakers suggested that this issue is timely and may be the most important resolution to pass at this session, as this a statement of the AMA's values. Speakers noted that other organizations, including the World Health Organization, define health care as a basic human right, and that the AMA cannot address health care without acknowledging that it is a right. Limited testimony was offered in opposition, expressing concern about the use of the term "right", as such a term creates an obligation. Testimony was also offered suggesting that other organizations define health care as a "good," but not a "right." Your Reference Committee recommends that Resolution 021 be adopted.

(12) RESOLUTION 023 – DISTRIBUTION AND DISPLAY OF HUMAN TRAFFICKING AID INFORMATION IN PUBLIC PLACES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 023 be adopted.

Resolution 023 asks that our AMA adopt as policy that readily available signs, notices, posters, placards and other readily available educational materials providing information about reporting human trafficking activities or aiding victims and survivors must be permitted in local clinics, emergency departments and other medical settings. The resolution also asks our AMA to utilize its website or internet presence to provide downloadable materials displaying the National Human Trafficking Hotline Number to aid in displaying such information in the aforementioned settings, and advocate that other recognized medical professional organizations do the same. Additionally, the resolution asks our AMA to urge the federal government to make changes in laws to advocate for the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings.

Limited testimony was heard that was generally supportive of the resolution. Testimony was offered that some victims of human trafficking are not aware that they are being exploited, and that visible public signage would be quite helpful when caring for these patients. Testimony was also offered for referral, as there are multiple phone numbers that can be utilized for this purpose, in addition to posted information advising victims and survivors to call 9-1-1, and that this resolution has the potential to confuse individuals regarding proper cause of action. However, your Reference Committee believes that publicly posting this information is ultimately beneficial, and recommends that Resolution 023 be adopted.

(13) RESOLUTION 024 – ELIMINATING USE OF THE TERM "MENTAL RETARDATION" BY PHYSICIANS IN CLINICAL SETTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 024 be adopted.

Resolution 024 asks that our AMA recommend that physicians adopt the term "intellectual disability" rather than "mental retardation" in clinical settings.

Your Reference Committee heard testimony that unanimously supported Resolution 024. Speakers noted that words matter, and the term "retardation" is both outdated and used to demean individuals. Your Reference Committee recommends that Resolution 024 be adopted.

(14) RESOLUTION 025 – GENDER EQUITY IN HOSPITAL MEDICAL STAFF BYLAWS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 025 be adopted.

Resolution 025 asks that our AMA affirm that hospital medical staff bylaws should promote, and not impede, gender equity in their implementation. The resolution also asks that our AMA study existing hospital medical staff bylaws as to how they impact on issues of gender equity, directly or indirectly, and suggest any addition(s) to its model bylaws to assure this issue is properly addressed, and gender equity affirmed.

Your Reference Committee heard unanimous support for Resolution 025. Speakers testified to the importance of gender equity in professional medicine and how the documented inequities and gender bias that exist within the profession must be recognized and addressed. It is appropriate that our AMA should play a critical role in taking measures in helping to address this problem, which includes examination of hospital bylaws and their impact on the problem. Your Reference Committee recommends that Resolution 025 be adopted.

(15) RESOLUTION 026 – RESTRICTIVE COVENANTS OF LARGE HEALTH CARE SYSTEMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 026 be adopted.

Resolution 026 asks that our AMA, through its Organized Medical Staff Section, educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including, but not limited to, the impact on patient choice and access to care. The resolution also asks that our AMA study the impact that restrictive covenants have across all practice settings, including, but not limited to, the effect on patient access to health care, the patient-physician relationship, and physician autonomy, with report back at I-19.

Your Reference Committee heard testimony largely supportive of Resolution 026, with speakers noting that this is a significant issue that is rarely looked at, that physicians often are not given a choice but to sign a covenant, and that students are rarely educated on the practice before entering the workforce. Speakers also noted that the practice has negative ramifications for rural medicine, and that physicians can be limited from even volunteering to practice in retirement due to restrictive covenants. Your Reference Committee recommends that Resolution 026 be adopted.

(16) RESOLUTION 027 – MODEL LEGISLATION FOR "MATURE MINOR" CONSENT TO VACCINATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 027 be adopted.

Resolution 027 asks that our AMA support physicians in assessing whether a minor has met maturity and medical decision-making capacity requirements when providing consent for vaccinations and in developing protocols for appropriate documentation. The resolution also asks our AMA to develop model legislation to aid states in developing their own policies to allow "mature minors", defined as "certain older minors who have the capacity to give informed consent to do so for care that is within the mainstream of medical practice, not high risk, and provided in a nonnegligent manner," to self-consent for vaccinations.

Limited testimony was offered in unanimous support of Resolution 027. Your Reference Committee recommends that Resolution 027 be adopted.

(17) RESOLUTION 004 – REIMBURSEMENT FOR CARE OF PRACTICE PARTNER RELATIVES

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association support changes in the Medicare guidelines to allow a physician~~, who is a partner in the practice,~~ to care for and receive appropriate reimbursement for immediate relatives of one of the ~~other partners~~ colleagues in their practice. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 004 be adopted as amended.

Resolution 004 asks that our AMA support changes in the Medicare guidelines to allow a physician who is a partner in a practice to care for and receive appropriate reimbursement for immediate relatives of other partners in their practice.

Limited testimony was heard in support of Resolution 004. Testimony suggested that this issue is particularly relevant in rural areas and smaller communities, in which physicians often refer family members to their colleagues by necessity, and that is unfair to expect the resulting work to be done for free due to Medicare guidelines. An amendment was offered that the word "partner" be changed, as it is often used colloquially, and may have

unintended consequences as it is also used a legal term. Thus, your Reference Committee recommends that Resolution 004 be adopted as amended.

(18) RESOLUTION 005 – RIGHT FOR GAMETE PRESERVATION THERAPIES

RECOMMENDATION A:

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

RESOLVED, That fertility preservation services be ~~officially~~ recognized by our American Medical Association as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies (New HOD Policy); and be it further

RESOLVED, That our AMA ~~officially~~ support the right of transgender or non-binary individuals to seek gamete preservation therapies. (New HOD Policy); and be it further

RESOLVED, That our American Medical Association supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility (New HOD Policy).

RECOMMENDATION B:

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

Resolution 005 asks that fertility preservation services be officially recognized by our AMA as an option for members of the transgender and non-binary communities who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies, and asks that our AMA officially support the right of transgender or non-binary individuals to seek gamete preservation therapies.

Your Reference Committee heard testimony that unanimously supported Resolution 005. Speakers discussed the barriers that transgender and non-binary individuals often face when seeking fertility preservation services. Testimony agreed that our AMA should address these barriers by recognizing that transgender and non-binary individuals have the right to seek gamete preservation therapies. Testimony reflected the need for two minor amendments. The first amendment adds a third resolve clause reflecting testimony that the AMA should also support insurance coverage with regards to gamete preservation. The second amendment reflects testimony that the word “officially” be struck from the resolved clauses, as such word is redundant and implied, as all actions that the

AMA takes are "official." Your Reference Committee recommends that Resolution 005 be adopted as amended.

(19) RESOLUTION 007 – DELEGATION OF INFORMED CONSENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolved clause in Resolution 007 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association in cooperation with other relevant stakeholders advocate that a qualified physician, while retaining the ultimate responsibility for all aspects of the informed consent process, be able to delegate tasks associated with the process to other qualified members of the health care team ~~or her duty to obtain informed consent to another provider that~~ who ~~has~~ have knowledge of the patient, the patient's condition, and the procedures to be performed on the patient (Directive to Take Action);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 007 be adopted as amended.

Resolution 007 asks that our AMA, in cooperation with other relevant stakeholders, advocate that a qualified physician be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient's condition and the procedures to be performed on the patient. The resolution also asks that our AMA study the implication of the *Shinal v. Toms* ruling and its potential effects on the informed consent process. *Shinal v. Toms* was a 2017 Pennsylvania Supreme Court Ruling that mandated that a physician may not delegate to others his or her obligation to provide sufficient information to obtain a patient's informed consent, and that the duty of informed consent is a non-delegable duty owed by the physician conducting the surgery or treatment.

Your Reference Committee heard testimony largely supportive of Resolution 007. A number of amendments were offered to the resolution, suggesting the addition of language indicating that the physician retain the ultimate responsibility of the informed consent process. The original authors of the resolution as well as other speakers offered support for the proposed amendments. Other speakers expressed concern about the use of the term "provider," and suggested that it should be changed to "physician." Limited testimony was offered in support of referral, suggesting that the issue may require further study, however the second Resolved clause satisfies this concern. Your Reference Committee recommends that Resolution 007 be adopted as amended.

(20) RESOLUTION 008 – PREVENTING ANTI-TRANSGENDER VIOLENCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends the sixth Resolved clause in Resolution 008 be deleted:

~~RESOLVED, That our AMA issue a press release following the conclusion of the annual House of Delegates meeting with updates to be published in both scientific and mainstream publications regarding the prevalence of physical and mental health conditions and barriers faced by the LGBTQ community. (Directive to Take Action)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 008 be adopted as amended.

Resolution 008 asks that our AMA partner with other medical organizations and stakeholders to immediately increase efforts to educate the public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths. The resolution also asks that our AMA advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; for demographic data on an individual's birth sex and gender identity to be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System; for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity; for stronger law enforcement policies regarding interactions with transgender individuals; and for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience. Resolution 008 also asks our AMA to issue a press release following the conclusion of the Annual Meeting with updates to be published in both scientific and mainstream publications regarding the prevalence of physical and mental health conditions and barriers faced by the LGBTQ community.

Testimony was offered in unanimous support of the first five resolved clauses of Resolution 008. Speakers noted that the issue is critical and in line with current AMA policy on hate crimes and access to health care. A number of speakers expressed reservations about the sixth resolved clause, which asks our AMA to issue a press release at the conclusion of the Annual Meeting and publishing updates in both scientific and mainstream publications regarding the prevalence of physical and mental health conditions and barriers faced by the LGBTQ community. However, your Reference Committee recognizes that the AMA media team routinely develops press releases regarding adopted policy, and cannot control publication in outside media. Therefore, your Reference Committee recommends that Resolution 008 be adopted as amended.

(21) RESOLUTION 011 – MATURE MINOR CONSENT TO VACCINATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 011 be amended by addition and deletion to read as follows:

Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; and (f) supports state policies allowing minors ~~adolescents~~ to override their parent's refusal ~~and provide consent~~ for vaccinations; ~~provide their own consent for vaccination~~ and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 011 be adopted as amended.

Resolution 011 asks that our AMA amend policy H-440.830, "Education and Public Awareness on Vaccine Safety and Efficacy," by adding language to support state policies that allow adolescents to provide their own consent for vaccination, as well as encouraging state legislatures to establish comprehensive vaccine and minor consent policies.

Your Reference Committee heard testimony largely in support of the sentiment of Resolution 011. Some concern was heard about a lack of clarity in regards to the scope of vaccine consent and refusal by mature minors, as well as the term “mature minor” itself. Amendments were offered to clarify the appropriate scope of the decisions a mature minor should be able to make in these situations. Your Reference Committee also recognizes that mature minor doctrines are established clearly on a state level and thus do not need further clarification in this instance. Your Reference Committee therefore recommends that Resolution 011 be adopted as amended.

(22) RESOLUTION 012 – IMPROVING BODY DONATION REGULATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 012 be amended by addition to read as follows:

RESOLVED, That our American Medical Association recognize the need for ethical, transparent, and consistent body and body part donation regulations. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 012 be adopted as amended.

Resolution 012 asks that our AMA recognize the need for ethical, transparent, and consistent body donation regulations.

Your Reference Committee heard limited testimony in general support of Resolution 012. A proposed amendment suggested that the resolution also address body parts and not only the whole body. Your Reference Committee recommends that Resolution 012 be adopted as amended.

(23) RESOLUTION 013 – OPPOSING OFFICE OF REFUGEE RESETTLEMENT'S USE OF MEDICAL AND PSYCHIATRIC RECORDS FOR EVIDENCE IN IMMIGRATION COURT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolved clause in Resolution 013 be amended by addition to read as follows.

RESOLVED, That our American Medical Association advocate that healthcare services provided to minors in immigrant detention and border patrol stations focus solely

on the health and well-being of the children (Directive to Take Action);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 013 be adopted as amended.

Resolution 013 asks that our AMA advocate that health care services provided to minors in immigrant detention focus solely on the health and well-being of the children. The resolution also asks that our AMA condemn the use of confidential medical and psychological records and social work case files as evidence in immigration courts without patient consent.

Your Reference Committee heard testimony in unanimous support of Resolution 013. An amendment was offered to include the mention of border patrol stations in addition to immigrant detention in the first resolved clause, and subsequent testimony supported the amendment. Therefore, your Reference Committee recommends that Resolution 013 be adopted as amended.

(24) RESOLUTION 015 – OPPOSING MANDATED REPORTING OF PEOPLE WHO QUESTION THEIR GENDER IDENTITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 015 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association oppose mandated reporting of ~~youth~~ individuals who question or express interest in exploring their gender identity. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 015 be adopted as amended.

Resolution 015 asks that our AMA oppose mandated reporting of youth who question or express interest in exploring their gender identity.

Your Reference Committee heard testimony in unanimous support of the spirit of the resolution. Speakers noted that it is inappropriate to ask patients to share personal information and then report what they have been told; confidentiality is essential. Other speakers noted that this resolution is in line with AMA policy. An amendment was offered to change the word “youth” to “individuals.” Your Reference Committee recommends that Resolution 015 be adopted as amended.

(25) RESOLUTION 016 – SEXUAL AND GENDER MINORITY POPULATIONS IN MEDICAL RESEARCH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 016 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association amend policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," by addition and deletion as follows:

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) in medical documentation and related forms, including in electronic health records, in a culturally sensitive and voluntary manner; and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of ~~sexual orientation/gender identity~~ sexual orientation, gender identity, and other sexual and gender minority traits ~~such as differences/disorders of sex development~~ for the purposes of research into patient and population health. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 016 be adopted as amended.

Resolution 016 asks that our AMA amend policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation." The amended language would stipulate that our AMA advocate for the collection of patient data in medical documentation and medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits such as differences and disorders of sex development.

Your Reference Committee heard testimony that unanimously supported Resolution 016. There was clear support for the importance of collecting data of sexual and gender minority populations for research and that that modification of H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation" should be modified to make it inclusive of the important of collecting this data with regards to the medical research. Testimony reflected the need for one minor amendment by deletion be made with regards to the language "such as differences/disorders of sex development". Such language was deemed to be problematic, as "differences of sex development" is an umbrella term that encompasses many different conditions, and there is not uniform

agreement of what constitutes "differences of sex development", rendering the terminology imprecise and both under-and over-inclusive. Your Reference Committee recommends that Resolution 016 be adopted as amended.

(26) BOARD OF TRUSTEES REPORT 26 – RESEARCH HANDLING OF DE-IDENTIFIED PATIENT INFORMATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 26 be referred.

Board of Trustees Report 26 responds to Policy D-315.975, "Research Handling of De-Identified Patient Information," adopted A-18. This policy directs the AMA to study handling of de-identified patient data. This report outlines appropriate and inappropriate use of de-identified patient data, perspectives from stakeholders in organized medicine, potential ethical concerns of the commercial use of such data, regulatory implications, and the future use of de-identified patient data. BOT 26 recommends that our AMA reaffirm Policies H-315.974, "Guiding Principles Collection and Warehousing of Electronic Medical Record Information," H-315.983, "Patient Privacy and Confidentiality," H-315.975, "Policy, Payer, and Government Access to Patient Health Information," H-315.978, "Privacy and Confidentiality," and H-315.987, "Limiting Access to Medical Records." The report further recommends that our AMA support state-based efforts to protect patient privacy including a patient's right to know whether information is being disclosed or sold and to whom, as well as the right to opt out of the sale of their data. The report also recommends that our Council on Ethical and Judicial Affairs consider re-examining existing guidance relevant to the confidentiality of patient information in light of new practices regarding de-identified patient data, including the use of exclusive de-identified data licensing agreements in health care. Finally, the report recommends that Policy D-315.975, "Research Handling of De-Identified Patient Information," be rescinded, as it was fulfilled by this report.

Significant testimony was offered in favor of referral. Concerns raised included the impact on patient registries, inconsistency of laws across state lines, and the necessity to consider underserved populations. The report authors agreed that referral was acceptable. Your Reference Committee therefore recommends that Board of Trustees Report 26 be referred.

(27) COUNCIL ON CONSTIRUTION AND BYLAWS REPORT 1 – CLARIFICATION TO THE BYLAWS: DELEGATE REPRESENTATION, REGISTRATION AND CREDENTIALING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 1 be referred.

Council on Constitution and Bylaws Report 1 recommends amended bylaw language for consideration of the House of Delegates to eliminate ambiguity/inconsistencies related to representation, registration and credentialing of AMA delegates and alternate delegates. Several proposed changes clarify to delegates, alternate delegates and those responsible for certifying them that AMA membership and membership in the organization being represented is mandatory. Recommended bylaw amendments also address the individuals responsible for certifying organization's delegations, the formal recredentialing process and the timing of such, and parity for specialty society presidents to allow the specialties, like the states, to credential their president as an extra alternate delegate.

Your Reference Committee heard testimony largely in favor of referral. A number of speakers noted that the unique challenges for medical students and trainees—whose schedules are often out of their control—make it necessary to utilize everyone present in order to fill their allotted seats. Other speakers also noted that the proposed changes may similarly make it difficult for smaller delegations to fill their seats. Speakers noted that our AMA's goal should be inclusivity, and barriers to an inclusive democratic process should be removed, not added. Your Reference Committee therefore recommends that Council on Constitution and Bylaws report 01 be referred.

(28) RESOLUTION 001 – OPPOSING ATTORNEY PRESENCE AT AND/OR RECORDING OF INDEPENDENT MEDICAL EXAMINATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 001 be referred.

Resolution 001 asks that Policy H-365.981, "Workers' Compensation," be amended by addition to include language that opposes the ability of courts to compel recording and videotaping of, or allow a court reporter or opposing attorney to be present during, the independent medical examination, as a condition for the physician's medical opinion to be allowed in court.

Your Reference Committee heard testimony largely in opposition to Resolution 001. Speakers noted that states have different laws regarding the recording of independent medical examinations (IME) regarding workers' compensation; the state-by-state nature of the laws preclude the prescribing of workers' compensation guidelines. Supportive testimony noted that third parties should not be present for a private medical exam, and that the resolution is consistent with the ethical guidelines of other organizations.

(29) RESOLUTION 010 – COVENANTS NOT TO COMPETE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 010 be referred.

Resolution 010 asks that our AMA consider as the basis for model legislation the New Mexico statute allowing a requirement that liquidated damages be paid when a physician

partner who is a part owner in practice is lured away by a competing hospital system. The resolution also asks our AMA to ask our Council on Ethical and Judicial Affairs to reconsider their blanket opposition to covenants not to compete in the case of a physician partner who is a part owner of a practice, in light of the protection that liquidated damages can confer to independent physician owned partnerships, and because a requirement to pay liquidated damages does not preclude a physician from continuing to practice in his or her community.

Your Reference Committee heard mixed testimony on Resolution 010. A number of speakers suggested that more information is necessary and that the item should be referred to the Board for further study. Testimony was offered suggesting that the Board of Trustees, and not CEJA, is the appropriate entity to study this issue. Speakers also expressed hesitation in basing model legislation on the New Mexico statute, as well as hesitation to basing AMA policy on state law. Your Reference Committee recommends that Resolution 010 be referred.

(30) RESOLUTION 017 – NATIONAL GUIDELINES FOR GUARDIANSHIP

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 017 be referred.

Resolution 017 asks that our AMA collaborate with relevant stakeholders to advocate for federal creation and adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures.

Your Reference Committee heard limited testimony in opposition of the resolution as written, with some speakers lauding the intent but expressing concern that the issue of guardianship is a complex one, relating to both the individual and the property in question, and requires further study. Testimony was also heard suggesting that the ask in the resolution is not specific enough. Your Reference Committee therefore recommends that Resolution 017 be referred.

(31) RESOLUTION 019 – OPPOSITION TO REQUIREMENTS FOR GENDER-BASED MEDICAL TREATMENTS FOR ATHLETES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 019 be referred.

Resolution 019 asks that our AMA oppose any regulations requiring mandatory medical treatment or surgery for athletes with Differences of Sex Development (DSD) to be allowed to compete in alignment with their identity. The resolution also asks our AMA to oppose the creation of distinct hormonal guidelines to determine gender classification for athletic competitions.

Your Reference Committee heard testimony largely in favor of referral, with speakers noting that the topic is complex and that data can be interpreted differently. Speakers noted that further study may broaden the issue beyond what is explicitly addressed in the resolution. Testimony was also offered suggesting that the AMA should reach out to other organizations with expertise on the issues. Therefore, your Reference Committee recommends that Resolution 019 be referred.

(32) RESOLUTION 022 – OPPOSITION TO INVOLUNTARY CIVIL COMMITMENT FOR SUBSTANCE USE DISORDER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends Resolution 022 be referred.

Resolution 022 asks that out AMA oppose involuntary civil commitment without judicial involvement of persons for reasons solely related to substance use disorder. The resolution also asks that our AMA work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services.

Your Reference Committee heard mixed testimony on Resolution 022, with some speakers supporting the resolution and others in support of referral. Testimony was offered suggesting that involuntary commitment can be performed for laudable reasons, and that patients coerced into commitment have better outcomes than patients who are committed voluntarily. Other speakers suggested that the decision on commitment should be made by a physician, and that judicial oversight is essential. An amendment was offered suggesting that criminalization of substance use disorder during pregnancy should be treated as though the patient is not pregnant.

(33) RESOLUTION 002 – ADDRESSING EXISTENTIAL SUFFERING IN END-OF-LIFE CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 002 not be adopted.

Resolution 002 asks that our AMA ask the Council on Ethical and Judicial Affairs (CEJA) to review Ethical Opinion 5.6, “Sedation to Unconsciousness in End-of-Life Care,” to address (1) appropriate treatments beyond social, psychological or spiritual support to treat existential suffering, and (2) the recognition of a patient’s previously expressed wishes with end of life care.

Your Reference Committee heard testimony in general opposition to Resolution 002. Testimony suggested that current CEJA ethical opinions are adequate on the issue, and that to adopt this resolution while other related, controversial issues are still on the table will serve to complicate the issues. Testimony also suggested that the public’s trust in physicians is based on the confidence that physicians will not cause them harm. Your Reference Committee recommends that Resolution 002 not be adopted.

(34) RESOLUTION 020 – CEJA OPINION E-5.7

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 020 be not be adopted.

Resolution 020 asks that our AMA's Council on Judicial and Ethical Affairs (CEJA) be strongly encouraged to modify Opinion E-5.7, "Physician-Assisted Suicide," to adopt the ethical position of "Engaged Neutrality," defined as neither in favor of nor or in opposition to Physician Assisted Dying (PAD), while providing reassurance that our AMA will be a resource to lawmakers, physicians and the public to ensure compliance with standards of lawful medical practice, and to protect physicians' freedom to participate or not participate in PAD in accordance with their personal beliefs and our AMA's Opinion E-1.1.7, "Physician Exercise of Conscience."

Your Reference Committee heard mixed testimony on Resolution 020. Speakers suggested that elements of the Code of Medical Ethics, particularly Opinions E-5.7 and E-1.1.7 are inconsistent. Speakers suggested that resolution adds ambiguity to the issue by using unclear terminology, and that engaged neutrality is not neutral and implies acceptance to physician assisted suicide. Testimony argued against the use of the term "suicide" in addressing this issue due to the associated stigma. Testimony was also offered suggesting that this resolution is attempting to tell CEJA how to write their report. Your Reference Committee recommends that Resolution 020 not be adopted.

Madam Speaker, this concludes the report of Reference Committee on Amendments to Constitution and Bylaws. I would like to thank Robert Gibbs, MD, Bassam Nasr, MD, MBA, Jill Owens, MD, Scott Pasichow, MD, MPH, Abdul Rehman, MD, Richard Wilbur, MD, JD, and all those who testified before the Committee.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)

Report of Reference Committee A

John Montgomery, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 2 - Covering the Uninsured under the AMA Proposal for Reform
   in lieu of
   Resolution 116 - Medicare for All
2. Council on Medical Service Report 3 - Medicare Coverage for Dental Services
3. Council on Medical Service Report 5 - The Impact of Pharmacy Benefit Managers on Patients and Physicians
4. Council on Medical Service Report 6 - Preventive Prostate Cancer Screening
5. Resolution 102 - Use of HSAs for Direct Primary Care

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

6. Council on Medical Service Report 4 - Reclassification of Complex Rehabilitation Technology
7. Resolution 105 - Payment for Brand Medications When the Generic Medication is Recalled
8. Resolution 107 - Investigate Medicare Part D – Insurance Company Upcharge
9. Resolution 113 - Ensuring Access to Statewide Commercial Health Plans
   Resolution 114 - Ensuring Access to Nationwide Commercial Health Plans
10. Resolution 115 - Safety of Drugs Approved by Other Countries
    Resolution 129 - The Benefits of Importation of International Pharmaceutical Medications
11. Resolution 117 - Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use
12. Resolution 119 - Returning Liquid Oxygen to Fee Schedule Payment
13. Resolution 122 - Reimbursement for Telemedicine Visits
14. Resolution 124 - Increased Affordability and Access to Hearing Aids and Related Care
    in lieu of
    Resolution 120 - Medicare Coverage of Hearing Aids
15. Resolution 126 - Ensuring Prescription Drug Price Transparency from Retail Pharmacies

RECOMMENDED FOR REFERRAL FOR DECISION

16. Resolution 131 - Update Practice Expense Component of Relative Value Units

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

17. Resolution 101 - Health Hazards of High Deductible Insurance
    Resolution 125 - Mitigating the Negative Effects of High-Deductible Health Plans
18. Resolution 109 - Part A Medicare Payment to Physicians
19. Resolution 111 - Practice Overhead Expense and the Site-of-Service Differential
    Resolution 132 (Late Resolution 1003) – Site of Service Differential
20. Resolution 112 - Health Care Fee Transparency
21. Resolution 123 - Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder
22. Resolution 127 - Eliminating the CMS Observation Status

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

- Resolution 103 - Health System Improvement Standards
- Resolution 104 - Adverse Impacts of Single Specialty Independent Practice Associations
- Resolution 106 - Raising Medicare Rates for Physicians
- Resolution 108 - Congressional Healthcare Proposals
- Resolution 110 - Establishing Fair Medicare Payer Rates
- Resolution 118 - Pharmaceutical Pricing Transparency
- Resolution 121 - Maintenance Hemodialysis for Undocumented Persons
- Resolution 128 - Elimination of CMS Hospital Readmission Penalties
- Resolution 130 - Notification of Generic Drug Manufacturing Changes

(1) COUNCIL ON MEDICAL SERVICE REPORT 2 - COVERING THE UNINSURED UNDER THE AMA PROPOSAL FOR REFORM
RESOLUTION 116 - MEDICARE FOR ALL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted in lieu of Resolution 116 and the remainder of the report be filed.

Council on Medical Service Report 2 recommends that our AMA support eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); support increasing the generosity of premium tax credits; support expanding eligibility for cost-sharing reductions; support increasing the size of cost-sharing reductions; and reaffirm Policies H-165.828, H-165.842, H-165.824, D-290.979, H-290.965, H-290.976, H-290.971, H-290.982, D-290.982 and D-165.942.

Resolution 116 asks that our AMA gather current, accurate data on the reimbursement from Medicare for private practice physicians, medical clinics, hospital outpatient services, hospitals including rural hospitals and critical access hospitals, and healthcare systems along with accurate data as to how the reimbursement compares to the cost for providing the medical care for these services; evaluate what would happen to the healthcare economics of the United States and the ability to continue outpatient medical practice if the current Medicare reimbursement, compared to the cost of providing that care, became the major financing resource for medical care and predict what effect this would have on the access to medical care in the U.S.; evaluate how the current differential payments in Medicare to various entities for the same service would change in a "Medicare for all" scenario; after analysis of the data, provide to the patients and physicians of our country the relevant questions that we can ask of political candidates advocating "Medicare for all"; and provide a better understanding of the impact of "Medicare for all" in terms of healthcare financing, workforce, ability to continue private practice medical care, incentives for physicians to join hospital systems, availability of care, and help understand how this might change the provision of healthcare in the United States.

Your Reference Committee heard predominantly supportive testimony on Council on Medical Service Report 2. In introducing the report, a member of the Council on Medical Service underscored that by putting forward strong recommendations to improve the Affordable Care Act (ACA), the Council report appropriately targets providing coverage to the uninsured population, as well as making coverage more affordable for millions of Americans. At the same time, the report recommendations recognize that almost 60 percent of nonelderly Americans (more than 156 million) are enrolled in employer-sponsored insurance, and are generally satisfied with their coverage.

Testimony on Resolution 116 was mixed. Notably, many speakers stressed that adopting Resolution 116 would have unintended consequences. Importantly, a member of the Council on Medical Service noted that Council on Medical Service Report 2 addressed the intent of Resolution 116, and should be adopted in lieu of the resolution.

The President of the AMA urged support for Council on Medical Service Report 2. In her testimony, she noted that the recommendations of Council on Medical Service Report 2 build upon the AMA's extensive policy foundation—supporting individually owned health insurance with tax credits inversely related to income—that was established in 1998. She continued that the Council's recommendations respond to policy gaps to ensure that the AMA proposal for reform has the potential to cover millions more Americans. Important to those in our House who are disappointed that the Council on Medical Service did not recommend removing AMA's opposition to single payer proposals, she stressed that the AMA will be at the table as health reform proposals are introduced and debated—just as we were from when our "Voice for the Uninsured" campaign launched in 2007 up to the passage of the ACA.

A member of the Council on Legislation also testified in strong support of the report, noting that since the enactment of the ACA in 2010, the AMA has been highly engaged on the legislative, regulatory and judicial fronts regarding the law's implementation, guided by policy. Notably, the member of the Council on Legislation noted that the recommendations of CMS Report 2 to eliminate the "subsidy cliff", make premium tax credits more generous, and expand eligibility for and increase the size of cost-sharing reductions are in line with recent federal legislation that has been introduced to improve the ACA. The Council member stated that having policy specifically on point for these provisions would be incredibly meaningful to AMA advocacy efforts, and lead to millions more Americans to get covered. Finally, the member of the Council on Legislation stated that it looked forward to continuing to review legislation that is introduced, ranging from ACA improvement legislation to other bills that may not be in clear alignment with AMA policy. Importantly, it was stressed that having policy in opposition to single payer proposals would not prevent the Council on Legislation from evaluating proposals as they are introduced, that will vary greatly in substance and scope.

An amendment was offered for our AMA to support public choice options that would allow individuals and families a choice of publicly-financed or private insurance as long as payments to physicians are appropriate, sufficient, fair, and sustainable (not limited to Medicare rates) to ensure access to care. The amendment received strong support. A member of the Council on Medical Service welcomed study of the coverage options outlined in the amendment. Your Reference Committee agrees with need for study, and believes that the impacts of the options outlined in the amendment on coverage rates, affordability, health plan choice, the Medicare Trust Fund, and crowd-out from private to public coverage must be comprehensively analyzed before enacting any change to AMA policy. Accordingly, your Reference Committee is proposing such a study alongside Resolutions 113 and 114 (see item 9). Your Reference Committee also notes that our AMA already has policy addressing a public option. Policy H-165.838 states that insurance coverage options offered in a health insurance exchange be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

An amendment was also offered to remove AMA policy opposition to single-payer proposals – which is the focus of the referred resolution to which Council on Medical Service Report 2 responded. Your Reference Committee agrees with the Council on Medical Service that our AMA proposal for reform provides a strong policy foundation to

use in evaluating health reform proposals as they get introduced in the coming years, regardless of whether they are tied to the ACA. Your Reference Committee heard testimony from members of the Board of Trustees and the Council on Legislation that even with policy opposition to single-payer proposals, our AMA will continue to thoughtfully engage in discussions of health reform proposals, which will vary greatly in their structure and scope.

Your Reference Committee thanks the Council on Medical Service for a comprehensive report. Your Reference Committee agrees that our AMA proposal for reform, including the report recommendations, outlines a strong strategy to cover the remaining uninsured, with specific, targeted policy proposals for the uninsured subpopulations. Importantly, your Reference Committee notes that the Council report recommendations promote physician practice viability by maintaining the variety in the potential payer mix for physician practices that is essential to cover practice expenses, as well as support payment and delivery reforms. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 2 be adopted in lieu of Resolution 116, and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 3 - MEDICARE COVERAGE FOR DENTAL SERVICES

RECOMMENDATION:

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

Council on Medical Service Report 3 recommends that our AMA reaffirm Policy D-160.925; support continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and support initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

Testimony on Council on Medical Service Report 3 was unanimously supportive. In introducing the report, a member of the Council on Medical Service underscored the fact that the ADA is currently engaged in their own study of a potential Medicare dental benefit so that they can make an informed recommendation for their profession. The Surgeon General testified supporting oral health and efforts to cover oral health care. The Surgeon General explained that while he is not permitted to express an advocacy opinion on the matter, he applauded Council on Medical Service Report 3, and thanked the AMA for taking on this issue. Your Reference Committee believes that the recommendations of the report constitute important steps to improve dental care for Medicare beneficiaries, and recommends that the recommendations of Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 5 - THE IMPACT OF PHARMACY BENEFIT MANAGERS ON PATIENTS AND PHYSICIANS

RECOMMENDATION:

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

Council on Medical Service Report 5 recommends that our AMA support the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance; develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight; support requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale; support efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity; support outlined principles to improve transparency of PBM operations; encourage increased transparency in how DIR fees are determined and calculated; and reaffirm Policies H-125.979, H-320.939, H-285.965, D-330.910 and H-320.958.

Your Reference Committee heard highly supportive testimony on Council on Medical Service Report 5. In introducing the report, a member of the Council on Medical Service underscored that the recommendations of the report aim to increase transparency in PBM operations, while taking steps to increase state and federal regulation of PBMs in response to their role in managing drug benefits, which now resembles the typical role of insurers.

There was an amendment offered to advocate for stronger PBM reform at the federal level, including advocating for the elimination of rebates. A member of the Council on Medical Service raised concerns with the amendment, noting that the elimination of rebates would have unintended consequences, including higher premiums and cost-sharing. Further, a member of the Council on Legislation testified in support of Council on Medical Service Report 5, noting that the AMA has been highly engaged in advocating for PBM transparency and improved regulation of PBMs, from testifying before congressional committees, to submitting regulatory comments, to supporting federal legislation, to leveraging model state legislation. For example, in his statement to the U.S. House of Representatives Energy and Commerce Committee Health Subcommittee for the hearing “Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain,” Dr. Jack Resneck, Chair, AMA Board of Trustees, testified in support of increased PBM transparency. In its statement for the record to the US House of Representatives Committee on Oversight and Reform on examining the actions of drug companies in raising prescription drug prices in January 2019, the AMA called for improved regulation and transparency of PBMs, priorities that were also echoed in the comments of the AMA submitted in response to American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs (Blueprint) in July 2018.

Your Reference Committee believes that Council on Medical Service Report 5 is highly consistent with AMA advocacy efforts in support of increased transparency and regulation of PBMs. As such, your Reference Committee recommends that the recommendations of Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 6 - PREVENTIVE PROSTATE CANCER SCREENING

RECOMMENDATION:

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

Council on Medical Service Report 6 recommends that our AMA encourage public and private payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making; encourage national medical specialty societies to promote public education around the importance of informed physician-patient shared decision-making regarding medical services that are particularly sensitive to patient values and circumstances, such as prostate cancer screening; amend Policy D-450.957 to change the title to read, “Clinical Guidelines and Evidence Regarding Benefits of Prostate Cancer Screening and Other Preventive Services,” and to add a new subsection, “(3) encouraging scientific research to address the evidence gaps highlighted by organizations making evidence-based recommendations about clinical preventive services”; and reaffirm Policies D-185.979, H-185.939, H-373.997, H-450.938, D-185.980 and H-425.997.

Testimony on Council on Medical Service Report 6 was unanimously and strongly supportive. In introducing the report, a member of the Council on Medical Service explained how medical services currently qualify for insurance coverage without patient cost-sharing and placed prostate cancer screening in the context of other cancer screening services that do not currently meet the evidentiary threshold required to qualify for coverage without cost-sharing. In addition, the co-authors of the original resolution testified in strong support of Council on Medical Service Report 6 and thanked the Council for its report. Your Reference Committee believes that the recommendations of the report build off of existing policy guiding the coverage of preventive services, and recommends that the recommendations of Council on Medical Service Report 6 be adopted and the remainder of the report be filed.

(5) RESOLUTION 102 - USE OF HSAs FOR DIRECT PRIMARY CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 102 be adopted.

Resolution 102 asks that our AMA adopt policy that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense; and seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.

Your Reference Committee heard testimony supportive of the intent of Resolution 102. Your Reference Committee believes that Resolution 102 is consistent with existing policy and advocacy efforts, and as such recommends its adoption.

(6) COUNCIL ON MEDICAL SERVICE REPORT 4 - RECLASSIFICATION OF COMPLEX REHABILITATION TECHNOLOGY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 of Council on Medical Service Report 4 be amended by addition and deletion to read as follows:

3. That our AMA support, upon reclassification of CRT as a distinct category, the development by the Centers for Medicare & Medicaid Services, with the advice of physicians with appropriate training and expertise, of appropriate, simplified and streamlined ~~of additional~~ requirements ~~and/or regulations~~ specific to CRT that reduce the administrative burden on physicians.~~, beyond those that exist under the broad category of durable medical equipment.~~ (New HOD Policy)

RECOMMENDATION B

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

Council on Medical Service Report 4 recommends that our AMA support the reclassification of complex rehabilitation technology (CRT) as a separate, distinct, and adequately funded payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and

appropriately manage their medical needs; support state medical association and national medical specialty society efforts to accomplish adequately funded reclassification of CRT; and support, upon reclassification of CRT as a distinct category, the development by the Centers for Medicare & Medicaid Services of additional requirements and/or regulations specific to CRT, beyond those that exist under the broad category of durable medical equipment.

Testimony on Council on Medical Service Report 4 was supportive. In introducing the report, a member of the Council on Medical Service noted that the Council specifically considered the potential impacts of reclassifying CRT as a separate and adequately funded payment category, and concluded that the reclassification was warranted. An amendment was offered to Recommendation 3 to strengthen and clarify the recommendation. A member of the Council on Medical Service testified in support of this amendment. Your Reference Committee accordingly recommends adoption of Council on Medical Service Report 4 as amended.

(7) RESOLUTION 105 - PAYMENT FOR BRAND MEDICATIONS WHEN THE GENERIC MEDICATION IS RECALLED

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 105:

RESOLVED, That our AMA support health plans and pharmacy benefit managers providing a process for expedited formulary exceptions in the event of a recall of a generic medication, to ensure patient access to the brand medication or more affordable, alternative treatment options (New HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-110.987, which supports the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage or no available comparable generic drug (Reaffirm HOD Policy); and be further

RESOLVED, That our AMA reaffirm Policy H-100.956, which outlines policy priorities to respond to national drug shortages (Reaffirm HOD Policy).

Resolution 105 asks that our AMA petition the Centers for Medicare and Medicaid Services as well as third party payers to allow reimbursement for brand medications at the lowest copayment tier so that patients can be effectively treated until the medication manufacturing crisis is resolved.

There was no testimony on Resolution 105. Your Reference Committee notes that in the case of a generic medication recall, the physician should be able to request an

expedited formulary exception request for coverage of the brand if the patient needs to stay on the same drug product. Your Reference Committee also notes that recalls of generic medications can lead to other generic manufacturers of the same product to significantly increase their prices. As such, your Reference Committee has crafted an alternate resolution that addresses the intent of Resolution 105, and responds to the potential impacts of generic medication recalls.

H-100.956 National Drug Shortages
1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients. 2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion. 3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage. 4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant. 5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages. 6. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The federal Centers for Medicare & Medicaid Services (CMS) should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages. 7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons. 8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history. 9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs. 10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine

whether such an activity has the potential to worsen drug shortages. 11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding production locations of drugs and provide more detailed information regarding the causes and anticipated duration of drug shortages. 12. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes. 13. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities. 14. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan. (CSAPH Rep. 2, I-11; Modified: CSAPH Rep. 7, A-12; Modified: CSAPH Rep. 2, I-12; Modified: CSAPH Rep. 8, A-13; Modified in lieu of Res. 912, I-13; Modified: CSAPH Rep. 3, A-14; Modified: CSAPH Rep. 2, I-15; Appended: CSAPH Rep. 04, I-17; Modified: CSAPH Rep. 02, A-18)

H-110.987 Pharmaceutical Costs

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients. 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of

10% or more each year or per course of treatment. 11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase. 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency. (CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18)

(8) RESOLUTION 107 - INVESTIGATE MEDICARE PART D – INSURANCE COMPANY UPCHARGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 107 be amended by addition and deletion to read as follows:

~~RESOLVED, That our American Medical Association investigate Medicare Part D rules which allow providers to keep up to 5% more than their actual cost of providing pharmacy prescription services while at the same time they are eligible to get paid by Centers for Medicare and Medicaid Services reinsurance rules for certain losses. (Directive to Take Action)~~

RESOLVED, That our AMA support a US Government Accountability Office (GAO) study of Medicare Part D plan risk assessment behaviors and strategies, and their impact on direct subsidy, reinsurance subsidy and risk corridor payments. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 107 be adopted as amended.

Resolution 107 asks that our AMA investigate Medicare Part D rules which allow providers to keep up to 5% more than their actual cost of providing pharmacy prescription services while at the same time they are eligible to get paid by Centers for Medicare and Medicaid Services reinsurance rules for certain losses.

Your Reference Committee heard mixed testimony on Resolution 107. A speaker raised concerns about whether the AMA would be the appropriate entity to conduct the investigation called for in Resolution 107. As such, your Reference Committee is offering an amendment to bring the study under the auspices of the US Government Accountability Office. Accordingly, your Reference Committee recommends that Resolution 107 be adopted as amended.

(9) RESOLUTION 113 - ENSURING ACCESS TO STATEWIDE COMMERCIAL HEALTH PLANS
RESOLUTION 114 - ENSURING ACCESS TO NATIONWIDE COMMERCIAL HEALTH PLANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolutions 113 and 114:

RESOLVED, That our AMA study the impacts of various approaches that offer a public option in addition to current sources of coverage, private or public, including but not limited to a Medicare buy-in; a public option offered on health insurance exchanges; and buying into either the Federal Employees Health Benefits Program or a state employee health plan (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm Policy H-165.838 addressing a public option, which states that insurance coverage options offered in a health insurance exchange be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians (Reaffirm HOD Policy).

Resolution 113 asks that our AMA study the concept of offering state employee health plans to every state resident, including exchange participants qualifying for federal subsidies, and report back to the House of Delegates this year; and advocate that State Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity.

Resolution 114 asks that our AMA advocate that Federal Employees Health Benefits Program health insurance plans should become available to everyone to purchase at actuarially appropriate premiums as well as be eligible for federal premium tax credits; and advocate that Federal Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity.

Your Reference Committee heard generally supportive testimony on Resolution 113, and calls for referral for Resolution 114. A member of Council on Medical Service welcomed referral of both resolutions for study, and suggested broadening the study to incorporate other approaches to a public option as outlined in the amendment offered by

the American College of Physicians (ACP) during discussion of Council on Medical Service Report 2. Your Reference Committee agrees, and believes that the impacts of the various options outlined in Resolutions 113 and 114, and outlined in the ACP amendment, must be assessed. Such a study can analyze the impacts of various public option proposals on coverage rates, affordability, health plan choice, the Medicare Trust Fund, and crowd-out from private to public coverage. Your Reference Committee believes that such a comprehensive study will be helpful in guiding future AMA policy development pertaining to health system reform. Accordingly, your Reference Committee recommends adoption of an alternate resolution in lieu of Resolutions 113 and 114.

H-165.838 Health System Reform Legislation
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials d. Investments and incentives for quality improvement and prevention and wellness initiatives e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care f. Implementation of medical liability reforms to reduce the cost of defensive medicine g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens 2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation. 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States. 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. <u>5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.</u> 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician. 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals. 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation: a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an

expenditure target and potential payment reductions under the Medicare physician payment system c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy. 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform. 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal. 12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform. 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18)

(10) RESOLUTION 115 - SAFETY OF DRUGS APPROVED
BY OTHER COUNTRIES
RESOLUTION 129 - THE BENEFITS OF IMPORTATION
OF INTERNATIONAL PHARMACEUTICAL
MEDICATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be <u>adopted in lieu of Resolutions 115 and 129</u>:

RESOLVED, That our AMA support the personal importation of prescription drugs only if:

a. patient safety can be assured;
b. product quality, authenticity and integrity can be assured;
c. prescription drug products are subject to reliable, "electronic" track and trace technology; and
d. prescription drug products are obtained directly from a licensed foreign pharmacy, located in a country that has statutory and/or regulatory standards for the approval and sale of prescription drugs that are comparable to the standards in the United States (New HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy D-100.983, which guides AMA advocacy with respect to the prescription drug importation by wholesalers and pharmacies (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm D-100.985, which states that our AMA will continue to actively oppose illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting (Reaffirm HOD Policy).

Resolution 115 asks that our AMA compare the results of our US Food and Drug Administration (FDA) and the European Medicines Agency (EMA) approval processes in terms of determining the safety and efficacy of pharmaceuticals using whatever data is available in order to determine whether the health of the citizens of the United States would be at risk if drugs approved by the EMA were imported and used as compared to the FDA; and estimate what the reduction in the cost of medications would be for our patients if they were allowed to import EMA certified medications for use in the United States and thereby increasing competition for some of our current expensive pharmaceuticals.

Resolution 129 asks that our AMA study the implications of prescription drug importation for personal use and wholesale prescription drug purchase across our southern and northern borders.

Your Reference Committee heard generally supportive testimony on the intent of Resolutions 115 and 129. A representative from the US Food and Drug Administration raised significant concerns with Resolution 115 pertaining to patient safety, drug quality and integrity, and innovation and drug development. A member of the Council on Legislation offered an amendment that would establish AMA policy on the personal importation of prescription drugs that would apply to potential legislation addressing importation from Canada, Mexico, European countries and other countries. The member of the Council on Legislation noted that existing Policy D-100.983 blanketly addresses importation by wholesalers and pharmacies. The Council on Medical Service strongly supported the COL amendment. Your Reference Committee agrees that the COL amendment builds off of existing AMA policy with respect to prescription drug

importation, and ensures that our policy is able to be used to evaluate state and federal proposals on importation as they are introduced, regardless of countries included in the proposals. Accordingly, your Reference Committee recommends adoption of an alternate resolution in lieu of Resolutions 115 and 129.

D-100.983 Prescription Drug Importation and Patient Safety
Our AMA will:(1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if: (a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations; (b) the drug distribution chain is "closed," and all drug products are subject to reliable, "electronic" track and trace technology; and (c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported; (2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured; (3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS) Task Force on Drug Importation and, as appropriate, revise its position on whether or how patient safety can be assured under legalized drug importation; (4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts; (5) support the in-person purchase and importation of Health Canada-approved prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity; and (6) advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured. (BOT Rep. 3, I-04; Reaffirmation A-09; Reaffirmed in lieu of: Res. 817, I-16; Appended: CMS Rep. 01, I-18)

D-100.985 Federal Regulation and Computerized Tracking of Pharmaceuticals During Shipping and Handling from Manufacture Until Ultimately Received by Patient
Our AMA will: (1) continue to actively oppose illegal drug diversion, illegal Internet sales of drugs, illegal importation of drugs, and drug counterfeiting; and (2) work with the Congress, the Food and Drug Administration, the Drug Enforcement Administration, and other federal agencies, the pharmaceutical industry, and other stakeholders to ensure that these illegal activities are minimized. (Res. 501, A-04; Reaffirmation I-06; Reaffirmed: BOT Rep. 06, A-16; Reaffirmed: CMS Rep. 01, I-18)

(11) RESOLUTION 117 - SUPPORT FOR MEDICARE DISABILITY COVERAGE OF CONTRACEPTION FOR NON-CONTRACEPTIVE USE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 117 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and other stakeholders to include coverage for all US Food and Drug Administration-approved ~~contraception~~ contraceptive methods for contraceptive and non-contraceptive use for all patients covered by Medicare, regardless of eligibility pathway (age or disability). (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 117 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 117 be changed to read as follows:

SUPPORT FOR MEDICARE COVERAGE OF CONTRACEPTIVE METHODS

Resolution 117 asks that our AMA work with the Centers for Medicare and Medicaid Services and other stakeholders to include coverage for all US Food and Drug Administration-approved contraception for non-contraceptive use for patients covered by Medicare.

Your Reference Committee heard generally supportive testimony on Resolution 117. A member of the Council on Medical Service testified that AMA policy already addresses the intent of Resolution 117. Several speakers testified in support of Resolution 117, emphasizing the importance of AMA action on this issue. An amendment was offered to broaden the scope of Resolution 117. Your Reference Committee accepts the amendment and recommends Resolution 117 be adopted as amended.

(12) RESOLUTION 119 - RETURNING LIQUID OXYGEN TO FEE SCHEDULE PAYMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 119 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association support policy to remove liquid oxygen from the competitive bidding system and return payments for liquid oxygen to a Medicare fee schedule basis. (New HOD Policy)~~; and be it further~~

~~RESOLVED, That our AMA convey its patient quality and access concerns for Medicare beneficiaries obtaining insurance coverage for liquid oxygen in comments to the Centers for Medicare and Medicaid Services, including the forthcoming proposed rule, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) for Calendar Year 2020. (Directive to Take Action)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 119 be adopted as amended.

Resolution 119 asks that our AMA support policy to remove liquid oxygen from the competitive bidding system and return payments for liquid oxygen to a Medicare fee schedule basis; and convey its patient quality and access concerns for Medicare beneficiaries obtaining insurance coverage for liquid oxygen in comments to the Centers for Medicare and Medicaid Services (CMS), including the forthcoming proposed rule, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) for Calendar Year 2020.

Testimony on Resolution 119 was supportive. The sponsor of Resolution 119 testified, emphasizing the importance of returning liquid oxygen to a Fee For Service schedule. Consistent with this testimony, your Reference Committee suggests an amendment to delete reference to specific advocacy efforts to allow the AMA to advocate for any avenues as appropriate. Accordingly, your Reference Committee recommends that Resolution 119 be adopted as amended.

(13) RESOLUTION 122 - REIMBURSEMENT FOR TELEMEDICINE VISITS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 122 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with third-party payers, ~~and~~ the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement ~~for both synchronous and asynchronous telemedicine services~~ for telehealth to ensure ~~encourage~~ increased access and use of these services by patients and physicians.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 122 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 122 be changed to read as follows:

REIMBURSEMENT FOR TELEHEALTH

Resolution 122 asks that our AMA work with third-party payers and the Centers for Medicare and Medicaid Services at the national level to provide reimbursement for both synchronous and asynchronous telemedicine services to encourage increased access and use of these services by patients and physicians.

Your Reference Committee heard highly supportive testimony on Resolution 122. A member of the Council on Legislation testified that while the AMA has overarching policy guiding the coverage for and payment of telemedicine adopted by the House in 2014, the AMA does need to advocate that commercial payers provide payment parity for physicians who offer in-person and virtual services. The member of the Council on Legislation also noted that the impediment to synchronous telehealth is not the Centers for Medicare and Medicaid Services – it is the Social Security Act. As such, the Council member offered an amendment to include Congress and state medical associations, as well as use the term “telehealth” to be all-encompassing of synchronous and asynchronous telemedicine as well as digital health services, and remove confusion in the terms used.

(14) RESOLUTION 124 - INCREASED AFFORDABILITY AND ACCESS TO HEARING AIDS AND RELATED CARE
RESOLUTION 120 - MEDICARE COVERAGE OF HEARING AIDS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 124 be amended by deletion to read as follows:

RESOLVED, That our AMA support the availability of over-the-counter hearing aids for the treatment of ~~age-related~~ mild-to-moderate hearing loss. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 124 be adopted as amended in lieu of Resolution 120.

Resolution 120 asks that our AMA urge Medicare to cover some or all of the costs of a "reasonable" device for both ears if a patient has had an audiological exam that identifies the need, and for Medicare to identify a vendor, or vendors, of hearing devices that produce a quality product without an exorbitant retail price.

Resolution 124 asks that our AMA support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly; encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss.

Testimony on Resolution 124 was supportive, and testimony on Resolution 120 was mixed. A member of the Council on Medical Service testified in support of adopting Resolution 124 in lieu of Resolution 120, explaining that the Council recently issued a report on hearing aid coverage that specifically addressed the intent of Resolution 120 and is consistent with the intent of Resolution 124. The member from the Council on Medical Service explained that in their report, the Council explicitly considered and decided not to recommend that the AMA support Medicare coverage of hearing aids. Other speakers testified that Resolution 124 offers a novel approach to the issue highlighted by both Resolutions 120 and 124.

Your Reference Committee believes that Resolution 124 is consistent with existing AMA policy regarding improving coverage of and access to hearing aids, and suggests an amendment to broaden the impact of Resolution 124. Moreover, your Reference Committee believes that Resolution 124 accomplishes the purpose of Resolution 120. Accordingly, your Reference Committee recommends that Resolution 124 be adopted as amended, and that amended Resolution 124 be adopted in lieu of Resolution 120.

(15) RESOLUTION 126 - ENSURING PRESCRIPTION DRUG PRICE TRANSPARENCY FROM RETAIL PHARMACIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 126 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association amend policy H-110.991, "Price of Medicine," by addition and deletion as follows:

Our AMA: (~~1) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard; (1)~~ advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency ~~and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication~~; and (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale. (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 126 be adopted as amended.

Resolution 126 asks that our AMA amend Policy H-110.991 as follows: Our AMA: (1) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard; ~~(1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications;~~(2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency ~~and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication~~; and (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale.

Your Reference Committee heard highly supportive testimony on Resolution 126. An amendment was offered to reinstate language that our AMA will disseminate model state legislation to prohibit "clawbacks." Your Reference Committee accepts the amendment. Your Reference Committee also is offering an amendment to retain the original first clause of Policy H-110.991, while also accepting the new language proffered in Resolution 126. Accordingly, your Reference Committee recommends that Resolution 126 be adopted as amended.

(16) RESOLUTION 131 - UPDATE PRACTICE EXPENSE COMPONENT OF RELATIVE VALUE UNITS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that that Resolution 131 be referred for decision.

Resolution 131 asks that our AMA pursue efforts to update resource-based relative value unit practice expense methodology so it accurately reflects current physician practice costs, with a report back at the AMA House of Delegates 2019 Interim Meeting.

Your Reference Committee heard mixed testimony on Resolution 131. A member of the Council on Medical Service recommended reaffirmation of existing Policy D-330.902 in lieu of the resolution. This policy directive specifically calls for our AMA to "urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and

that this survey collect data to ensure that all physician practice costs are captured." Further, the policy calls for our AMA to "collect data and conduct research to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery." The CMS attested that this study is currently underway.

The authors provided ardent testimony that the AMA should conduct a new study of current physician practice costs for its members, since hospitals do so annually and have seen increases in payments. Further, physicians have borne the entire burden of budget neutrality while all stakeholders should be accountable. Compelling testimony was provided by the AMA's representative to the RVS Update Committee (RUC) which acknowledged the inequitableness in a conversion factor that is not increasing while costs are, but explained that a new survey would only lead to redistribution of funds within the payment schedule. As the Medicare physician payment schedule is a budget neutral system, a survey to update the practice expense relative values would lead only to redistribution and not to an overall increase in physician payment.

Your Reference Committee acknowledges the importance and complexity of this issue. Moreover, the $5 million fiscal note deserves consideration by the AMA Board of Trustees. For these reasons, your Reference Committee recommends that Resolution 131 be referred for decision.

(17) RESOLUTION 101 - HEALTH HAZARDS OF HIGH DEDUCTIBLE INSURANCE
RESOLUTION 125 - MITIGATING THE NEGATIVE EFFECTS OF HIGH-DEDUCTIBLE HEALTH PLANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Policies H-165.846, D-185.979 and H-165.828 be reaffirmed in lieu of Resolutions 101 and 125.

Resolution 101 asks that our AMA support health insurance deductibles of not more than $1,000 for an individual per year, especially to patients with significant chronic disease. Resolution 125 asks that our AMA advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments.

Resolution 125 asks that our AMA advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments.

Your Reference Committee heard mixed testimony on Resolutions 101 and 125. Testimony stressed that high deductibles and cost-sharing requirements can serve as barriers to patients accessing the care they need. A member of the Council on Medical Service testified that the approaches put forward in Resolutions 101 and 125 would have the unintended consequence of increasing premiums, potentially making health insurance coverage unaffordable for many. Furthermore, the Council member stated that both resolutions would severely limit patient choice of health plan, and Resolution 101 in

particular would hamper patient use of health savings accounts. Your Reference Committee notes that, in addition, Resolution 125 could cause cost-sharing requirements for benefits not included in the resolution to increase, in order to maintain a plan's actuarial value (the percentage of total average costs for covered benefits that a plan will cover).

The Council member continued that existing policy addresses the spirit of Resolutions 101 and 125. In addition, the recommendations of Council on Medical Service Report 2 being considered at this meeting also call for more people to be eligible for cost-sharing reductions for ACA exchange coverage, and for such reductions to be more generous in size. Policy H-165.846 states that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. Policy D-185.979 supports innovations that expand access to affordable care, including changes needed to allow high-deductible health plans paired with health savings accounts to provide pre-deductible coverage for preventive and chronic care management services. In addition, for low-income individuals who qualify for cost-sharing reductions who instead enroll in a bronze plan with higher out-of-pocket costs, Policy H-165.828 encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account partially funded by an amount determined to be equivalent to the cost-sharing subsidy. This change would help affected individuals meet the deductibles and other cost-sharing obligations of their bronze plan.

Your Reference Committee agrees that existing policy addresses the intent of Resolutions 101 and 125. As such, your Reference Committee recommends the reaffirmation of Policies H-165.846, D-185.979 and H-165.828 in lieu of Resolutions 101 and 125.

> H-165.828 Health Insurance Affordability
> 1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA). 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage. 3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy. 4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible. 5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. 6. Our AMA supports

efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges. 7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA. (CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17)

H-165.846 Adequacy of Health Insurance Coverage Options
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options: A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose. B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services. 2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children. 3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. (CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17)

D-185.979 Aligning Clinical and Financial Incentives for High-Value Care
1. Our AMA supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of “clinical nuance,” recognizing that (a) medical services may differ in the amount of health produced, and (b) the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided. 2. Our AMA supports initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics. 3. Our AMA will develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels. 4. Our AMA will

develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient. 5. Our AMA will continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients. 6. Our AMA will continue to support implementing innovative VBID programs in Medicare Advantage plans. 7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive services; and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services. 8. Our AMA encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. (Joint CMS CSAPH Rep. 01, I-18)

(18) RESOLUTION 109 - PART A MEDICARE PAYMENT TO PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-390.969 and D-330.902 be reaffirmed in lieu of Resolution 109.

Resolution 109 asks that our AMA work for enactment of legislation to direct cash payments from Part A Medicare to physicians in direct proportion to demonstrated savings that are made in Part A Medicare through the efforts of physicians.

Your Reference Committee heard testimony in favor of reaffirmation of Resolution 109. Significant testimony from the Council on Medical Service highlighted that existing policy addresses the intent of the resolution. The Council's report from the last meeting (D-330.902) recommended a study to document the role that physicians have played in reducing Medicare spending, as noted in the third Whereas clause, and existing policy on parity in Medicare reimbursement directly aligns with the Resolved clause. The authors expressed that existing policy should be made a top priority of the Association. Your Reference Committee empathizes but agrees that existing policy is sufficient for supporting continued AMA efforts in this important area. As such, your Reference Committee recommends that Policies D-390.969 and D-330.902 be reaffirmed in lieu of Resolution 109.

D-390.969 Parity in Medicare Reimbursement
Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the reductions in Medicare payment for imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005; (2) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications,

shorter lengths-of-stays, and fewer hospital readmissions; and (3) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing. (Referred for decision Res. 236, A-06; Reaffirmation I-08; Modified: BOT Rep. 09, A-18; Reaffirmed in lieu of: Res. 823, I-18)

D-330.902 The Site-of-Service Differential
1. Our AMA supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. 2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. 3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. 4. Our AMA encourages CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. 5. Our AMA will collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery. (CMS Rep. 04, I-18)

(19) RESOLUTION 111 - PRACTICE OVERHEAD EXPENSE AND THE SITE-OF-SERVICE DIFFERENTIAL
RESOLUTION 132 (LATE RESOLUTION 1003) - SITE OF SERVICE DIFFERENTIAL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-330.902, D-390.969, H-240.993 and H-400.957 be reaffirmed in lieu of Resolution 111 and Late Resolution 1003.

Resolution 111 asks that our AMA appeal to the US Congress for legislation to direct the Centers for Medicare and Medicaid Services (CMS) to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office; appeal to the US Congress for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense; and appeal to the US Congress for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.

Resolution 132 (Late Resolution 1003) asks that our American Medical Association advocate for site of service payment equalization to be calculated in a manner that both enhances physician reimbursement while maintaining hospital rates for physician services at an objectively justifiable level, including but not limited to the filing of amicus briefs in relevant lawsuits as determined appropriate by the Office of General Counsel.

Your Reference Committee heard mixed testimony on Resolution 111 and Resolution 132 which spoke to the historical inequality between payments for Medicare part A and part B. The majority of testimony favored reaffirmation of existing policies, in particular D-330.992 from CMS Report 4-I-18 "The Site-of-Service Differential." The third resolve clause for Resolution 111 uses language verbatim from this report. Testimony from the authors called for a serious legislative initiative and did not believe that the resolution was redundant. The AMA's representative to the RVS Update Committee (RUC) provided testimony stating that the AMA is already working with the Centers for Medicaid and Medicare Services (CMS) and that the best course of action is reaffirmation. Further, regarding the second resolve of Resolution 111, the CPT recently revised the E/M office visits and the RUC made recommendations to CMS that would be applied across the entire Medicare payment schedule, if adopted. In addition, the AMA submitted an OPPS/ASC comment letter last year which states that savings should be reinvested back into the physician fee schedule but did not specifically point to E/M payments. Regarding Resolution 132, your Reference Committee concurs that current policy is supportive of AMA action in this area including the filing of amicus briefs. For these reasons, your Reference Committee recommends that Policies D-330.902, D-390.969, H-240.993 and H-400.957 be reaffirmed in lieu of Resolution 111 and Resolution 132.

D-330.902 The Site-of-Service Differential
1. Our AMA supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments. 2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. 3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured. 4. Our AMA encourages CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care. 5. Our AMA will collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery. (CMS Rep. 04, I-18)

D-390.969 Parity in Medicare Reimbursement
Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the reductions in Medicare payment for imaging services furnished in physicians'

offices, as mandated by the Deficit Reduction Act of 2005; (2) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (3) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gainsharing. (Referred for decision Res. 236, A-06 Reaffirmation I-08 Modified: BOT Rep. 09, A-18 Reaffirmed in lieu of: Res. 823, I-18)

H-240.993 Discontinuance of Federal Funding for Ambulatory Care Centers
The AMA strongly urges more aggressive implementation by HHS of existing provisions in federal legislation calling for equity of reimbursement between services provided by hospitals on an outpatient basis and similar services in physicians' offices. (CMS Rep. B, A-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmation I-98 Reaffirmation I-03 Reaffirmation I-07 Reaffirmed: CMS Rep. 3, A-13 Reaffirmation A-15 Reaffirmed: CMS Rep. 04, I-18)

H-400.957 Medicare Reimbursement of Office-Based Procedures
Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery. (Sub. Res. 103, I-93 Reaffirmed by Rules & Credentials Cmt., A-96 Reaffirmation A-04 Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmed: CMS Rep. 3, A-14 Reaffirmed in lieu of Res. 216, I-14 Reaffirmed: CMS Rep. 04, I-18)

(20) RESOLUTION 112 - HEALTH CARE FEE TRANSPARENCY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that <u>Policies H-105.988, D-155.987 and H-373.998 be reaffirmed in lieu of Resolution 112</u>.

Resolution 112 asks that our AMA advocate for federal legislation and/or regulation to require disclosure of hospital prices negotiated with insurance companies in effort to achieve third-party contract transparency; and advocate for federal legislation and/or regulation to require pharmaceutical companies to disclose drug prices in their television (TV) ads in order to provide consumers more choice and control over their healthcare.

There was mixed testimony on Resolution 112. In the introduction of the resolution, the sponsor of Resolution 112 stated that the second resolve of the resolution is indeed a reaffirmation of already existing policy. Further, members of the Council on Medical Service and Council on Legislation called for reaffirmation of existing policy in lieu of Resolution 112 in its entirety. The member of the Council on Medical Service stated that

existing policy enables the AMA to advocate in response to the provisions of the 21st Century Cures Act (Cures Act) highlighted by the sponsor of Resolution 112.

In addition, the member of the Council on Legislation underscored that the AMA has engaged in advocacy efforts directly addressing the intent of Resolution 112. For example, the AMA submitted a letter to select U.S. Senators, which provided feedback on Congressional efforts to increase health care price and information transparency to empower patients, improve the quality of health care, and lower health care costs. Furthermore, the AMA submitted a letter to CMS Administrator Seema Verma in response to the proposed rule requiring the disclosure of prescription drug list prices in direct-to-consumer advertisements on television.

Your Reference Committee believes that Resolution 112 is already addressed by existing AMA policy and ongoing advocacy efforts. As such, your Reference Committee recommends that Policies H-105.988, D-155.987 and H-373.998 be reaffirmed in lieu of Resolution 112.

> H-105.988 Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices
> 1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices. 2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines: (a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used. (b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing. (c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products. (d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended. (e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable. (f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient. (g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative

management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition. (h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed. (i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement. (j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved. (k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines. 3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product. 4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA. 5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it. 6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA. 7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public. 8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine. 9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion. 10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States

to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution. 11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes. 12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary. 13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA). 14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs. BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07; BOT Action in response to referred for decision: Res. 927, I-15; Modified: BOT Rep. 09, I-16; Appended: Res. 236, A-17; Reaffirmed in lieu of: Res. 223, A-17)

D-155.987 Price Transparency
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible. 2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs. 3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide. 4. Our AMA will work with states to support and strengthen the development of all-payer claims databases. 5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients. 6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving. 7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments. (CMS Rep. 4, A-15; Reaffirmed in lieu of:

Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18)

H-373.998 Patient Information and Choice
Our AMA supports the following principles: 1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system. 2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system. 3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit. 4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs. 5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice. 6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront. BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107, I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; BOT Rep. 36 - I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 4,

A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, A-15; Reaffirmation: A-17; Reaffirmed: Res. 108, A-17)

(21) RESOLUTION 123 - STANDARDIZING COVERAGE OF APPLIED BEHAVIORAL ANALYSIS THERAPY FOR PERSONS WITH AUTISM SPECTRUM DISORDER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-90.968 and H-185.963 be reaffirmed in lieu of Resolution 123.

Resolution 123 asks that our AMA support the coverage and reimbursement for Applied Behavioral Analysis for the purpose of treating Autism Spectrum Disorder.

Your Reference Committee heard mixed testimony on Resolution 123. A member of the Council on Medical Service testified that existing policy addresses the intent of Resolution 123 by seeking public and private insurance coverage that reflects the true cost of health care for individuals with intellectual and developmental disabilities. In addition, the member of the Council on Medical Service testified that the AMA has engaged in advocacy efforts to advance access to care for individuals with developmental disabilities, such as autism. Finally, the Council member explained that AMA policy generally avoids mandating coverage of specific benefits, both to better allow markets to determine benefit packages and to avoid jeopardizing current coverage. Other testimony supported Resolution 123, specifically because it is seeking mandated coverage for a specific treatment.

Your Reference Committee believes that existing policy addresses the intent of Resolution 123. Accordingly, your Reference Committee recommends that Policies H-90.968 and H-185.963 be reaffirmed in lieu of Resolution 123.

H-90.968 Medical Care of Persons with Developmental Disabilities
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple comorbid medical conditions in any setting; (f) medical schools and graduate medical education programs to

establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities. 2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals. 3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them. 4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities. 5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community. 6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities. 7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities. 8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities. 9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities. 10. Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.

H-185.963 Insurance Coverage for Adults with Childhood Diseases
Our AMA: (1) urges public and private third party payers to increase access to health insurance products for adults with congenital and/or childhood diseases that are designed for the unique needs of this population; and
(2) emphasizes that any health insurance product designed for adults with congenital and/or childhood diseases include the availability of specialized treatment options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of an adequate number of physicians specializing in the care of this unique population. (CMS Rep. 2, I-99 Modified and Reaffirmed: CMS Rep. 5, A-09)

(22) RESOLUTION 127 - ELIMINATING THE CMS OBSERVATION STATUS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-160.932, D-280.988, D-280.989, and H-185.941.be reaffirmed in lieu of Resolution 127.

Resolution 127 asks that our AMA request, for the benefit of our patients' financial, physical and mental health, that the Centers for Medicare and Medicaid Services (CMS) terminate the "48 hour observation period" and observation status in total.

Your Reference Committee heard mixed testimony on Resolution 127. A member of the Council on Medical Service testified that AMA policy addresses the intent of Resolution 127 and that the AMA has already taken the advocacy action sought by Resolution 127. The member of the Council on Medical Service also noted that the Council presented a report in 2014 on the Place-of-Service Code for Observation Services that resulted in the reaffirmation and adoption of policy that speaks to the resolution's request. In addition, a member of the Council on Legislation called for reaffirmation, noting that the AMA has already engaged in advocacy efforts that address the intent of Resolution 127. Specifically, the AMA has written to CMS advocating repeal of the "two-midnight" policy several times, including in 2018, 2017, and 2014. Other testimony consistently requested action on this issue.

Your Reference Committee agrees that existing policy addresses the intent of Resolution 127, and supports advocacy efforts to achieve the resolution's objective. The policies recommended for reaffirmation include three directives to take action, and the AMA has, in fact, undertaken significant advocacy action on this issue. As alluded to in testimony by the member of the Council on Legislation, the AMA has repeatedly, over many years, asked CMS resolve this problem. Key advocacy includes:

- In a June 2014 comment letter, the AMA stated, "The AMA has written to CMS numerous times to communicate our serious concerns with CMS' two midnight policy and the rise of observation care, and most recently submitted testimony on this issue before the House Committee on Ways & Means . . . The AMA opposes Medicare's two-midnight policy and believes it should be rescinded in its entirety. Adding to the complexity of the two-midnight policy is the inconsistency between when a hospital stay is considered to be inpatient for purposes of

hospital reimbursement versus when a patient is considered an inpatient for purposes of coverage . . . This policy is having very real and negative impact on patient safety. Emergency physicians are reporting patients coming to the emergency department often ask whether they are being admitted as inpatients. If these patients are not given assurances that they will be treated as an inpatient, they leave—even when they clearly require medical attention."

- In a June 2017 comment letter, the AMA stated, "The '2-Midnight' rule has had significant unintended negative consequences that burden Medicare beneficiaries. It remains an artificial construct reflecting a flawed approach that gets in the way of the physician-patient relationship and unnecessarily increases the administrative burden of admitting physicians. . . CMS should rescind the 2-midnight rule in favor of clinical judgement for determining a patient's inpatient/observation status."
- The AMA restated its June 2017 comments in a November 2018 comment letter.

In recognition of existing policy calling for action on this issue and the AMA's longstanding, ongoing zealous advocacy, your Reference Committee believes that an additional directive to take action is unnecessary and would not help the AMA achieve this advocacy goal. Accordingly, your Reference Committee recommends that Policies D-160.932, D-280.988, D-280.989, and H-185.941 be reaffirmed in lieu of Resolution 127.

D-160.932 Medicare's Two-Midnight Rule
Our AMA will petition the Centers for Medicare & Medicaid Services to repeal the August 19 rules regarding Hospital Inpatient Admission Order and Certification. (Res. 223, I-13 Reaffirmed: CMS Rep. 4, A-14 Reaffirmation A-14)

D-280.988 Observation Status and Medicare Part A Qualification
Our AMA will advocate for Medicare Part A coverage for a patient's direct admission to a skilled facility if directed by their physician and if the patient's condition meets skilled nursing criteria. (Res. 117, A-13 Reaffirmed: CMS Rep. 4, A-14 Reaffirmation A-15)

D-280.989 Inclusion of Observation Status in Mandatory Three Day Inpatient Stay
1. Our AMA will continue to monitor problems with patient readmissions to hospitals and skilled nursing facilities and recoding of inpatient admissions as observation care and advocate for appropriate regulatory and legislative action to address these problems. 2. Our AMA will continue to advocate that the Centers for Medicare & Medicaid Services explore payment solutions to reduce the inappropriate use of hospital observation status. (BOT Rep. 32, A-09 Appended: CMS Rep. 4, A-14)

H-185.941 Patient Cost-Sharing Requirements for Hospital Inpatient and Observation Services
Our AMA will advocate that patients be subject to the same cost-sharing requirements whether they are admitted to a hospital as an inpatient, or for observation services. (Res. 117, A-12 Reaffirmed: CMS Rep. 4, A-14)

Madam Speaker, this concludes the report of Reference Committee A. I would like to thank William Davison, MD, Gregory Fuller, MD, Russell Libby, MD, Loralie Ma, MD, Kevin Nohner, MD, Laura Shea, MD, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, Julie Marder JD, and Rebecca Gierhahn, MS.

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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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Chris Pittman, MD
American Vein and Lymphatic Society

Stephen Rockower, MD
Maryland

Charles Rothberg, MD
New York
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)

Report of Reference Committee C

Nicole D. Riddle, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 25 – All Payer Graduate Medical Education Funding
2. Council on Medical Education Report 1 – Council on Medical Education Sunset Review of 2009 House Policies
3. Council on Medical Education Report 2 – Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 316-A-18)
4. Resolution 321 – Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical Profession
5. Resolution 323 – Improving Access to Care in Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model
6. Resolution 324 - Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary Reimbursement

RECOMMENDED FOR ADOPTION AS AMENDED

7. Council on Medical Education Report 3 – Standardizing the Residency Match System and Timeline (CME Report 6-A-17)
8. Council on Medical Education Report 4 – Augmented Intelligence in Medical Education (Resolution 317-A-18)
9. Council on Medical Education Report 6 – Study of Medical Student, Resident, and Physician Suicide (Resolution 959-I-18)
   Resolution 307 – Mental Health Services for Medical Students
   Resolution 310 – Mental Health Care for Medical Students
10. Council on Medical Education/Council on Science and Public Health Report 01 – Protecting Medical Trainees from Hazardous Exposure (Resolution 301-A-18)
11. Resolution 302 – The Climate Change Lecture for US Medical Schools
12. Resolution 303 – Graduate Medical Education and the Corporate Practice of Medicine
13. Resolution 304 – Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs
14. Resolution 313 – Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows
15. Resolution 314 – Evaluation of Changes to Residency and Fellowship Application and Matching Processes
16. Resolution 315 – Scholarly Activity by Resident and Fellow Physicians
17. Resolution 316 – Medical Student Debt
18. Resolution 317 – A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
19. Resolution 318 – Rural Health Physician Workforce Disparities

20. Resolution 319 – Adding Pipeline Program Participation Questions to Medical School Applications
21. Resolution 322 – Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools

RECOMMENDED FOR REFERRAL

22. Resolution 308 – Maintenance of Certification Moratorium
23. Resolution 311 – Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure

RECOMMENDED FOR NOT ADOPTION

24. Resolution 301 – American Board of Medical Specialties Advertising
25. Resolution 312 – Unmatched Medical Graduates to Address the Shorgate of Primary Care Physicians

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

Resolution 305 – Lack of Support for Maintenance of Certification
Resolution 306 – Interest Rates and Medical Education
Resolution 309 – Promoting Addiction Medicine During a Time of Crisis
Resolution 320 – Opioid Education in Medical Schools

(1) BOARD OF TRUSTEES REPORT 25 – ALL PAYER GRADUATE MEDICAL EDUCATION FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 25 be adopted and the remainder of the report be filed.

Board of Trustees Report 25 recommends: 1. That our AMA amend Policy D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," with the addition of a new clause to read as follows, and that the remainder of the report be filed: Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs. 2. That our AMA rescind section 33 of Policy D-305.967, which directed the AMA to conduct the study herein.

Your Reference Committee heard testimony uniformly in favor of the Board of Trustees report, which seeks to encourage government funders to identify and collect the data needed to evaluate how institutions with residency programs are utilizing government financial resources to meet the nation's health care workforce needs. This is viewed as critical information to determine the true cost of residency programs and ensure sufficient funding for residency education. Therefore, your Reference Committee recommends that Board of Trustees Report 25 be adopted.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 1 – COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2009 HOUSE POLICIES

RECOMMENDATION:

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

Council on Medical Education Report 1 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 limited testimony in favor of the report. Therefore, your Reference Committee recommends that Council on Medical Education Report 1 be adopted.

(3) COUNCIL ON MEDICAL EDUCATION REPORT 2 – UPDATE ON MAINTENANCE OF CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION (RESOLUTION 316-A-18)

RECOMMENDATION:

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

Council on Medical Education Report 2 asks: 1. That our American Medical Association (AMA), through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification. 2. That our AMA, to be consistent with terminology now used by the American Board of Medical Specialties, amend the following policies by addition and deletion to read as follows: Policy H-275.924, Amend the title to read, "~~Maintenance of~~ Continuing Board Certification" (AMA Principles on ~~Maintenance of~~ Continuing Board Certification), and replace the terms "Maintenance of Certification" and "MOC" with "Continuing Board Certification" and "CBC" throughout the policy, as shown in Appendix H. Policy D-275.954, Amend the title to read, "~~Maintenance of Certification and Osteopathic Continuous Certification~~Continuing Board Certification," and replace the terms "Maintenance of Certification" and "MOC" with "Continuing Board Certification" and "CBC" throughout the policy, as shown in Appendix H. 3. That our AMA rescind Policy D-275.954 (37), "Maintenance of Certification and Osteopathic Continuous Certification," that asks the AMA to "Through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission," as this has been accomplished. 4. That our AMA rescind Policy D-275.954 (38), which asks our AMA to "Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards," as this has been accomplished. 5. That our AMA rescind Policy D-275.954 (39) "Maintenance of Certification and Osteopathic Continuous Certification," as this has been accomplished through this report.

Your Reference Committee heard testimony in support of the Council's comprehensive annual report to the HOD. During testimony, it was noted that the Council's efforts in working with the American Board of Medical Specialties (ABMS) and its member boards are improving the process for diplomates in many specialties by, for example, offering shorter, more frequent examinations as well as the high-stakes, point-in-time

examination to provide a pluralistic approach for all diplomates. The Council on Medical Education continues to be actively engaged in following the recommendations of "Continuing Board Certification: Vision for the Future Commission," which was established to modernize continuing board certification and engage physicians, the public, and key stakeholders in a collaborative process. The ABMS and ABMS member boards, in collaboration with professional organizations and other stakeholders, will prioritize these recommendations and develop the strategies and infrastructure to implement them. A summary of the Commission's recommendations is provided in Council on Medical Education Report 2. Therefore, your Reference Committee recommends that the report be adopted.

(4) RESOLUTION 321 – PHYSICIAN HEALTH PROGRAM ACCOUNTABILITY, CONSISTENCY, AND EXCELLENCE IN PROVISION OF SERVICE TO THE MEDICAL PROFESSION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 321 be adopted.

Resolution 321 asks: That our AMA amend policy D-405.990, "Educating Physicians About Physician Health Programs," by addition and deletion to read as follows: Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990 1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; ~~and~~ 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training; and 5) Our AMA will continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; 6) Our AMA will continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.

Your Reference Committee reviewed nearly unanimous online and in-person testimony in support of Resolution 321. Testimony noted that the Physician Health Program (PHP) model encourages physicians to proactively seek and receive the confidential health care services they need. The Federation of State Physician Health Programs, with the support of key stakeholder organizations, is developing a Performance Enhancement

and Effectiveness Review (PEER™) Program and a Provider Accreditation Program. The PEER program will create and manage an on-site review process of PHPs across the United States and Canada, validate current PHP practices, and identify areas that will benefit from improvements. During testimony it was noted that Resolution 321 is aligned with the AMA's Professional Satisfaction and Practice Sustainability strategic arc, and that the AMA is well positioned to prioritize advocacy efforts that have potential impact on the physician workforce and access to care. Therefore, your Reference Committee recommends that Resolution 321 be adopted.

(5) RESOLUTION 323 – IMPROVING ACCESS TO CARE IN MEDICALLY UNDERSERVED AREAS THROUGH PROJECT ECHO AND THE CHILD PSYCHIATRY ACCESS PROJECT MODEL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 323 be adopted.

Resolution 323 asks: 1. That our AMA promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; 2. That our AMA work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and 3. That our AMA monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

Your Reference Committee heard testimony uniformly in support of this resolution. Programs such as Project ECHO and the Child Psychiatry Access Project, which promote collaboration between academic health centers and community-based primary care physicians, have made significant impacts. Awareness of such programs should be promoted, and barriers to their broader implementation should be identified and addressed. In addition, payment for participation in these activities should be monitored. Therefore, your Reference Committee recommends that Resolution 323 be adopted.

(6) RESOLUTION 324 – RESIDENCY AND FELLOWSHIP PROGRAM DIRECTOR, ASSISTANT/ASSOCIATE PROGRAM DIRECTOR, AND CORE FACULTY PROTECTED TIME AND SALARY REIMBURSEMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 324 be adopted.

Resolution 324 asks: That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors. (Directive to Action)

Your Reference Committee heard strong support for Resolution 324. Testimony noted that this concept is important and that institutions should support faculty for their time spent teaching. It was also noted that other organizations, such as the American College of Physicians, have similar policy. Therefore, your Reference Committee recommends that Resolution 324 be adopted.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 3 – STANDARDIZING THE RESIDENCY MATCH SYSTEM AND TIMELINE (CME REPORT 6-A-17)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Education Report 3 be amended by addition, to read as follows:

4. That our AMA encourage the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to "couples matching," and to ensure that all applicants have access to robust, informative statistics to assist in decision-making. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 3 be amended by the addition of a fifth Recommendation, to read as follows:

5. That our AMA encourage the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully "couples match" with their significant others due to staggered entry into residency, utilization of

unlinked match services, or other causes. (Directive to Take Action)

RECOMMENDATION C:

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

Council on Medical Education Report 3 asks: 1. That our AMA encourage appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions; 2. That our AMA work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) to create local PGY-1 positions that will enable coordinated applications and interviews for medical students; 3. That our AMA encourage the NRMP to design a process that will allow competency-based student graduation and off-cycle entry into residency programs; and 4. That our AMA encourage the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

Your Reference Committee heard testimony applauding the work of the Council on Medical Education concerning this challenging topic, to help ensure a residency matching process that is student-centered and eases the burdens and stresses of this critical career transition. Particular attention, however, was directed towards the issue of "couples matching," and the need for continued data collection and analysis on this and related concerns, including the impact of separate matches on medical students lives and livelihoods. Accordingly, your Reference Committee proffers the amended language shown above, and recommends that Council on Medical Education Report 3 be adopted as amended.

(8) COUNCIL ON MEDICAL EDUCATION REPORT 4 – AUGMENTED INTELLIGENCE IN MEDICAL EDUCATION (RESOLUTION 317-A-18)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be amended by the addition of a new sixth Recommendation, to read as follows:

6. That our AMA encourage the study of how differences in institutional access to AI may impact disparities in

education for students at schools with fewer resources and less access to AI technologies. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be amended by the addition of a new eighth Recommendation, to read as follows:

8. That our AMA encourage the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be amended by the addition of a new eleventh Recommendation, to read as follows:

11. That our AMA encourage close collaboration with and oversight by practicing physicians in the development of AI applications. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 4 (with existing items 6, 7, and 8 of the Report renumbered as 7, 9, and 10) be adopted as amended and the remainder of the report be filed.

Council on Medical Education Report 4 asks: 1. That our AMA encourage accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards; 2. That our AMA encourage medical specialty societies and boards to consider production of specialty-specific educational modules related to AI; 3. That our AMA encourage research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes; 4. That our AMA encourage institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules; 5. That our AMA encourage stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems; 6. That our AMA encourage enhanced training across the continuum of medical education regarding

assessment, understanding, and application of data in the care of patients; 7. That our AMA encourage institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and 8. That Policy D-295.328, "Promoting Physician Lifelong Learning," be reaffirmed.

Your Reference Committee reviewed testimony uniformly in favor of Council on Medical Education Report 4. This report summarizes existing AMA policy related to AI, provides definitions of related terms, reviews current efforts related to AI in medical education, and provides additional policy to be incorporated by the AMA. While testimony was supportive of the report itself, testimony also called for additional policy related to AI and disparities as well as AI and clinician oversight of its development and implementation. Your Reference Committee agreed, and this testimony was incorporated into three additional recommendations. Therefore, your Reference Committee recommends that Council on Medical Education Report 4 be adopted as amended.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 6 – STUDY OF MEDICAL STUDENT, RESIDENT, AND PHYSICIAN SUICIDE (RESOLUTION 959-I-18)

RESOLUTION 307 – MENTAL HEALTH SERVICES FOR MEDICAL STUDENTS

RESOLUTION 310 – MENTAL HEALTH CARE FOR MEDICAL STUDENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 6 be <u>amended by addition</u>, to read as follows:

1. That our American Medical Association (AMA) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and <u>confidentially</u> maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Education Report 6 be <u>amended by addition and deletion</u>, to read as follows:

3. That our AMA supports the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free ~~behavioral~~ mental health and substance use disorder services. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Education Report 6 be amended by addition, to read as follows:

4. That our AMA collaborate with other stakeholders to study the incidence of and risk factors for depression and suicide among physicians, residents, and medical students. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 6 be adopted as amended in lieu of Resolutions 307 and 310 and the remainder of the report be filed.

Council on Medical Education Report 6 asks: 1. That our AMA explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; 2. That our AMA monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; 3. That our AMA supports the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free behavioral health services; 4. That our AMA collaborate with other stakeholders to study the incidence of suicide among physicians, residents, and medical students; and 5. That Policy D-345.984, “Study of Medical Student, Resident, and Physician Suicide,” be rescinded, as having been fulfilled by this report and through requests for action by the Liaison Committee on Medical Education and ACGME.

Resolution 307 asks: That our AMA recommend that the Association of American Medical Colleges strengthen their recommendations to all medical schools that medical schools provide confidential in-house mental health services at no cost to students, without billing health insurance, and that they set up programs to educate both students and staff about burnout, depression, and suicide.

Resolution 310 asks: 1. That our AMA encourage all medical schools to assign a mental health provider to every incoming medical student; 2. That our AMA encourage all medical schools to provide an easy way for medical students to select a different provider at any time; 3. That our AMA encourage all medical schools to require each student's mental health professional or related staff to contact the student once per semester to ask if the student would like to meet with their mental health professional, unless the student already has an appointment to do so or has asked not to be contacted with regards to mental health appointments; and 4. That our AMA encourage all medical schools to provide an easy process for students to initiate treatment with school mental health professionals at no cost to the student or professional from the mental health community at affordable cost to the student, and without undue bureaucratic burden.

Your Reference Committee reviewed unanimous online and in-person testimony in support of Council on Medical Education Report 6. Testimony noted that this report recognizes the serious matter of medical student, resident, and physician burnout, depression, and suicide, and notes increased rates compared to age and education matched peers in the general population. There was also support for the AMA's plans to conduct a pilot study to evaluate the reliability of the National Death Index as a tool for long-term study of medical student and physician suicide. In addition, it was noted that continued partnerships with organizations such as the ACGME and AAMC to support provider mental health benefits medical students, residents, physicians, and patients. There was also strong support for Resolution 307. However, it was felt that Recommendation 3 in CME Report 6 was very similar and consistent with the intent of Resolution 307. Testimony was also supportive of the intent of Resolution 310. However, the recommendations appeared to be prescriptive and created a potentially intrusive situation in the medical student's life unless the student asks not to be contacted. Furthermore, testimony noted that the recommendations in Resolution 310 were already covered in CME Report 6. Therefore, your Reference Committee recommends that Council on Medical Education Report 6 be adopted in lieu of Resolutions 307 and 310.

(10) COUNCIL ON MEDICAL EDUCATION / COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 – PROTECTING MEDICAL TRAINEES FROM HAZARDOUS EXPOSURE (RESOLUTION 301-A-18)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 of Council on Medical Education / Council on Science and Public Health Report 1 be <u>amended by addition,</u> to read as follows:

3. That our AMA recommend a) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and b) that medical school policies on continuity of

educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to minimize the risks of hazardous exposures that may affect ~~her~~ the trainee's and/or fetus' personal health status.

RECOMMENDATION B:

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

Council on Medical Education/Council on Science and Public Health Report 1 asks:
1. That our American Medical Association (AMA) amend Policy H-295.939, "OSHA Regulations for Students," by addition and deletion, to read as follows: H-295.939, "~~OSHA Regulations for Students~~ Protecting Medical Trainees from Hazardous Exposure" Our AMA will ~~The AMA, working in conjunction with its Medical School Section, to~~ encourage~~s~~ all health care-related educational institutions to apply the ~~existing~~ Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen ~~S~~standards and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows~~students~~. 2. That our AMA recommend that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site. 3. That our AMA recommend a) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and b) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a pregnant trainee wishes to minimize the risks of hazardous exposures that may affect her personal health status. 4. That our AMA recommend that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff. 5. That our AMA recommend that medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff.

Your Reference Committee reviewed testimony online and in-person in overwhelming support of the report. Therefore, your Reference Committee recommends that Council on Medical Education/Council on Science and Public Health Report 1 be amended and adopted with the addition as shown.

(11) RESOLUTION 302 – THE CLIMATE CHANGE LECTURE FOR US MEDICAL SCHOOLS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 302.

CLIMATE CHANGE EDUCATION ACROSS THE MEDICAL EDUCATION CONTINUUM

RESOLVED, That our American Medical Association (AMA) support teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change (Directive to Take Action); and be it further

RESOLVED, That our AMA make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education. (Directive to Take Action); and be it further

RESOLVED, That our AMA communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education (Directive to Take Action).

Resolution 302 asks: 1. That our AMA recommend that one hour of teaching on climate change, "The Climate Change Lecture," be required for all medical students before graduation with the M.D. or D.O. degree as a minimum standard, with more than one hour of teaching encouraged for medical schools that so choose; 2. That our AMA recommend that the goals of "The Climate Change Lecture" be for medical students upon graduation to have a basic knowledge of the science of climate change, to be able to describe the risks that climate change poses to human health, and be prepared to advise patients how to protect themselves from the health risks posed by climate change; 3. That our AMA recommend that medical schools be exempted from the requirement of "The Climate Change Lecture" that have already implemented pedagogy on this topic that amounts to an hour or more of required learning on climate change and health for medical students; 4. That our AMA prepare a prototype PowerPoint slide presentation and lecture notes for "The Climate Change Lecture," which could be used by medical schools, or schools may create their own lecture, video or online course to

fulfill the requirements of “The Climate Change Lecture”; 5. That our AMA write to the Commission on Osteopathic College Accreditation (COCA) which is the accrediting organization for schools offering the D.O. degree in the United States; to the Liaison Committee on Medical Education (LCME), which is the accrediting organization for schools offering the M.D. degree in the United States (including for the Uniformed Services University of the Health Sciences); and to the LCME representative from the AMA Medical Student Section, to recommend that “The Climate Change Lecture,” using AMA’s prototype PowerPoint presentation and notes, or other formats, become a requirement for all M.D. and D.O. degrees for United States medical schools beginning with 2021 graduates; and 6. That our AMA delegation to the World Medical Association present a similar resolution to the World Medical Association recommending the concept of the “The Climate Change Lecture” for medical schools worldwide.

Your Reference Committee heard significant testimony on this resolution. There was support for education on a topic as timely and important as climate change and its impacts on human health, but, as the AMA does not favor curricular mandates (because they are too prescriptive to allow for the autonomy of individual medical schools to innovate on such topics), the resolution was rewritten by the original authors. Testimony on this updated version was generally in support of its revisions, with a request to encompass the continuum of medical education. Your Reference Committee agrees and has incorporated graduate and continuing medical education into the rewritten resolution and changed the title to reflect its expanded scope. Therefore, your Reference Committee recommends that the alternate resolution be adopted in lieu of Resolution 302.

(12) RESOLUTION 303 – GRADUATE MEDICAL EDUCATION AND THE CORPORATE PRACTICE OF MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 303 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association recognize and support that the environment for education of residents and fellows must be free of the conflict of interest created between ~~corporate-owned lay entities'~~ a training site’s fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that second Resolve of Resolution 303 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~support~~ encourage ~~that~~ the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources. ~~require that graduate medical education programs must be established in compliance with all state laws, including prohibitions on the corporate practice of medicine, as a condition of accreditation~~. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 303 be amended by addition of a new third Resolve, to read as follows:

RESOLVED, That our AMA study issues, including waiver of due process requirements, created by corporate-owned lay entity control of graduate medical education sites. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 303 be adopted as amended.

Resolution 303 asks: 1. That our AMA recognize and support that the environment for education of residents and fellows must be free of the conflict of interest created between corporate-owned lay entities' fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; and 2. That our AMA support that the Accreditation Council for Graduate Medical Education require that graduate medical education programs must be established in compliance with all state laws, including prohibitions on the corporate practice of medicine, as a condition of accreditation.

Your Reference Committee heard testimony in favor of this item, particularly in light of the need for expanded graduate medical education slots to help meet the growing workforce demands of the nation. As a country of innovation and new ideas, the United States is a natural laboratory for the development of corporate-funded sponsorships in medical education. That said, the unintended consequences of a potentially pernicious influence in medical education and interference in training by corporate interests highlight the need for hypervigilance by the house of medicine. Ensuring high standards in education for our next generation of physicians was indeed one of the founding principles of the AMA in 1847. Towards this end, testimony was shared that this resolution was not worded strongly enough: For example, corporations that administer residency programs may require trainees to waive their contractual rights to due

process, which could lead to unfair termination. This issue requires continued attention and study. Accordingly, your Reference Committee proposes the language shown in the new third Resolve. In addition, we agree (as did the majority of testimony) with edits to the original item as proposed by the Council on Medical Education, to include all training sites where there is a fiduciary responsibility to shareholders. In addition, as the Council noted, the ACGME has an existing position statement on the relationship between GME and various funding sources, so your Reference Committee recommended this language be updated to include these newer programs with shareholder interests, and that Resolution 303 be adopted as amended.

(13) RESOLUTION 304 – TRACKING OUTCOMES AND SUPPORTING BEST PRACTICES OF HEALTH CARE CAREER PIPELINE PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 304 be amended by addition, to read as follows:

1. That our AMA support the publication of a white paper chronicling health care career pipeline programs (also known as pathway programs) across the nation aimed at increasing the number of programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes;

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 304 be adopted as amended.

Resolution 304 asks: 1. That our AMA support the publication of a white paper chronicling health care career pipeline programs across the nation aimed at increasing the number programs and promoting leadership development of underrepresented minority health care professionals in medicine and the biomedical sciences, with a focus on assisting such programs by identifying best practices and tracking participant outcomes; and 2. That our AMA work with various stakeholders, including medical and allied health professional societies, established biomedical science pipeline programs and other appropriate entities, to establish best practices for the sustainability and success of health care career pipeline programs.

Your Reference Committee reviewed online and in-person testimony in overwhelming support of this resolution. Testimony addressed the contribution that pipeline programs (also known as pathway programs) have made towards increasing diversity among

underrepresented groups in medicine such as women and racial and ethnic minorities. Therefore, your Reference Committee recommends that Resolution 304 be adopted as amended.

(14) RESOLUTION 313 – CLINICAL APPLICATIONS OF PATHOLOGY AND LABORATORY MEDICINE FOR MEDICAL STUDENTS, RESIDENTS AND FELLOWS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 313 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association study current ~~standards~~ practices within medical education regarding the clinical use of pathology and laboratory medicine information to identify potential gaps in training in the principles of decision making and the utilization of quantitative evidence. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 313 be adopted as amended.

Resolution 313 asks: That our AMA study current standards within medical education regarding pathology and laboratory medicine to identify potential gaps in training.

Your Reference Committee heard mixed testimony on this item, ranging from adoption to not adoption. The Council on Medical Education, for example, testified that this issue is undeniably important but is within the purview of the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education, rather than the AMA. Other testimony noted that inappropriate use and interpretation of laboratory and other diagnostic tests can lead to shortfalls in patient safety, harm to patients, and malpractice claims. The need for students and trainees to learn effective stewardship of health care resources was cited as well. This issue goes beyond those in the pathology field to encompass all physicians; indeed, as noted in testimony, approximately three of every four medical decisions derive from lab tests, and the dramatic increase in the number of tests underscore the need for at least minimal training in the medical education continuum and a better understanding of evidence-based medicine across the continuum. Your Reference Committee believes its proposed edits address these concerns and clarify some prior confusion on the resolution's intent, and therefore recommends adoption as amended.

(15) RESOLUTION 314 – EVALUATION OF CHANGES TO RESIDENCY AND FELLOWSHIP APPLICATION AND MATCHING PROCESSES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 314 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~support~~ oppose ~~proposed~~ changes to residency and fellowship application requirements ~~only when~~ unless (a) those changes have been evaluated by working groups which have students and residents as representatives; (b) there are data which demonstrate~~s~~ that the proposed application components contribute to an accurate representation of the candidate; (c) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of ~~implicit~~ bias that affects medical students and residents from underrepresented minority backgrounds; and (d) the costs to medical students and residents are mitigated (New HOD Policy): and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 314 be amended by deletion of the second Resolve, to read as follows:

~~RESOLVED, That our AMA oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met (New HOD Policy); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 314 be adopted as amended.

Resolution 314 asks: 1. That our AMA support proposed changes to residency and fellowship application requirements only when (a) those changes have been evaluated by working groups which have students and residents as representatives; (b) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate; (c) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of

implicit bias that affects medical students and residents from underrepresented minority backgrounds; and (d) the costs to medical students and residents are mitigated; 2. That our AMA oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met; and 3. That our AMA continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

Your Reference Committee heard testimony that the test implementation of the standardized video interview (SVI) in emergency medicine residency program applications has raised issues of its validity and lack of fairness to applicants, for example, from underrepresented minority populations or those who speak English as a second language. Medical students should not be subject to additional bias in an already stressful application process. Edits to the first Resolve was proffered, to incorporate the spirit of the second Resolve and remove the word "implicit," thereby expanding the scope of any bias to be addressed through the proposed policy. Finally, your Reference Committee believes that the second Resolve should be deleted and recommends that Resolution 314 be adopted as amended.

(16) RESOLUTION 315 – SCHOLARLY ACTIVITY BY RESIDENT AND FELLOW PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 315 be amended by addition and deletion of the first Resolve, to read as follows:

RESOLVED, That our American Medical Association a) define resident and fellow scholarly activity as any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, ~~national~~ leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity, and b) encourage partner organizations to utilize the inclusion of this definition to ensure that residents and fellows are able to fulfill scholarly activity requirements. (New HOD Policy~~); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that second Resolve of Resolution 315 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA work with partner organizations to ensure that residents and fellows are able to fulfill scholarly activity requirements with any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity. (Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 315 be adopted as amended.

Resolution 315 asks: 1. That our AMA define resident and fellow scholarly activity as any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity; and 2. That our AMA work with partner organizations to ensure that residents and fellows are able to fulfill scholarly activity requirements with any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity.

Your Reference Committee reviewed testimony online and in-person that was mixed but overwhelmingly supportive of this resolution. Testimony supported developing a broader definition of scholarly activity to allow for expansion of the scope of learning, while acknowledging the range of academic rigor involved in health policy analysis. It was also suggested to examine the intersection of scholarly activity and changes and improvement in medical education, as evidenced by the work of Accelerating Change in Medical Education consortium. The Reference Committee noted that Resolves one and two reiterated the same language; to make the item easier to comprehend, we have merged both Resolves into one to capture the essence and intent of this item. Therefore, your Reference Committee recommends that Resolution 315 be adopted as amended.

(17) RESOLUTION 316 – MEDICAL STUDENT DEBT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 316 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association formulate a task force to look at undergraduate medical education training as it relates to ~~specialty~~ career choice, and develop new polices and novel approaches to prevent debt from influencing ~~primary care~~ specialty and subspecialty choice. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 316 be adopted as amended.

Resolution 316 asks: That our AMA formulate a task force to look at undergraduate medical education training as it relates to specialty choice, and develop new polices and novel approaches to prevent debt from influencing primary care specialty choice.

Your Reference Committee heard significant testimony that was generally supportive of this resolution. Education debt continues to be a significant burden on medical students, residents, and physicians and influences all aspects of life. In response to testimony about how education debt impacts all fields, not just primary care, the resolution was amended. Therefore, your Reference Committee recommends that Resolution 316 be adopted as amended.

(18) RESOLUTION 317 – A STUDY TO EVALUATE BARRIERS TO MEDICAL EDUCATION FOR TRAINEES WITH DISABILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 317 be amended by addition of a new second Resolve, to read as follows:

RESOLVED, That our AMA work with relevant stakeholders to study available data on medical graduates with disabilities and challenges to employment after training. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 317 be adopted as amended.

Resolution 317 asks: That our AMA work with relevant stakeholders to study available data on medical trainees with disabilities and consider revision of technical standards for medical education programs.

Your Reference Committee reviewed strong online and in-person testimony in support of Resolution 317. During testimony it was noted that this request for a study aligns with the Americans with Disabilities Act of 1990 and existing AMA policy. In addition, there was strong support for a study that collects data on medical trainees with disabilities, enumerates the various obstacles the trainees face, describes how a variety of medical schools have overcome those obstacles (best practices), and reviews potential revision of technical standards for medical education. Testimony also recommended that the study include available data on medical graduates with disabilities and challenges to employment after training. Therefore, your Reference Committee recommends that Resolution 317 be adopted as amended.

(19) RESOLUTION 318 – RURAL HEALTH PHYSICIAN WORKFORCE DISPARITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 318 be amended by addition, to read as follows:

That our AMA undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 318 be adopted as amended.

Resolution 318 asks: That our AMA undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies to alleviate rural physician workforce shortages.

Your Reference Committee reviewed testimony online and in-person in overwhelming support of this issue. AMA has clear policy that looks toward correcting the methodology used by the Centers for Medicare & Medicaid Services (CMS) in determining payment rates, but much of the policy addresses Practice Expense (PE) differences in rent costs.

Lacking is the inclusion of the costs necessary for physician recruitment and retention and the effect of these costs on overall practice expense realities. This resolution looks to incorporate these data in a study to evaluate the overall effects that these trends produce, and the possibility that improvements in fee schedules may result, thus assisting in addressing physician shortages. Additionally, the Council on Medical Education has a report in progress related to this issue and will look to include material on this matter in that report. Testimony suggested the addition of "telemedicine and telehealth"; your Reference Committee would proposed use of the broader term "telehealth," in that telemedicine is encompassed within telehealth. Testimony also addressed the need to alleviate payment to rural physicians without negatively impacting payment to other regions. Therefore, your Reference Committee recommends that Resolution 318 be adopted as amended.

(20) RESOLUTION 319 – ADDING PIPELINE PROGRAM PARTICIPATION QUESTIONS TO MEDICAL SCHOOL APPLICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 319 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~collaborate~~ work with the Association of American Medical Colleges (AAMC) and other stakeholders ~~to coalesce the data~~ to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order ~~allow applicants to identify previous pipeline program participation~~ to determine the effectiveness of pipeline programs ~~those who are underrepresented in medicine in their decisions to pursue careers in medicine~~. (and be it further)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 319 be amended by deletion of the second Resolve, to read as follows:

~~RESOLVED, That our AMA develop a plan to analyze the data once this question is implemented with input from key stakeholders, including AAMC, the Accreditation Council for Graduate Medical Education, and interested medical societies and premed pipeline programs. (Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 319 be adopted as amended.

Resolution 319 asks: 1. That our AMA collaborate with the Association of American Medical Colleges (AAMC) and other stakeholders to coalesce the data to create a question for the AAMC electronic medical school application to allow applicants to identify previous pipeline program participation to determine the effectiveness of pipeline programs those who are underrepresented in medicine in their decisions to pursue careers in medicine; and 2. That our AMA develop a plan to analyze the data once this question is implemented with input from key stakeholders, including AAMC, the Accreditation Council for Graduate Medical Education, and interested medical societies and premed pipeline programs.

Your Reference Committee reviewed testimony online and in-person in overwhelming support of this resolution. Testimony requested the consideration of the use of pathway programs in addition to pipeline programs due to different uses of the term pipeline regionally. Additionally, testimony requested that the second resolve be struck completely because it presumptively depends on the availability of future data, which would be necessary in order to stand as an independent policy statement. Therefore, your Reference Committee recommends that Resolution 319 be adopted as amended.

(21) RESOLUTION 322 – SUPPORT FOR THE STUDY OF THE TIMING AND CAUSES FOR LEAVE OF ABSENCE AND WITHDRAWAL FROM UNITED STATES MEDICAL SCHOOLS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 322 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved~~.~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 322 be amended by addition of a second Resolve, to read as follows:

RESOLVED, that our AMA encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical undergraduate and graduate education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved (New HOD Policy).

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 322 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 322 be changed, to read as follows:

SUPPORT FOR THE STUDY OF THE TIMING AND CAUSES FOR LEAVE OF ABSENCE AND WITHDRAWAL FROM UNITED STATES ALLOPATHIC AND OSTEOPATHIC MEDICAL UNDERGRADUATE AND GRADUATE EDUCATION PROGRAMS

Resolution 322 asks: That our AMA support the study of factors surrounding leaves of absence and withdrawal from allopathic and osteopathic medical education programs, including the timing of and reasons for these actions, as well as the sociodemographic information of the students involved.

Your Reference Committee reviewed testimony online and in-person in overwhelming support of this resolution. Testimony reflected that many felt this policy could help inform potential medical school applicants, current students and medical school administrators. It was requested that gender be included, and your Reference Committee felt the term sociodemographic was inclusive of gender. Therefore, your Reference Committee recommends that Resolution 322 be adopted as amended.

(22) RESOLUTION 308 – MAINTENANCE OF CERTIFICATION MORATORIUM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 308 be referred.

Resolution 308 asks: 1. That our AMA call for an immediate end to the high stakes examination components as well as an end to the Quality Initiative (QI)/Practice

Improvement (PI) components of Maintenance of Certification (MOC); 2. That our AMA call for retention of continuing medical education (CME) and professionalism components (how physicians carry out their responsibilities safely and ethically) of MOC only; and 3. That our AMA petition the American Board of Medical Specialties for the restoration of certification status for all diplomates who have lost certification status solely because they have not complied with MOC requirements.

Your Reference Committee reviewed mixed online and in-person testimony on this resolution. Testimony noted that continuing certification has become another element that contributes to stress and burnout, and that many physicians find elements of Continuous Certification/Maintenance of Certification problematic. However, the Council on Medical Education is currently studying the issues raised in this resolution. In addition, the ABMS has convened a Stakeholders Council to address the recommendations of the recently released report of the "Continuing Board Certification: Vision for the Future Commission" that may address some of these concerns. The AMA also has representation on the ABMS Continuing Certification Committee, which monitors and approves alternative models within the existing components of Continuing Certification and is considering how to integrate the assessment of standards into everyday practice activities. A thorough review and analysis of the issues raised in this item is needed. Therefore, your Reference Committee recommends that Resolution 308 be referred with a report back to the House of Delegates at the A-20 meeting.

(23) RESOLUTION 311 – GRANDFATHERING QUALIFIED APPLICANTS PRACTICING IN U.S. INSTITUTIONS WITH RESTRICTED MEDICAL LICENSURE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 311 be referred.

Resolution 311 asks: That our AMA work with the Federation of State Medical Boards, the Organized Medical Staff Section and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. health care system.

Your Reference Committee heard mixed testimony that was largely in favor of referral, due to the complexity of this issue. Testimony from an international medical graduate academic physician who has trained many residents and fellows in the United States, but who is ineligible to obtain a medical license, reflected the impetus for this item. A physician from Florida testified how that state continues to grapple with the issue of physician immigrants from Cuba and other foreign countries who do not meet state licensure requirements yet seek to find a way in which to put their (often considerable) skills to work in their new country in service to patients and society. This issue merits additional study by the Council on Medical Education, which welcomes the referral, as do the authors of the resolution. Therefore, your Reference Committee recommends that Resolution 311 be referred.

(24) RESOLUTION 301 – AMERICAN BOARD OF MEDICAL SPECIALTIES ADVERTISING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 301 not be adopted.

Resolution 301 asks: That our AMA oppose the use of any physician fees, dues, etc., for any advertising by the American Board of Medical Specialties or any of their component boards to the general public.

Your Reference Committee reviewed mixed online and in-person testimony regarding Resolution 301, which noted the existence of public information and advertising campaigns used to inform patients about the value of board certification. Testimony noted that hospitals, insurance companies, malpractice insurers, and others often require board certification for a physician to practice medicine and that physicians are essentially required to maintain active certification and pay yearly fees to their specialty boards. While the AMA maintains robust policy on MOC, including policy related to the cost of development and administration of the MOC components and transparency of finances of the ABMS and its member boards, this policy does not attempt to exert control over ABMS policies and procedures. In addition, this resolution is not consistent with AMA policy that supports informing the public about the value of board certification. Therefore, your Reference Committee recommends that Resolution 301 not be adopted.

(25) RESOLUTION 312 – UNMATCHED MEDICAL GRADUATES TO ADDRESS THE SHORTAGE OF PRIMARY CARE PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 312 not be adopted.

Resolution 312 asks: 1. That our AMA advocate for the state medical boards to accept medical graduates who have passed USMLE Steps 1 and 2 as their criterion for limited license, thus using the existing physician workforce of trained and certified physicians in the primary care field and allowing them to get some credit towards their residency training as is being contemplated in Utah; and 2. That our AMA work with regulatory, licensing, medical, and educational entities dealing with physician workforce issues: the American Board of Medical Specialties, the Association of American Medical Colleges (AAMC), the Association for Hospital Medical Education, Accreditation Council for Graduate Medical Education (ACGME), the Federation of State Medical Boards, and the National Medical Association work together to integrate unmatched physicians in the primary care workforce in order to address the projected physician shortage.

Your Reference Committee heard, after further consideration, that the sponsors decided to withdraw Resolution 312 from consideration. Therefore, Your Reference Committee recommends that Resolution 312 not be adopted.

Madam Speaker, this concludes the report of Reference Committee C. I would like to thank Ricardo Correa, MD; Albert M. Kwan, MD; George M. Lange, MD; Elizabeth U. Parker, MD; Richard Pieters, Jr, MD; Charles W. Van Way, III, MD; and all those who testified before the committee, as well as our AMA staff, including Catherine Welcher, Fred Lenhoff, Tanya Lopez, and Alejandro Aparicio, MD.

Ricardo Correa, MD (Alternate)
International Medical Graduates

Albert M. Kwan, MD
American Society of General Surgeons

George M. Lange, MD
Wisconsin

Elizabeth U. Parker, MD (Alternate)
Sectional Resident and Fellow

Richard S. Pieters, Jr, MD
Massachusetts

Charles W. Van Way, III, MD
Missouri

Nicole D. Riddle, MD
US and Canadian Academy of Pathology
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)

Report of Reference Committee D

Diana Ramos, MD, MPH, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 11 – Policy and Economic Support for Early Child Care
2. Board of Trustees Report 16 – Developing Sustainable Solutions for Discharge of Chronically Homeless Patients
3. Board of Trustees Report 28 – Opposition to Measures that Criminalize Homelessness
4. Council on Science and Public Health Report 3 – Low Nicotine Product Standard
5. Council on Science and Public Health Report 4 – Vector-borne Diseases
6. Resolution 403 – White House Initiative on Asian Americans and Pacific Islanders
7. Resolution 407 – Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents
8. Resolution 425 – Distracted Driver Education and Advocacy
9. Resolution 427 – Utility of Autonomous Vehicles for Individuals Who are Visually Impaired of Developmentally Disabled

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

10. Board of Trustees Report 29 – Improving Safety and Health Code Compliance in School Facilities
11. Resolution 401 – Support Pregnancy Intention Screening to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies
12. Resolution 404 – Shade Structures in Public and Private Planning and Zoning Matters
13. Resolution 405 – Gun Violence Prevention: Safety Features
14. Resolution 406 – Reduction in Consumption of Processed Meats
15. Resolution 410 – Addressing Health Disparities Through Education
16. Resolution 413 – End the Epidemic of HIV Nationally
17. Resolution 415 – Distracted Driving Legislation
18. Resolution 416 – Non-medical Exemptions from Immunizations
19. Resolution 417 – Improved Health in the United States Prison System Through Hygiene and Health Education Programming for Inmates and Prison Staff
20. Resolution 419 – Universal Access for Essential Public Health Services
21. Resolution 420 – Coordinating Correctional and Community Healthcare
22. Resolution 421 – Contraception for Incarcerated Women
23. Resolution 423 – Mandatory Immunizations for Asylum Seekers
24. Resolution 426 – Health Care Accreditation of Correctional, Detention and Juvenile Facilities

25. Resolution 428 – Dangers of Vaping
26. Resolution 432 – Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals
27. Resolution 433 – Transformation of Rural Community Public Health Systems

RECOMMENDED FOR REFERRAL

28. Resolution 402 – Bullying in the Practice of Medicine
29. Resolution 408 – Banning Edible Cannabis Products
30. Resolution 411 – AMA to Analyze Benefits / Harms of Legalization of Marijuana
31. Resolution 414 – Patient Medical Marijuana Use in Hospitals
32. Resolution 424 – Physician Involvement in State Regulation of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury
33. Resolution 430 – Compassionate Release for Incarcerated Patients

RECOMMENDED FOR REFERRAL FOR DECISION

34. Resolution 418 – Eliminating the Death Toll from Combustible Cigarettes

RECOMMENDED FOR NOT ADOPTION

35. Resolution 409 – Addressing the Vaping Crisis
36. Resolution 431 – Eliminating Recommendations to Restrict Dietary Cholesterol and Fat

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

37. Resolution 412 – Regulating Liquid Nicotine and E-Cigarettes
38. Resolution 434 – Change in Marijuana Classification to Allow Research

Resolutions handled via the Reaffirmation Consent Calendar:
Resolution 422 – Promoting Nutrition Education Among Healthcare Providers

(1) BOARD OF TRUSTEES REPORT 11 – POLICY AND ECONOMIC SUPPORT FOR EARLY CHILD CARE

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 11 be adopted and the remainder of the report be filed.

Board of Trustees Report 11 asks that our AMA (1) reaffirm Policy H-440.823, which recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; (2) encourage employers to offer and/or expand paid parental leave policies; (3) encourage state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (4) advocate for improved social and economic support for paid family leave to care for newborns, infants and young; and (5) advocate for federal tax incentives to support early child care and unpaid child care by extended family members

Your Reference Committee heard testimony that was supportive of the recommendations in Board of Trustees Report 11. The Board was thanked for its consideration of the testimony heard on this report last year and for this revised version. There was strong support for the Board's position that policy supporting paid parental leave for the care of children is good public policy. It was noted that these policies have a positive impact on children's health outcomes. Therefore, your Reference Committee recommends that Board of Trustees Report 11 be adopted.

(2) BOARD OF TRUSTEES REPORT 16 – DEVELOPING SUSTAINABLE SOLUTIONS TO DISCHARGE OF CHRONICALLY HOMELESS PATIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 16 be adopted and the remainder of the report be filed.

Board of Trustees Report 16 asks that our AMA: (1) partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs; (2) encourage the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital; (3) encourage the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients; (4) reaffirm Policy H-160.903, Eradicating Homelessness, which "supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services."; (5) reaffirm Policy H-160.978, The Mentally Ill Homeless, which states that "public policy initiatives directed to the homeless, including the homeless mentally ill population, should…[promote] care that is

sensitive to the overriding needs of this population for food, clothing, and residential facilities."; (6) reaffirm Policy H-160.942, Evidence-Based Principles of Discharge and Discharge Criteria, which "calls on physicians, specialty societies, insurers, and other involved parties to join in developing, promoting, and using evidence-based discharge criteria that are sensitive to the physiological, psychological, social, and functional needs of patients."; (7) reaffirm Policy H-130.940, Emergency Department Boarding and Crowding, which "supports dissemination of best practices in reducing emergency department boarding and crowding."; and (8) reaffirm Policy H-270.962, Unfunded Mandates, which "vigorously opposes any unfunded mandates on physicians."

Your Reference Committee heard testimony in support of the Board's recommendations for evidenced-based discharge planning. It was noted that homelessness is an exacerbating factor in emergency department overuse, excess hospitalization, and preventable readmission. Testimony noted the necessity for collaborative partnerships to address homelessness. Therefore, your Reference Committee recommends that Board of Trustees Report 16 be adopted.

(3) BOARD OF TRUSTEES REPORT 28 – OPPOSITION TO MEASURES THAT CRIMINALIZE HOMELESSNESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 28 be adopted and the remainder of the report be filed.

Board of Trustees Report 28 recommends new policy stating that our AMA: (1) supports laws protecting the civil and human rights of individuals experiencing homelessness; (2) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; (3) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods; and (4) recommends reaffirming Policy H-160.903, "Eradicating Homelessness."

Your Reference Committee heard testimony in support of the Board's recommendations in opposition to criminalizing homelessness. Testimony noted that insufficient income and lack of affordable housing are leading causes of homelessness. Laws criminalizing homelessness have been found to violate international and, in some instances, federal law. Therefore, your Reference Committee recommends Board of Trustees Report 28 be adopted.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 – LOW NICOTINE PRODUCT STANDARD

RECOMMENDATION:

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

Council on Science and Public Health Report 3 recommends: (1). That AMA Policy H-495.988, "FDA Regulation of Tobacco Products" be amended by addition to read as follows:

1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.

2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

3. Our AMA: (A) will continue to monitor the FDA's progress towards establishing a low nicotine product standard for tobacco products and will submit comments on the proposed rule that are in line with the current scientific evidence and (B) recognizes that rigorous and comprehensive post-market surveillance and product testing to monitor for unintended tobacco use patterns will be critical to the success of a nicotine reduction policy. (Modify Current HOD Policy)

2. That American Medical Association Policy H-495.972, “Electronic Cigarettes, Vaping, and Health” be reaffirmed. (Reaffirm HOD Policy)

The Council on Science and Public Health introduced this report and noted that the AMA submitted extensive comments on this issue to the FDA in July of 2018. The comments were made based on the best available data on a low nicotine product standard. It was noted that the AMA specifically called for this standard to apply to all tobacco and nicotine products, not just combustible cigarettes. Some questions were raised in testimony regarding varying levels of addiction to nicotine among individuals and across populations, and how those most susceptible would be addressed. Your Reference Committee believes that the Council got this right. Federal law prohibits the FDA from taking the nicotine level to zero. Committing the AMA to continue to monitor the FDA’s progress as well as the evidence base on this issue is appropriate. Therefore, your Reference Committee recommends that Council on Science and Public Health Report 3 be adopted.

(5) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 – VECTOR-BORNE DISEASES

RECOMMENDATION:

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

Council on Science and Public Health Report 4 recommends:

1. That Policy H-440.820, “Vector-Borne Diseases,” be amended by addition and deletion to read as follows:

H-440.820 Vector-Borne Diseases
Due to the increasing threat and limited capacity to respond to vector-borne diseases, ~~Our~~ our AMA supports and will advocate for ~~local, state and national research, education, reporting and tracking on vector-borne diseases.~~

(1) Improved surveillance for vector-borne diseases to better understand the geographic distribution of infectious vectors and where people are at risk;
(2) The development and funding of comprehensive and coordinated vector-borne disease prevention and control programs at the state and local level;
(3) Investments that strengthen our nation’s public health infrastructure and the public health workforce;
(4) Education and training for health care professionals and the public about the risk of vector-borne diseases and prevention efforts as well as the dissemination of available information;
(5) Research to develop new vaccines, diagnostics, and treatments for existing and emerging vector-borne diseases, including Lyme disease;
(6) Research to identify novel methods for controlling vectors and vector-borne diseases; and
(7) Increased and sustained funding to address the growing burden of vector-borne diseases in the United States. (Modify Current HOD Policy)

2. That Policy H-135.438, "Global Climate Change and Human Health" and Policy, D-440.940, "Global Tracking System of Zoonotic Diseases," be reaffirmed. (Reaffirm HOD Policy)

The Council was thanked for its thorough and thoughtful report on the issue of vector-borne diseases. Overall, testimony was very supportive of this report. Several amendments were suggested, including putting the language referring to the local, state, and federal levels of government taking action back into the policy. Your Reference Committee believes that leaving it broad is the best approach, thereby ensuring it applies to all jurisdictions. There was also a recommendation to add the One Health Initiative into the recommendations. The Reference Committee felt that inserting the name of a specific coalition was unnecessary noting that we have existing policy on collaborations with veterinary medicine (H-440.871). Therefore, your Reference Committee recommends adoption.

(6) RESOLUTION 403 – WHITE HOUSE INITIATIVE ON ASIAN AMERICANS AND PACIFIC ISLANDERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 403 be adopted.

Resolution 403 asks that our AMA: (1) advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (2) support the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (3) support the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (4) report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Your Reference Committee heard strong support on the issue of disaggregation of data regarding Asian American and Pacific Islanders. It was noted that while there is existing AMA policy on this issue, these requests are more specific and necessary to address disparities in these populations. Therefore, your Reference Committee recommends that Resolution 403 be adopted.

(7) RESOLUTION 407 – EVALUATING AUTONOMOUS VEHICLES AS A MEANS TO REDUCE MOTOR VEHICLE ACCIDENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 407 be adopted.

Resolution 407 asks that our AMA monitor the development of autonomous vehicles, with particular focus on the technology's impact on motor vehicle related injury and death and promote driver, pedestrian, and general street and traffic safety as key priorities in the development of autonomous vehicles.

Your Reference Committee heard testimony in support of Resolution 407. It was noted that autonomous vehicle technology is being developed and applied rapidly. Testimony acknowledged the potential for fully autonomous vehicles to save lives and the need for monitoring to ensure safety is a priority in development. Therefore, your Reference Committee recommends that Resolution 407 be adopted.

(8) RESOLUTION 425 – DISTRACTED DRIVER EDUCATION AND ADVOCACY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 425 be adopted.

Resolution 425 asks that our AMA make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with the Centers for Disease Control and Prevention and other interested stakeholders; and explore developing an advertising campaign on distracted driving with report back to the House of Delegates at the 2019 Interim Meeting.

Your Reference Committee heard limited, but unanimous testimony in support of Resolution 425. The positive impact of distracted driving efforts was noted in testimony, using as an example hands-free legislation in Georgia that reduced motor vehicle collision mortality by 4 percent. While one individual suggested targeting education toward middle school and high school students as they begin driver education, your Reference Committee felt that the specifics of the educational programming should be addressed in collaboration with stakeholders. Therefore, your Reference Committee recommends that Resolution 425 be adopted.

(9) RESOLUTION 427 – UTILITY OF AUTONOMOUS VEHICLES FOR INDIVIDUALS WHO ARE VISUALLY IMPAIRED OR DEVELOPMENTALLY DISABLED

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 427 be adopted.

Resolution 427 asks that our AMA work with the National Transportation Safety Board to support physician input on research into the capability of autonomous or “self-driving” vehicles to enable individuals who are visually impaired or developmentally disabled to benefit from autonomous vehicle technology.

Your Reference Committee heard testimony in support of Resolution 427. Testimony acknowledged the potential of fully autonomous vehicles to expand mobility of those who cannot be mobile. It was noted that transportation is a significant barrier for employment among the developmentally disabled and autonomous vehicle technology could expand employment opportunities for this population. It was suggested that the elderly be added to this resolution as well, but your Reference Committee felt that this was outside the scope of

this resolution. Therefore, your Reference Committee recommends that Resolution 427 be adopted.

(10) BOARD OF TRUSTEES REPORT 29 – IMPROVING SAFETY AND HEALTH CODE COMPLIANCE IN SCHOOL FACILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first recommendations in Board of Trustees Report 29 be amended by addition to read as follows:

1. That our AMA adopt the following new policy:

"Environmental Health and Safety in Schools"
Our AMA: (1) supports the adoption of standards in schools that limit harmful substances from school facility environments, ensure safe drinking water, and indoor air quality, and promote childhood environmental health and safety in an equitable manner, (2) encourages the establishment of a system of governmental oversight, charged with ensuring the regular inspection of schools and identifying shortcomings that might, if left untreated, negatively impact the health of those learning and working in school buildings; (3) supports policies that increase funding for such remediations to take place, especially in vulnerable, resource-limited neighborhoods; and (4) supports continued data collection and reporting on the negative health effects of substandard conditions in schools. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the first recommendations in Board of Trustees Report 29 be adopted as amended and the remainder of the report be filed.

1. Board of Trustees Report 29 recommends that our AMA adopt the following new policy:

"Environmental Health and Safety in Schools"
Our AMA supports the adoption of standards in schools that limit harmful substances from school facility environments, ensure safe drinking water, and indoor air quality, and promote childhood environmental health and safety in an equitable manner.

2. That the following policies be reaffirmed: H-135.428, "Safe Drinking Water," and H-135.998, "AMA Position on Air Pollution."

Your Reference Committee heard testimony in support of the Board's recommendation on school compliance with health and safety codes. It was noted that while there are number of recommendations available to guide the implementation of programs to promote and protect children's health, few states have adopted these guidelines into law. Schools in lower income districts may be particularly vulnerable to environmental health hazards, which can contribute to health inequities. An amendment was proposed supporting the enforcement and implementation of these guidelines. Your Reference Committee agrees and therefore, recommends that Board of Trustees Report 29 be adopted as amended.

(11) RESOLUTION 401 – SUPPORT PREGNANCY INTENTION SCREENINGS TO IMPROVE THE DISCUSSION OF PREGNANCY INTENTION, PROMOTE PREVENTIVE REPRODUCTIVE HEALTH CARE AND IMPROVE COMMUNITY HEALTH OUTCOMES BY HELPING WOMEN PREPARE FOR HEALTHY PREGNANCIES AND PREVENT UNINTENDED PREGNANCIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 401 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the use of pregnancy intention screening~~, such as One Key Question®, PATH, or the Centers for Disease Control and Prevention (CDC) reproductive life planning,~~ and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be ~~built in electronic health records so that providers can document intention screening and services provided based on a woman's response~~ appropriately documented in the medical record. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 401 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 401 be changed to read as follows:

SUPPORT PREGNANCY INTENTION SCREENING

Resolution 401 asks that our AMA support the use of pregnancy intention screening, such as One Key Question®, PATH, or the Centers for Disease Control and Prevention (CDC) reproductive life planning, as part of routine well care and recommend it be built in electronic health records so that providers can document intention screening and services provided based on a woman's response.

Your Reference Committee heard testimony in support of this resolution. The importance of reducing unmet contraceptive need and increasing preconception care were noted. Testimony questioned whether specific tools should be recommended. It was also suggested that language related to documentation be streamlined to eliminate language around electronic health records. Therefore, Your Reference Committee recommends that Resolution 401 be adopted as amended.

(12) RESOLUTION 404 – SHADE STRUCTURES IN PUBLIC AND PRIVATE PLANNING AND ZOING MATTERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 404 be amended by addition to read as follows:

That our AMA support sun shade structures (such as trees, awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical important of sun protection as a public health measure.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 404 be adopted as amended.

Resolution 404 asks that our AMA support sun shade structures (such as awnings, gazebos and other structures providing shade) in the planning of public and private spaces, as well as in zoning matters and variances in recognition of the critical importance of sun protection as a public health measure.

Your Reference Committee heard testimony in support of Resolution 404. Skin cancer is a growing medical concern, and sun shade structures should be considered in public space planning. In addition, sun shade structures may provide other benefits, such as increasing use of public spaces and encouraging physical activity. An amendment to add the word trees was suggested. Therefore, your Reference Committee recommends that Resolution 404 be adopted as amended.

(13) RESOLUTION 405 –GUN VIOLENCE PREVENTION: SAFETY FEATURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 405 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for firearm ~~gun~~ safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm ~~gun~~ safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms ~~guns~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 405 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 405 be changed.

FIREARM VIOLENCE PREVENTION: SAFETY FEATURES

Resolution 405 asks that our AMA advocate for gun safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these gun safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured guns.

Your Reference Committee heard testimony that was mostly supportive of Resolution 405. It was noted in testimony that 37 percent of unintended firearm deaths could have been prevented through smart firearm technology. It was also noted that existing law has had a chilling effect on the sale of smart firearms in the United States. Your Reference Committee noted that what we are referring to in the resolution is firearms rather than guns and amended the language accordingly.

(14) RESOLUTION 406 – REDUCTION IN CONSUMPTION OF PROCESSED MEATS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 406 be amended by addition and deletion to read as follows:

That our AMA support: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for ~~coronary artery~~ cardiovascular disease, type 2 diabetes, and ~~colorectal~~ cancer (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) public awareness of the risks of processed meat consumption, ~~including research that better defines the health risks imposed by different methods of meat processing~~; and (4) programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 406 be adopted as amended.

Resolution 406 asks that our AMA support: (1) reduction of processed meat consumption, especially for patients diagnosed or at risk for coronary artery disease, type 2 diabetes and colorectal cancer; (2) initiatives to reduce processed meats consumed in public schools, hospitals, food markets and restaurants while promoting healthy alternatives such as a whole foods and plant-based nutrition; (3) awareness of the risks of processed meat consumption, including research that better defines the health risks imposed by different methods of meat processing; and (4) programs for health care professionals on the risks of processed meat consumption and the benefits of healthy alternatives.

Your Reference Committee heard testimony in support of Resolution 406. Testimony noted that consumption of processed meat is a serious health concern for patients, referencing recent studies linking consumption of processed meats to increased cancer risks. It was noted alternatives such as whole foods and plant-based nutrition should be offered in public schools, hospitals, food markets, and restaurants. It was also noted that more education for children and adults on the health risks of processed meat consumption is needed. Your Reference Committee recommends that Resolution 406 be adopted as amended.

(15) RESOLUTION 410 – REDUCING HEALTH DISPARITIES THROUGH EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that second Resolve of Resolution 410 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with Centers for Disease Control and Prevention and other stakeholders to promote ~~HHS and DOE to establish~~ a meaningful health curriculum (including nutrition) for grades kindergarten through 12 ~~which is required for high school graduation~~ (Directive to Take Action).~~; and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that third Resolve of Resolution 410 be deleted.

~~RESOLVED, That our AMA work nationally toward the same goals and strategies to reduce health disparities. (Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 410 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Policy H-60.917 be reaffirmed.

Resolution 410 asks that our AMA: (1) work with the Health and Human Services Department (HHS) and Department of Education (DOE) to raise awareness about the health benefits of education; (2) work with HHS and DOE to establish a meaningful health curriculum (including nutrition) for grades kindergarten through 12 which is required for high school graduation; and (3) work nationally toward the same goals and strategies to reduce health disparities.

Your Reference Committee heard testimony that was mostly supportive of the intent of this resolution. It was noted that the CDC already has a meaningful health curriculum that outlines the eight components of coordinated school health. Rather than develop a new curriculum, the AMA should promote the existing one. There was confusion around the focus of this resolution, with some supporting early child education and authors indicating their intent was actually to focus on health professional education. Your Reference Committee believes that AMA policy already addresses early childhood education. Therefore, your Reference Committee recommends that Resolution 410 be adopted as amended and existing policy be reaffirmed.

Policy recommended for reaffirmation:

Policy H-60.917, "Disparities in Public Education as a Crisis in Public Health and Civil Rights"
Our AMA: (1) considers continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation; (2) will issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education, including early childhood education, as one of the great unmet health and civil rights challenges of the 21st century; and (3) acknowledges the role of early childhood brain development in persistent educational and health disparities and encourage public and private stakeholders to work to strengthen and expand programs to support optimal early childhood brain development and school readiness.

(16) RESOLUTION 413 – END THE EPIDEMIC OF HIV NATIONALLY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 413 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (1) diagnosing individuals with HIV infection as early as possible, (2) treating HIV infection to achieve sustained viral suppression, (3) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (4) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission. ~~advocate that the federal budget include provisions to End the HIV epidemic and that such a plan be structured after New York State's EtE 2020 or other similar state programs.~~ (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 413 be adopted as amended.

Resolution 413 asks that our AMA advocate that the federal budget include provisions to End the HIV epidemic and that such a plan be structured after New York State's EtE 2020 or other similar state programs

Your Reference Committee heard testimony in strong support of plans to end the HIV epidemic nationally. Testimony noted that there is already a national plan in place, "Ending the HIV Epidemic: A Plan for America" for which the President's Fiscal Year 2020 Budget proposed $291 million to work towards ending the HIV epidemic in America by 2030. Your

Reference Committee felt that rather than naming specific plans in our policy, it would be best to outline the goals of the plan for which the AMA, the federation of medicine, and physicians should support. It was also noted that the AMA should advocate for funding to implement the plan. Your Reference Committee also acknowledges that funding should not be limited to federal funding, but broadly applicable to all levels of government. Therefore, your Reference Committee recommends that Resolution 413 be adopted as amended.

(17) RESOLUTION 415 – DISTRACTED DRIVER LEGISLATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 415 be amended by deletion to read as follows:

That our AMA actively lobby for ~~federal~~ legislation to~~: (1)~~ decrease distracted driving injuries and fatalities by banning the use of electronic communication such as texting, taking photos or video and posting on social media while operating a motor vehicle ~~and (2) require automobile manufacturers to integrate hands-free technology into new automobiles~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 415 be adopted as amended.

Resolution 415 asks that our AMA actively lobby for federal legislation to: (1) decrease distracted driving injuries and fatalities by banning the use of electronic communication such as texting, taking photos or video and posting on social media while operating a motor vehicle and (2) require automobile manufacturers to integrate hands-free technology into new automobiles.

Your Reference Committee heard testimony about the number of fatalities and injuries caused by distracted drivers in the United States. While testimony supported efforts to curb distracted driving, it was noted the federal legislation proposed in this resolution runs contrary to Section 8 of the U.S. Constitution; laws on distracted driving are therefore in the purview of the states. Your Reference Committee also noted that the research indicates that hands-free technology while driving still poses a risk to drivers. Therefore, your Reference Committee recommends that Resolution 415 be adopted as amended.

(18) RESOLUTION 416 – NON-MEDICAL EXEMPTIONS FROM IMMUNIZATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 416 be amended by addition and deletion to read as follows:.

RESOLVED, That our American Medical Association actively advocate for ~~federal~~ legislation, regulations, programs, and policies that incentivize~~s~~ states to eliminate non-medical exemptions ~~to~~ from mandated pediatric immunizations. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 416 be adopted as amended.

Resolution 416 asks that our AMA actively advocate for federal legislation that incentivizes states to eliminate non-medical exemptions to mandated pediatric immunizations.

Your Reference Committee heard unanimous support for this resolution, which is consistent with existing AMA policy. An amendment was offered by the U.S. Public Health Service, suggesting that this not be limited to federal legislation. It was suggested that programs such as, but not limited to the Center for Medicare and Medicaid Innovation and Head Start could also incentivize states to eliminate non-medical exemptions from immunizations. Your Reference Committee believes that the AMA should be broadly supporting these incentives and not limiting them to only federal jurisdictions. Therefore, your Reference Committee recommends that Resolution 416 be adopted as amended.

(19) RESOLUTION 417 – IMPROVED HEALTH IN THE UNITED STATES PRISON SYSTEM THROUGH HYGIENE AND HEALTH EDUCATION PROGRAMMING FOR INMATES AND PRISON STAFF

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 417 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in ~~state and local prison systems~~ correctional facilities.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 417 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 417 be changed to read as follows:

IMPROVED HEALTH IN CORRECTIONAL FACILITIES THROUGH HYGIENE AND HEALTH EDUCATIONAL PROGRAMMING FOR INMATES AND STAFF

Resolution 417 asks that our AMA collaborate with state medical societies to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in state and local prison systems.

Your Reference Committee heard testimony in support of this resolution. It was suggested that your Reference Committee consider the updated term “correctional facilities”, and that federal regulators be included. Therefore, your Reference Committee recommends that Resolution 417 be adopted as amended.

(20) RESOLUTION 419 – UNIVERSAL ACCESS FOR ESSENTIAL PUBLIC HEALTH SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 419.

UNIVERSAL ACCESS FOR ESSENTIAL PUBLIC HEALTH SERVICES

RESOLVED that our AMA: (1) supports updating the 10 Essential Public Health Services to bring them in line with current and future public health practice; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation’s public health system; and (4) Reaffirms existing Policy H-440.912.

Resolution 419 asks that our AMA study the options and/or make recommendations regarding the establishment of: (1) a list of all essential public health services that should be provided in every jurisdiction in the United States; (2) a federal data system that can capture the amount of federal, state, and local public health capabilities and spending that occurs in every jurisdiction to assure that their populations have universal access to all essential public health services; and (3) a federal data system that can capture actionable evidence-based outcomes data from public health activities in every jurisdiction. Resolution 419 also asks the AMA to prepare and publicize annual reports on current efforts and progress to achieve universal access to all essential public health services.

Your Reference Committee heard testimony in support of the intent of this resolution. The Council on Science and Public Health offered an amendment, noting that work is ongoing to address this issue by a number of public health organizations and that the AMA should work collaboratively with public health organizations on this effort. The current list of Essential Public Health Services were developed in 1994. The Public Health Accreditation Board recently announced that it will partner with the de Beaumont Foundation on a project aimed at updating the 10 Essential Public Health Services national framework. The Essential Public Health Services provide the basis for the standards and measures by which governmental public health departments' performance is evaluated through the Public Health Accreditation Board. Since the list of essential public health services exists and is being updated and these services are the basis of accreditation standards, your Reference Committee agreed that the AMA's efforts should be focused on working with public health organizations to assess and assure appropriate funding, service capacity, and an adequate public health infrastructure for the nation.

Policy recommended for reaffirmation:

> Policy H-440.912, "Federal Block Grants and Public Health"
> (1) Our AMA should collaborate with national public health organizations to explore ways in which public health and clinical medicine can become better integrated; such efforts may include the development of a common core of knowledge for public health and medical professionals, as well as educational vehicles to disseminate this information. (2) Our AMA urges Congress and responsible federal agencies to: (a) establish set-asides or stable funding to states and localities for essential public health programs and services, (b) provide for flexibility in funding but ensure that states and localities are held accountable for the appropriate use of the funds; and (c) involve national medical and public health organizations in deliberations on proposed changes in funding of public health programs. (3) Our AMA will work with and through state and county medical societies to: (a) improve understanding of public health, including the distinction between publicly funded medical care and public health; (b) determine the roles and responsibilities of private physicians in public health, particularly in the delivery of personal medical care to underserved populations; (c) advocate for essential public health programs and services; (d) monitor legislative proposals that affect the nation's public health system; (e) monitor the growing influence of managed care organizations and other third party payers and assess the roles and responsibilities of these organizations for providing preventive services in communities; and (f) effectively communicate with practicing physicians and the general public about important public health issues. (4) Our AMA urges state and county medical societies to: (a) establish more collegial relationships with public health agencies and increase interactions between private practice and public health physicians to develop mutual support of public health and clinical medicine; and (b)

monitor and, to the extent possible, participate in state deliberations to ensure that block grant funds are used appropriately for health-related programs. (5) Our AMA urges physicians and medical societies to establish community partnerships comprised of concerned citizens, community groups, managed care organizations, hospitals, and public health agencies to: (a) assess the health status of their communities and determine the scope and quality of population- and personal-based health services in their respective regions; and (b) develop performance objectives that reflect the public health needs of their states and communities.6. Our AMA: (a) supports the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, in order to assure preservation of many critical public health programs for chronic disease prevention and health promotion in California and nationwide, and to maintain training of the public health physician workforce; and (b) will communicate support of the continuation of the Preventive Health and Health Services Block Grant, or the securing of adequate alternative funding, to the US Congress.

(21) RESOLUTION 420 – COORDINATING COMMUNITY AND CORRECTIONAL HEALTH CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 420 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support linkage of those incarcerated to community clinics upon release in order to accelerate access to ~~primary~~ comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding (New HOD Policy);

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 420 be adopted as amended.

Resolution 420 asks that our AMA support (1) linkage of those incarcerated to community clinics upon release in order to accelerate access to primary care and improve health outcomes among this vulnerable patient population, as well as adequate funding and (2) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

Your Reference Committee heard supportive testimony on this resolution. It was noted that this should be more comprehensive beyond primary care and should include mental health and substance abuse services. Your Reference Committee recommends that Resolution 420 be adopted as amended.

(22) RESOLUTION 421 – CONTRACEPTION FOR INCARCERATED WOMEN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 422 be adopted as amended by addition and deletion to read as follows:

That our AMA support an ~~incarceration~~ incarcerated person's~~'~~ right prior to release to (1) accessible, comprehensive, ~~to~~ evidence-based contraception ~~counseling~~ education, (2) access to ~~all~~ reversible contraceptive methods, and (3) autonomy over ~~contraceptive~~ the decision-making ~~prior to release~~ process without coercion.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 421 be adopted as amended.

Resolution 421 asks that our AMA support incarcerated persons' access to evidence-based contraception counseling, access to all contraceptive methods and autonomy over contraceptive decision-making prior to release.

Your Reference Committee heard strong support for Resolution 421. Testimony noted that access to evidence-based contraception and education is limited for incarcerated women. American College of Obstetricians and Gynecologists (ACOG) noted the original language could include irreversible procedures such as sterilization and recommended the resolution as amended. Widespread testimony supported the amended resolution. Therefore, your Reference Committee recommends adoption of Resolution 421 as amended.

(23) RESOLUTION 423 – MANDATORY IMMUNIZATION FOR ASYLUM SEEKERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 423 be amended by addition to read as follows:

That our AMA call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 423 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 423 be changed to read as follows:

MEDICALLY APPROPRIATE CARE FOR ASYLUM SEEKERS

Resolution 423 asks that our AMA Call for asylum seekers to receive all medically-appropriate vaccinations upon presentation for asylum regardless of country of origin.

Your Reference Committee heard supportive testimony for this resolution. Testimony was heard requesting that the scope of the resolution be expanded to include all medically-appropriate care, to reflect the diverse health needs of asylum seekers. Testimony asked that 'mandatory' be replaced in the title to reflect this expanded scope. It was also noted that language and cultural barriers should be considered in the delivery of care to asylum seekers. Therefore, your Reference Committee recommends that Resolution 423 be adopted as amended.

(24) RESOLUTION 426 – HEALTH CARE ACCREDITATION OF CORRECTIONAL, DETENTION AND JUVENILE FACILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 426 be amended by deletion to read as follows:

RESOLVED, That our AMA work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC)~~, American Correctional Association (ACA)~~ and ~~others with accreditation expertise,~~ in developing a strategy to accredit all correctional, detention and juvenile facilities;

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 426 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that all correctional, detention and juvenile facilities be accredited by ~~a national accrediting organization, such as~~ the NCCHC ~~or ACA~~, no

later than 2025.; and support funding for correctional facilities to assist in this effort.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the Resolution 426 be adopted as amended.

Resolution 426 asks that our AMA work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC), American Correctional Association (ACA) and others with accreditation expertise, in developing a strategy to accredit all correctional, detention and juvenile facilities and advocate that all correctional, detention and juvenile facilities be accredited by a national accrediting organization, such as the NCCHC or ACA, no later than 2025.

Your Reference Committee heard testimony in support of Resolution 426. It was suggested that 90% of correctional facilities in the United States have no oversight even though accreditation is considered important in demonstrating adequate health care provisions. The National Commission of Correctional Health Care (NCCHC) testified that other organizations suggested in the resolution were not accredited based solely on health care, and that this distinction was important. Additional testimony noted the importance of securing funds to support the work outlined in this resolution. Therefore, your Reference Committee recommends that Resolution 426 be adopted as amended.

(25) RESOLUTION 428 – DANGERS OF VAPING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-495.989 be amended by addition and deletion to read as follows:

Tobacco Product Labeling H-495.989

Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to

include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" ~~and~~ (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets~~.~~; and (4) supports requiring warning labels on all ENDS products.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-495.989 be adopted as amended in lieu of Resolution 428.

Resolution 428 asks that our American Medical Association amend existing policy H-495.986, “Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E cigarettes,” by addition to read as follows:

Our AMA: (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21 and requirements to include warning labels on all electronic nicotine delivery systems (ENDS);(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years and require warning labels on all ENDS, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; and (g) requirements for warning labels on all ENDS; (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (5) opposes the use of vending machines to

distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and (9) opposes the sale of tobacco at any facility where health services are provided; and (10) supports that the sale of tobacco products be restricted to tobacco specialty stores. (Modify Current HOD Policy)

Your Reference Committee heard testimony that was mostly supportive of the intent of this resolution. Your Reference Committee felt that the best place for this language was in the AMA's existing policy on tobacco product labeling rather than the policy on sales and distribution. Therefore, your Reference Committee recommends amending existing policy in lieu of Resolution 428.

(26) RESOLUTION 432 – DECRIMINALIZATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) STATUS NON-DISCLOSURE IN VIRALLY SUPPRESSED INDIVIDUALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 432 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~support repealing~~ advocate for repeal of legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV ~~who have an undetectable viral load~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 432 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 432 be changed to read as follows:

DECRIMINALIZATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) STATUS NON-DISCLOSURE

Resolution 432 asks that our AMA support repealing legislation that criminalizes non-disclosure of Human Immunodeficiency Virus (HIV) status for people living with HIV who have an undetectable viral load.

Your Reference Committee heard testimony that was mostly supportive of the intent of this resolution. Generally, it was felt that criminalization laws are outdated and do not reflect the current science of HIV transmission or the fact that HIV is a chronic, but manageable medical condition. There was some discussion that focused on the need to reduce stigma outside of decriminalization, but others noted that stigma and decriminalization were linked. Your Reference Committee considered the fact that non-disclosure of other infectious diseases are not criminalized and supported the language removing reference to the language an "undetectable viral load." Therefore, your Reference Committee recommends that Resolution 432 be adopted as amended.

(27) RESOLUTION 433 – TRANSFORMATION OF RURAL COMMUNITY PUBLIC HEALTH SYSTEMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 433 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with other entities and organizations interested in public health to:
-Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health
-Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities
- ~~Periodically~~ sStudy efforts to optimize rural public health. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 433 be adopted as amended.

Resolution 433 asks that our AMA work with other entities and organizations interested in public health to: (1) identify and disseminate concrete examples of administrative leadership

and funding structures that support and optimize local, community-based rural public health and (2) develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities. Resolution 433 also asks the AMA to periodically study efforts to optimize rural public health.

Your Reference Committee heard testimony largely in support of this resolution. The Council on Science and Public Health supported a study, but suggested starting with one study rather than periodic studies; this friendly amendment was acknowledged by the author. Your Reference Committee recommends that Resolution 433 be adopted as amended.

(28) RESOLUTION 402 – BULLYING IN THE PRACTICE OF MEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 402 be referred.

Resolution 402 asks that our AMA help establish a clear definition of professional bullying, establish prevalence and impact of professional bullying, and establish guidelines for prevention of professional bullying with a report back at the 2020 Annual Meeting.

Your Reference Committee heard testimony that was in support of Resolution 402. This resolution is calling for a study on the issue of professional bullying; specifically, requests to define professional bullying, how it may appear within the field of medicine, and potential strategies to prevent it. Therefore, your Reference Committee recommends that Resolution 402 be referred for study.

(29) RESOLUTION 408 – BANNING EDIBLE CANNABIS PRODUCTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 408 be referred.

Resolution 408 asks that our AMA adopt policy supporting a total ban on recreational edible cannabis products and support or cause to be introduced legislation to ban all recreational edible cannabis products.

Your Reference Committee heard mixed testimony on this resolution. It is clear that edible cannabis products are a growing industry in the states that have legalized the sale of recreational cannabis. Products in forms that appeal to children have led to unintentional ingestion. A number of questions were raised regarding appropriate terminology and the application of this ban to cannabidiol products. Given these questions, your Reference Committee believes referral for study is warranted.

(30) RESOLUTION 411 – AMA TO ANALYZE BENEFITS / HARMS OF LEGALIZATION OF MARIJUANA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 411 be referred.

Resolution 411 asks that our AMA review pertinent data from those states that have legalized marijuana.

Your Reference Committee heard testimony indicating that a lot has happened in the states since the Council on Science and Public Health's last report on this topic in 2017. There was tremendous support for a review of the data from states that have legalized cannabis. Therefore, your Reference Committee recommends referral of Resolution 411.

(31) RESOLUTION 414 – PATIENT MARIJUANA USE IN HOSPITALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 414 be referred.

Resolution 414 asks that our AMA offer guidance to medical staffs regarding patient use of non-US Food and Drug Administration approved medical marijuana and cannabinoids on hospital property, including product use, storage in patient rooms, nursing areas and/or pharmacy, with report back to the House of Delegates at the 2019 Interim Meeting.

Your Reference Committee heard conflicting testimony on Resolution 414. It was noted that the AMA does not support the legalization of cannabis for medical purposes through the legislative, referendum, or ballot measure process. Some members testified that guidance from the AMA on this issue would be helpful. Others testified that the AMA should leave this alone, have the hospital associations address this issue, or refer further study. Your Reference Committee agrees that referral is appropriate.

(32) RESOLUTION 424 – PHYSICIAN INVOLVEMENT IN STATE REGULATIONS OF MOTOR VEHICLE OPERATION AND/OR FIREARM USE BY INDIVIDUALS WITH COGNITIVE DEFICITS DUE TO TRAUMATIC BRAIN INJURY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 424 be referred.

Resolution 424 asks that our AMA reaffirm current AMA policy, H 145.999, "Gun Regulation," stating it supports stricter enforcement of current federal and state gun legislation and

advocate for physician-led committees in each state to give further recommendations to the state regarding driving and/or gun use by individuals who are cognitively impaired and/or a danger to themselves or others.

Your Reference Committee heard mixed testimony on this resolution and numerous calls for referral. The resolution covers the issues of traumatic brain injury, cognitive decline, firearm use, and driving. Some noted that the issues of firearm use and driving motor vehicles should be considered separately and others noted the complexity around traumatic brain injuries and cognitive decline. Your Reference Committee believes that a study on this issue would be beneficial to offer guidance to physicians.

(33) RESOLUTION 430 – COMPASSIONATE RELEASE FOR INCARCERATED PATIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 430 be referred.

Resolution 430 asks that our AMA: (1) support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; (2) collaborate with appropriate stakeholders to draft model legislation that establishes clear, evidence-based eligibility criteria for timely compassionate release; and (3) promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

Your Reference Committee heard testimony in support of the resolution. However, testimony also called for additional study to better understand the points raised and guide the AMA's course of action. Therefore, your Reference Committee recommends that Resolution 430 be referred.

(34) RESOLUTION 418 – ELIMINATING THE DEATH TOLL FROM COMBUSTIBLE CIGARETTES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 418 be referred for decision.

Resolution 418 asks that our AMA study and report on the conditions under which our country could successfully eliminate the manufacture, distribution, and sale of combustible cigarettes and other combustible tobacco products at the earliest feasible date.

Your Reference Committee heard testimony in support of the concept of this resolution. Some members encouraged the Council on Science and Public Health to imagine that this could happen, while others cautioned that this is "pie in the sky." It was suggested that this not be limited to combustible cigarettes given the epidemic of e-cigarette use among youth. The Council on Science and Public Health noted that the Family Smoking Prevention and Tobacco Control Act prohibits banning certain classes of tobacco products and noted Native American tribes, as sovereign nations and self-governing entities, are able to engage in a variety of on-

reservation and off-reservation commercial tobacco activities. Given these concerns, your Reference Committee recommends referral for decision.

(35) RESOLUTION 409 – ADDRESSING THE VAPING CRISIS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 409 not be adopted.

Resolution 409 asks that our AMA advocate to the Food and Drug Administration that vaping devices should be available only by prescription for smokers who are trying to quit smoking.

Your Reference Committee heard testimony on the magnitude of the vaping crisis in the United States and use of vaping devices for smoking cessation. Testimony from the Food and Drug Administration noted that the Family Smoking and Tobacco Control Act prohibits making tobacco products, including vaping devices, available by prescription only. Furthermore, there is no evidence to support the use of vaping devices for the purposes of tobacco cessation. For these reasons, your Reference Committee recommends that Resolution 409 not be adopted.

(36) RESOLUTION 431 – ELIMINATING RECOMMENDATIONS TO RESTRICT DIETARY CHOLESTEROL AND FAT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 431 not be adopted.

Resolution 431 asks that American Medical Association amend Policy H-150.944, "Combating Obesity and Health Disparities," by addition and deletion to read as follows:

H-150.944 Combating Obesity and Health Disparities
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of ~~foods and beverages low in fat, added sugars, and cholesterol,~~ healthful foods and beverages. (Modify Current HOD Policy)

Your Reference Committee heard testimony that opposed removing dietary cholesterol and fat restriction language from current AMA policy. Cardiovascular disease, specifically the 2019 ACC/AHA Guidelines on the Primary Prevention of Cardiovascular Disease, was addressed by several speakers in support of the AMA's existing policy. Therefore, your Reference Committee recommends that Resolution 431 not be adopted.

(37) RESOLUTION 412 – REGULATING LIQUID NICOTINE AND E-CIGARETTES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-495.988 be reaffirmed in lieu of Resolution 412.

Resolution 412 asks that our AMA seek legislation or regulations that limit higher concentration nicotine salts (greater than 10mg) in nicotine vaping pods and restrict bulk sale of vaping products and associated paraphernalia.

Your Reference Committee heard mixed testimony on this resolution. Your Reference Committee discussed the perspectives and noted that AMA policy encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives that enhance addictiveness. Based on this policy, the AMA has called on the FDA to create a non-addictive nicotine level standard for all tobacco products – including electronic nicotine delivery systems (ENDS), "heat not burn products," and any other tobacco products containing nicotine for recreational use. That level would likely be well below the 10 mg called for in this resolution as the nicotine level for combustible tobacco products is 0.4 mg/g. Therefore, your Reference Committee recommends that Policy H-495.988 be reaffirmed in lieu of Resolution 412.

Policy recommended for reaffirmation:

Policy H-495.988, "FDA Regulation of Tobacco Products"
1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly

opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products. 2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

(38) RESOLUTION 434 – CHANGE IN MARIJUANA CLASSIFICATION TO ALLOW RESEARCH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-95.952 be reaffirmed in lieu of Resolution 434.

Resolution 434 asks that our AMA petition the US Food and Drug Administration / US Drug Enforcement Administration to change the schedule classification of marijuana so that it can be subjected to appropriate research.

Your Reference Committee heard testimony supportive of advancing research on cannabis. Some called for rescheduling cannabis to Schedule II, while others noted that the AMA's existing policy gets this right and that moving cannabis to Schedule II is not possible without an amendment to the Controlled Substances Act. The Council on Legislation testified that the AMA has been working with members of Congress and the administration on legislation to eliminate the barriers to researching cannabis and cannabidiol, which stipulates leaving cannabis in Schedule I. Your Reference Committee agrees that the AMA's existing policy gets this right and therefore recommends reaffirming H-95.952 in lieu of Resolution 434.

Policy recommended for reaffirmation:

Policy H-95.952, "Cannabis and Cannabinoid Research"
1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. 2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. 3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board

evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. 4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding. 5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.

Madam Speaker, this concludes the report of Reference Committee D. I would like to thank the members of the committee: Robert Dannenhoffer, MD, James D. Felsen, MD, MPH, Vito Imbasciani, MD, PhD, Shilpen A. Patel, MD, Rohan Rastogi, MPH, Kevin E. Taubman, MD; our AMA staff: Andrea Garcia, Rebecca Benson, Andrea Houlihan, and Amber Ryan; and all those who testified before the Committee.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)

Report of Reference Committee E

Leslie H. Secrest, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 502 – Destigmatizing the Language of Addiction
2. Resolution 511 – Mandating Critical Congenital Heart Defect Screening in Newborns
3. Resolution 519 – Childcare Availability for Persons Receiving Substance Use Disorder Treatment
4. Resolution 524 – Availability of Naloxone Boxes
5. Resolution 528 – Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing
6. Resolution 532 – Dispelling Myths of Bystander Opioid Overdose

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

7. Council on Science and Public Health Report 1 – CSAPH Sunset Review of 2009 House of Delegates Policies
8. Resolution 501 – USP 800
9. Resolution 503 – Addressing Healthcare Needs of Children of Incarcerated Parents
   Resolution 531 – Support for Children of Incarcerated Parents
10. Resolution 504 – Screening, Intervention, and Treatment for Adverse Childhood Experiences
    Resolution 526 – Trauma-Informed Care Resources and Settings
11. Resolution 508 – Benzodiazepine and Opioid Warning
12. Resolution 510 – The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) Initiative
13. Resolution 512 – Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients
14. Resolution 513 – Determining Why Infertility Rates Differ Between Military and Civilian Women
15. Resolution 514 – Opioid Addiction
16. Resolution 515 – Reversing Opioid Epidemic
17. Resolution 516 – Alcohol Consumption and Health
18. Resolution 517 – Compounding
19. Resolution 520 – Substance Use During Pregnancy
20. Resolution 522 – Improved Deferral Periods for Blood Donors
21. Resolution 525 – Support for Rooming-in of Neonatal Abstinence Syndrome Patients with Their Parents
22. Resolution 527 – Increasing the Availability of Bleeding Control Supplies
23. Resolution 529 – Adverse Impacts of Delaying the Implementation of Public Health Regulations

RECOMMENDED FOR REFERRAL

24. Resolution 518 – Chemical variability in pharmaceutical products

RECOMMENDED FOR REFERRAL FOR DECISION

25. Resolution 507 – Removing Ethylene Oxide as a Medical Sterilant from Healthcare

RECOMMENDED FOR NOT ADOPTION

26. Resolution 530 – Implementing Naloxone Training into the Basic Life Support Certification Program

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

27. Resolution 505 – Glyphosate Studies

Resolutions handled via the Reaffirmation Consent Calendar:

Resolution 506 – Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements
Resolution 509 – Addressing Depression to Prevent Suicide Epidemic
Resolution 523 – Availability and Use of Low Starting Opioid Doses
Resolution 521 – Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter

(1) RESOLUTION 502 – DESTIGMATIZING THE LANGUAGE OF ADDICTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 502 be adopted.

Resolution 502 asks that our American Medical Association (AMA) use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty and that our AMA and relevant stakeholders create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities.

Your Reference Committee heard testimony unanimously in favor of this resolution. Testimony noted that much of the terminology typically used around persons with substance use disorder is not clinically accurate and not in line with terminology used with other medical disorders. Words such as “abuse, junkie, dirty/clean tests,” and other commonly used terms convey stigma that can negatively affect physician’s attitudes, interfere with good patient care and negatively affect patient outcomes. Multiple parties testified that organizations and government entities such as the International Classification of Diseases (ICD), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Institutes of Health (NIH), are either changing their own language accordingly or being challenged to do so. There was compelling testimony from the US Surgeon General that physicians should be “wrapping our arms around” people who have substance use disorder instead of stigmatizing them. The testimony reflects that the ask of this resolution to replace stigmatizing terms regarding substance use disorder and persons with substance use disorder with non-stigmatizing terminology in AMA materials going forward is reasonable and in line with current AMA policy/efforts as well as actions and statements from other high level and authoritative bodies. Therefore, your Reference Committee recommends that Resolution 502 be adopted.

(2) RESOLUTION 511 – MANDATING CRITICAL CONGENITAL HEART DEFECT SCREENING IN NEWBORNS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 511 be adopted.

Resolution 511 asks that our American Medical Association support screening for critical congenital heart defects for newborns following delivery prior to hospital discharge.

Your Reference Committee heard strong support for this resolution. Testimony noted that Critical Congenital Heart Defect (CCHD) Screening is an important element of uniform newborn screening, and that it has already been adopted by all 50 states. Therefore, your Reference Committee recommends that Resolution 511 be adopted.

(3) RESOLUTION 519 – CHILDCARE AVAILABILITY FOR PERSONS RECEIVING SUBSTANCE USE DISORDER TREATMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 519 be adopted.

Resolution 519 asks that our American Medical Association support the implementation of childcare resources in existing substance use treatment facilities and acknowledge childcare infrastructure and support as a major priority in the development of new substance use programs.

Your Reference Committee heard testimony strongly in favor of this resolution. Evidence about the need for childcare services in addiction treatment primarily for women with children was noted. Testimony was heard that lack of childcare is a significant barrier to treatment and one among multiple barriers for women who have substance use disorder. Testimony supported the AMA calling for increasing capacity for childcare in addiction treatment settings and including childcare in the development of new treatment programs to help reduce barriers to treatment and to reduce incidents of young children and infants being separated from parents. Therefore, your Reference Committee recommends that Resolution 519 be adopted.

(4) RESOLUTION 524 – AVAILABILITY OF NALOXONE BOXES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that resolution 524 be adopted.

Resolution 524 asks that our American Medical Association (AMA) support the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription and that our AMA amend policy H-95.932, “Increasing Availability of Naloxone,” by addition and deletion as follows:

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. 2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone. 3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients. 4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing. 5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law. 6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively. 7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food

and Drug Administration. 8. Our AMA ~~urges the Food and Drug Administration to study the practicality and utility of~~ supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.

Your Reference Committee heard unanimously supportive testimony for this Resolution, including support from the U.S. Surgeon General. Your Reference Committee notes the logistical issues associated with publicly available naloxone boxes. These issues include the need for the FDA to regulate this practice and approve over-the-counter (OTC) availability of a naloxone product that would be suitable for placement in a public setting and amenable to untrained bystander use; a requirement for stability testing, expiration dating, and product replacement; and the need to place the product for maximum effectiveness. Despite these logistical issues, your Reference Committee understands the urgent need for the implementation of this type of program, encourages the evaluation of the feasibility of implementing this type of approach, and urges manufacturers and FDA to expedite the availability of OTC naloxone so this ask can be accomplished. Therefore, your Reference Committee recommends adoption of Resolution 524.

(5) RESOLUTION 528 – DEVELOPING DIAGNOSTIC CRITERIA AND EVIDENCE-BASED TREATMENT OPTIONS FOR PROBLEMATIC PORNOGRAPHY VIEWING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that resolution 528 be adopted.

Resolution 528 asks that our American Medical Association support research on problematic pornography use, including its physiological and environmental drivers, appropriate diagnostic criteria, effective treatment options, and relationships to erectile dysfunction and domestic violence.

Your Reference Committee heard largely supportive testimony for this resolution. It was noted that current evidence was not conclusive to support diagnostic criteria, and that additional study may be needed to determine what link, if any, there might be between problematic pornography use and health conditions or domestic violence. Testimony noted that obsessive and compulsive pornography viewing may be defined as problematic, which may also be analogous to other conditions such as video games or gambling. Additional testimony offered that other sexually explicit material use may be considered less problematic, such as use for sample collection in fertility clinics. Therefore, your Reference Committee recommends that Resolution 528 be adopted.

(6) RESOLUTION 532 – DISPELLING THE MYTHS OF BYSTANDER OPIOID OVERDOSE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 532 be adopted.

Resolution 532 asks that our American Medical Association (AMA) work with appropriate stakeholders to develop and disseminate educational materials aimed at dispelling the fear of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives and that our AMA work with appropriate stakeholders to identify those professions, such as first responders, most impacted by opioid overdose deaths in order to provide targeted education to dispel the myth of bystander overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives.

Your Reference Committee heard largely supportive testimony related to this resolution. Testimony from the authors strongly noted no verified evidence of any bystander opioid overdoses. Isolated concerns were raised about the enhanced risks of contact with carfentanil and other fentanyl analogs and the intense potency of these substances. However, no evidence was presented that showed a high level of risk of meaningful exposure to these analogs by first responders during the normal course of their duties and while taking normal, appropriate precautions. Several parties noted the anxiety that inaccurate media articles promote and that are not supported by any verifiable incidences. Although there is acknowledgement of the potency of carfentanil and other fentanyl analogs, the committee and testimony support the resolution to support first responders intervening in possible overdose and other situations without undue fear of harm. Guidelines from the American Academy of Clinical Toxicology and the American College of Medical Toxicology address potential dangers of dermal and respiratory contact with fentanyl and its analogs to prevent occupational exposure for emergency responders including the use of nitrile gloves and other evidence-based precautions. Therefore, your Reference Committee recommends that Resolution 532 be adopted.

(7) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 – CSAPH SUNSET REVIEW OF 2009 HOUSE OF DELEGATES POLICIES

RECOMMENDATION A:

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

That the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated, with the exception of Policy H-440.927 clause number 4, which should be retained, and the remainder of the report be filed.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Science and Public Health Report be adopted as amended.

Council on Science and Public Health Report 1 presents the Council's recommendations on the disposition of the House policies and directives from 2009 that were assigned to it. The report recommends that House of Delegates policies that are listed in the Appendix to the report be acted upon in the manner indicated and the remainder of the Report be filed.

The Council on Science and Public Health introduced its Sunset report, and testimony noted that clause four of Policy H-440.927, "Tuberculosis," should be retained because controlling tuberculosis globally is still important. Your Reference Committee agrees and therefore recommends adoption as amended.

(8) RESOLUTION 501 – USP 800

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 501 be amended by deletion to read as follows:

~~RESOLVED, That our American Medical Association (AMA) adopt as policy that physicians and other health care providers administering medications (defined as the mixing or reconstituting of a drug according to manufacturers' recommendations for a single patient for immediate use) not be subject to the USP 800 compounding guidance (New HOD Policy); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 501 be amended by deletion to read as follows:

~~RESOLVED, That our AMA support development of specialty specific white papers/best practices and systems for both safe medication administration practices and ongoing monitoring of potential complications from the administration of medications deemed suitable for exemptions from the National Institute for Occupational Safety and Health, United States Pharmacopeia, and other regulatory bodies when used in an office setting under the direction of a licensed physician (New HOD Policy); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 501 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA continue its compounding working group~~,~~ consisting of national specialty organizations, state medical societies, relevant agencies, and other appropriate stakeholders to advocate for ~~such exemptions~~ appropriate application of standards and to monitor policy impacting physicians. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 501 be adopted as amended.

Resolution 501 asks that our American Medical Association (AMA) adopt as policy that physicians and other health care providers administering medications (defined as the mixing or reconstituting of a drug according to manufacturers' recommendations for a single patient for immediate use) not be subject to the USP 800 compounding guidance, that our AMA support development of specialty specific white papers/best practices and systems for both safe medication administration practices and ongoing monitoring of potential complications from the administration of medications deemed suitable for exemptions from the National Institutes for Occupational Safety and Health, United States Pharmacopeia, and other regulatory bodies when used in an office setting under the direction of a licensed physician, and that our AMA continue its working group, consisting of national specialty organizations, state medical societies and other stakeholders to advocate for such exemptions.

Your Reference Committee heard passionate testimony on this issue. Several people noted the unintended consequences of the regulations outlined in <800>, yet others noted that the drugs included in <800> are indeed hazardous to those handling them, warranting safety standards for employees. USP offered testimony to clarify some of the points of the Resolution stating that Resolves one and two are already being addressed by existing efforts in

collaboration with the AMA and appropriate stakeholders. The five-year chapter review process is presently complete and there is no administrative mechanism for editing this chapter at this time. USP also noted that the principles of <800> are broadly relevant to hazardous drug handling activities across all facility types, and that they encourage the widespread adoption and use of <800> across all healthcare settings. They further specified that General Chapter <800> is compendially applicable – as opposed to informational – only to the extent to which USP General Chapters <795> and <797>, which are limited to non-sterile and sterile compounding respectively, apply. USP continued to note that State and other regulators may make their own determinations regarding the applicability and enforceability of <800> to entities within their jurisdiction, but that continued engagement with the AMA and appropriate stakeholders to develop resources and tools designed to protect patients and health care workers from potential harm of hazardous materials is a priority. Therefore, your Reference Committee recommends that Resolution 501 be adopted as amended.

(9) RESOLUTION 503 – ADDRESSING HEALTHCARE NEEDS OF CHILDREN OF INCARCERATED PARENTS

RESOLUTION 531 – SUPPORT FOR CHILDREN OF INCARCERATED PARENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate Resolution 503 be adopted in lieu of Resolutions 503 and 531:

CHILDREN OF INCARCERATED PARENTS

RESOLVED, That our American Medical Association support comprehensive evidence-based care, legislation, and initiatives that address the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who as at risk. (New HOD Policy)

Resolution 503 asks that our American Medical Association support comprehensive and evidence-based care that addresses the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who are at risk.

Resolution 531 asks that our American Medical Association support legislation and initiatives that provide resources and support for children of incarcerated parents.

Your Reference Committee heard testimony unanimously in support of both of these closely related resolutions. Therefore, your Reference Committee recommends that an alternate Resolution, which is a combination of the asks of the similar and original Resolutions 503 and 531, be adopted in lieu of them.

(10) RESOLUTION 504 – SCREENING, INTERVENTION, AND TREATMENT FOR ADVERSE CHILDHOOD EXPERIENCES

RESOLUTION 526 – TRAUMA-INFORMED CARE RESOURCES AND SETTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate Resolution 504 be adopted in lieu of Resolutions 504 and 526:

ADVERSE CHILDHOOD EXPERIENCES AND TRAUMA-INFORMED CARE

RESOLVED, That our American Medical Association supports:

1. evidence-based primary prevention strategies for Adverse Childhood Experiences (ACEs);
2. evidence-based trauma-informed care in all medical settings that focuses on the prevention of poor health and life outcomes after ACEs or other trauma occurs;
3. efforts for data collection, research and evaluation of cost-effective ACEs screening tools without additional burden for physicians;
4. efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACEs screening and trauma-informed care approaches into a clinical setting; and
5. funding for schools, behavioral and mental health services, professional groups, community and government agencies to support patients with ACEs or trauma;

(New HOD Policy)

Resolution 504 asks that our American Medical Association (AMA) support efforts for data collection, research and evaluation of Adverse Childhood Experiences (ACEs), cost-effective ACE screening tools without additional burden for physicians, and effective interventions, treatments and support services necessary for a positive screening practice in pediatric and adult populations, that our AMA support efforts to educate physicians about the facilitators, barriers and best practices for providers implementing ACE screening and trauma-informed care approaches into a clinical setting, and that our AMA support additional funding sources for schools, behavioral and mental health services, professional groups, community and government agencies to support children and adults with ACEs.

Resolution 526 asks that our American Medical Association (AMA) recognize trauma-informed care as a practice that recognizes the widespread impact of trauma on patients, identifies the signs and symptoms of trauma, and treats patients by fully integrating knowledge about trauma into policies, procedures, and practices and seeking to avoid re-traumatization and that our AMA support trauma-informed care in all settings, including but not limited to clinics, hospitals, and schools, by directing physicians and medical students to evidenced-based resources.

Your Reference Committee heard overwhelmingly supportive testimony for both Resolution 504 and Resolution 526. Many commenters noted the relationship between ACEs and trauma informed care. Many also commented that trauma is both physical and emotional and can occur throughout the lifespan of a patient. Physician testimony noted a need for clarification of the term "trauma-informed care." Your Reference Committee notes the phrase is an accepted term referring to the organizational structure and treatment framework involving the understanding, recognizing, and responding to the effects of all types of trauma, including physical, psychological and emotional safety. Because of the closely related ideas in these resolutions, your Reference Committee recommends that an alternate Resolution that combines concepts into a comprehensive policy be adopted in lieu of Resolution 504 and Resolution 526.

(11) RESOLUTION 508 – BENZODIAZEPINE AND OPIOID WARNING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 508 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) raise the awareness of ~~its members~~ physicians and patients regarding ~~of~~ the increased use of illicit benzodiazepine ~~sedative~~/opioid combinations leading to addiction and overdose death (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 508 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA warn ~~members~~ physicians and patients about the risks associated with concomitant use of benzodiazepines and opioids ~~this public health problem~~.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 508 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 508 be changed to read as follows:

CONCOMITANT USE OF BENZODIAZEPINES AND OPIOIDS

Resolution 508 asks that our American Medical Association (AMA) raise the awareness of its members of the increased use of illicit sedative/opioid combinations leading to addiction and

overdose death and that our AMA warn members and patients about this public health problem.

Your Reference Committee heard testimony largely in favor of this resolution as amended. Evidence from authoritative sources was brought up in testimony and illustrated the significant risks of concurrent benzodiazepine and opioid use. These risks include dramatic increase in the risk of opioid related overdose, dependence, and other adverse events. Research and reports from the National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration confirming these dangers and increases in benzodiazepine-related emergency visits was discussed and considered. The FDA black box warnings on benzodiazepine medications was noted in considering this Resolution. Evidence was discussed that overall, benzodiazepine prescribing as well as concomitant benzodiazepine and opioid use has been increasing. Testimony noted that increased risks apply in legitimately prescribed combinations of these drugs as well. Increased physician and public awareness on the risks of benzodiazepine and opioid combining is warranted in the interest of public health. Therefore, your Reference Committee recommends that Resolution 508 be adopted as amended.

(12) RESOLUTION 510 – THE INTRACRANIAL HEMORRHAGE ANTICOAGULATION REVERSAL (ICHAR) INITIATIVE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 510 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support initiatives to improve education, and reduce ~~the~~ barriers, (including lack of resources) for ~~to~~ the use of anticoagulation reversal agents, in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening conditions ~~clinical indications.~~ (New HOD Policy)

RECOMMENDATION: B

Madam Speaker, your Reference Committee recommends that Resolution 510 be adopted as amended.

Resolution 510 asks that our American Medical Association support initiatives to improve and reduce the barriers to the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening clinical indications.

Your Reference Committee heard largely supportive testimony for this resolution, including studies and guidelines supporting the use anticoagulant reversal agents in the emergency setting. There was commentary pertaining to the lack of resources being a prohibitive factor to using anticoagulation reversal agents, and not just lack of education. Therefore, your Reference Committee recommends that Resolution 510 be adopted as amended.

(13) RESOLUTION 512 – FERTILITY PRESERVATION IN PEDIATRIC AND REPRODUCTIVE AGED CANCER PATIENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 512 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) ~~encourage~~ supports as best practice the disclosure to cancer and other patients ~~on~~ of risks to fertility when gonadotoxic ~~gonadotoxicity due to cancer~~ treatment is used. ~~a possibility~~ (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 512 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ongoing education for providers who counsel patients ~~that~~ who may benefit from fertility preservation. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the Resolution 512 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 512 be changed to read as follows:

DISCLOSURE OF RISK TO FERTILITY WITH GONADOTOXIC TREATMENT

Resolution 512 asks that our American Medical Association (AMA) encourage disclosure to cancer patients on risks to fertility when gonadotoxicity due to cancer treatment is a possibility and that our AMA support education for providers who counsel patients that may benefit from fertility preservation.

Your Reference Committee heard testimony in strong support of this resolution. It was noted that existing guidelines support fertility counseling for at risk patients in advance of treatment, including for cancer patients. It was also noted that this principle may be applicable for other indications such as transplantation and the use of non-oncologic systemic agents that pose a risk of gonadotoxicity. A change in title was proposed to broaden the resolution to apply to additional conditions beyond cancer, and to ensure no overemphasis for certain age groups. Amendments were proposed to emphasize that disclosure is best practice and that education

should be ongoing, along with broadening to patients with other conditions. Testimony from NIH and USPHS supported amendments. Therefore, your Reference Committee recommends that Resolution 512 be adopted as amended with a change in title, to support disclosure of risks to fertility for all at risk patients.

(14) RESOLUTION 513 – DETERMINING WHY INFERTILITY RATES DIFFER BETWEEN MILITARY AND CIVILIAN WOMEN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 513 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~advocate for~~ support additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 513 be adopted as amended.

Resolution 513 asks that our American Medical Association advocate for additional research to better understand whether higher rates of infertility in service women may be linked to military service and which approaches might reduce the burden of infertility among service women.

Your Reference Committee heard testimony in strong support of this resolution. Testimony noted that a recent report documented higher rates of infertility among service women in a small study. Investigators who are actively researching this topic note the need for continued and additional work to understand the issue. An amendment was proposed to “support” instead of “advocate” for the research as clarification, given the role of the military and Congress in funding the research. Therefore, your Reference Committee recommends that Resolution 513 be adopted as amended.

(15) RESOLUTION 514 – OPIOID ADDICTION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-420.962 be reaffirmed in lieu of the first Resolve of Resolution 514.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 514 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~advocate that women who use opioids prior to caesarian section are offered~~ support a stepwise, multi-modal~~ities~~ approach to analgesia management (which may include nonpharmacologic and pharmacologic therapies including opioids) using a shared decision-making approach to minimize pain and ~~control pain and~~ improve function after caesarean birth ~~the procedure~~ with the goal of transitioning to other methods of pain control for long term. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 514 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with hospitals and relevant stakeholders ~~constituent organizations~~ to ~~assure that the~~ support the adoption of enhanced recovery after surgery protocol for caesarian section ~~is widely adopted~~ to optimize recovery and improve function while decreasing use of opioid medications for pain~~, especially given the impact of such use in breast-feeding mothers and their infants~~. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 514 be amended by the addition of the following new Resolve:

RESOLVED, that our AMA support counseling of women who are prescribed opioid analgesics following caesarean birth about the risk of central nervous system depression in the woman and the breastfed infant. (Directive to Take Action)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 514 be adopted as amended.

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that the title of Resolution 514 be changed to read as follows:

PAIN MANAGEMENT FOLLOWING CAESAREAN BIRTH

Resolution 514 asks that our American Medical Association (AMA) work with constituent organizations to assure that women of child-bearing age who are using opioids and are accessing the health care system undergo evaluation for pregnancy and, if pregnancy, be offered prenatal care, that our AMA advocate that women who use opioids prior to caesarian section are offered multi-modalities to control pain and improve function after the procedure with the goal of transitioning to other methods of pain control for long term, and that our AMA work with hospitals and relevant constituent organizations to assure that the enhanced recovery after surgery protocol for caesarian section is widely adopted to optimize recovery and improve function while decreasing use of opioid medications for pain, especially given the impact of such use in breast-feeding mothers and their infants.

Your Reference Committee heard testimony largely in favor of this resolution. Several amendments were offered to clarify the language of the Resolution. Your Reference Committee agrees with proffered amendments and, therefore, recommends that Resolution 514 be adopted as amended with a change in title.

Policy recommended for reaffirmation:

H-420.962, “Perinatal Addiction - Issues in Care and Prevention”

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

(16) RESOLUTION 515 – REVERSING OPIOID EPIDEMIC

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 515 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association include educational materials for physicians regarding sex-based differences in their resources related to the opioid epidemic ~~program, Reversing the Opioid Epidemic~~, ~~educational materials for physicians regarding sex-based differences~~. These sex-based differences include ~~in~~ the perception of pain, ~~including~~ the impact of co-morbid conditions, ~~sex-based differences in~~ response to opioids, ~~and~~ risks for opioid use disorder ~~addiction~~, ~~and~~ issues with access~~ing~~, and outcomes of addiction treatment programs among women.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 515 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 515 be changed to read as follows:

EDUCATION ON SEX-BASED RESPONSE TO OPIOIDS

Resolution 515 asks that our American Medical Association include in their program, Reversing the Opioid Epidemic, education materials for physicians regarding sex-based differences in perception of pain, including the impact of co-morbid conditions, sex-based differences in response to opioids and risks for opioid addiction, and issues with accessing and outcomes of addiction programs among women.

Your Reference Committee heard testimony in favor of adopting this resolution based on evidence of sex-based differences in women's response to opioids, issues of co-morbid conditions, and risk for opioid use disorder. Testimony and evidence presented related to sex-based responses to pain, co-morbid conditions, and that interventions for women should be based on the current sex-based research. Incongruency of the resolution and the title was noted and testimony was heard supporting changing the title of the resolution. Therefore, your Reference Committee recommends that Resolution 515 be adopted as amended with a change in title.

(17) RESOLUTION 516 – ALCOHOL CONSUMPTION AND HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 516 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) recognize that alcohol consumption at any level, not just ~~as well as~~ heavy alcohol ~~abuse~~ use or addictive alcohol use, ~~as~~ is a modifiable risk factor for cancer (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 516 be adopted as amended.

Resolution 516 asks that our American Medical Association (AMA) recognize alcohol consumption as well as alcohol abuse as a modifiable risk factor for cancer, that our AMA support research and educational efforts about the connection between alcohol consumption and several types of cancer, and that our AMA amend policy H-425.993, "Health Promotion and Disease Prevention," by addition and deletion to read as follows:

> "…(4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol consumption, ~~abuse,~~ particularly that which leads to illness, cancer, and accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits…"

Your Reference Committee heard testimony largely in support of this resolution. The connection between alcohol as a modifiable risk factor and cancer is well established, a public health need exists to communicate this risk to patients, but this is not covered by existing AMA policy. Therefore, your Reference Committee recommends that Resolution 516 be adopted as amended.

(18) RESOLUTION 517 – COMPOUNDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 517 be amended by deletion to read as follows:

~~RESOLVED, That our AMA oppose any state medical board action to delegate authority or oversight of physicians preparing medications in physicians' offices to another regulatory body (e.g., state pharmacy board) (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 517 be amended by addition to read as follows:

RESOLVED, That our AMA work with medical specialty societies to preserve a physician's ability to prepare medications in physicians' offices, and to be able to do so without being subject to unreasonable and burdensome equipment and process requirements by engaging with state policymakers (including but not limited to state legislatures, state medical boards, and state pharmacy boards) as well as accreditors.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 517 be adopted as amended.

Resolution 517 asks that our American Medical Association (AMA) provide a 50-state analysis of state law requirements governing in-office preparation of medications in physicians' offices, including which states have adopted USP Chapter 797 and how compounding is defined by state law, that our AMA oppose any state medical board action to delegate authority or oversight of physicians preparing medications in physicians' offices to another regulatory body (e.g., state pharmacy board), and that our AMA work with medical specialty societies to preserve a physician's ability to prepare medications in physicians' offices and be able to do so without being subject to unreasonable and burdensome equipment and process requirements.

Your Reference Committee heard mixed testimony on this resolution. Testimony noted that there is a need to better understand state law governing compounding which is addressed by Resolve one. Additional testimony noted that there might be a risk that physician ability to prepare medication may be impacted due to such legislation and additional understanding is necessary. USP provided strong testimony highlighting its ongoing collaboration with the AMA, dermatology associations, and physicians in the revision of <797> which was published on June 1, 2019 and reflects the advancements in science and practice as well as the input

from patients, health care practitioners, policymakers, academicians, and industry to ensure and maintain patient safety and access to quality of medicine. Your Reference Committee believes that the intent of Resolve two is unclear as it assumes that medical boards proactively delegate authority on this issue as opposed to pharmacy boards assuming it. Therefore, your Reference Committee recommends that Resolution 517 be adopted as amended.

(19) RESOLUTION 520 – SUBSTANCE USE DURING PREGNANCY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 520 be amended by addition and deletion to read as follows:

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance ~~ab~~use disorder during pregnancy represents child abuse; ~~and~~ (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy~~.~~; ~~and~~ (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate ~~an evaluation from a social worker.~~ and (4) advocate for appropriate medical evaluation, which takes into account the patient's treatment status and current impairment when substance use is suspected, prior to removal of the child. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 520 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Policy H-95.985 be reaffirmed.

Resolution 520 asks that our American Medical Association amend policy H-420.950, "Substance Use Disorders During Pregnancy," by addition as follows:

> Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse; and (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy.; and (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without an evaluation from a social worker.

Your Reference Committee heard testimony largely in favor of this amendment to AMA policy. Testimony noted that substance use disorder should be seen primarily as a disease and that the focus should be on proper assessment and treatment for the patient and not on criminality. Also noted was the idea that a single drug test does not provide conclusive evidence of

substance use disorder or child abuse or neglect; this concept is addressed in current policy. Therefore, your Reference Committee recommends that Resolution 520 should be adopted as amended and Policy H-95.985 reaffirmed.

Policy recommended for reaffirmation:

H-95.985, “Drug Testing”

Our AMA believes that physicians should be familiar with the strengths and limitations of drug testing techniques and programs:

1. Due to the limited specificity of the inexpensive and widely available non-instrumented devices such as point-of-care drug testing devices, acceptable clinical drug testing programs should include the ability to access highly specific, analytically acceptable confirmation techniques, which definitively establish the identities and quantities of drugs, in order to further analyze results from presumptive testing methodologies. Physicians should consider the value of data from non-confirmed preliminary test results, and should not make major clinical decisions without using confirmatory methods to provide assurance about the accuracy of the clinical data.
2. Results from drug testing programs can yield accurate evidence of prior exposure to drugs. Drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use, nor does it provide valid or reliable information about harm or potential risk of harm to children or, by itself, provide indication or proof of child abuse, or neglect or proof of inadequate parenting.
3. Before implementing a drug testing program, physicians should: (a) understand the objectives and questions they want to answer with testing; (b) understand the advantages and limitations of the testing technology; (c) be aware of and educated about the drugs chosen for inclusion in the drug test; and (d) ensure that the cost of testing aligns with the expected benefits for their patients. Physicians also should be satisfied that the selection of drugs (analytes) and subjects to be tested as well as the screening and confirmatory techniques that are used meet the stated objectives.
4. Since physicians often are called upon to interpret results, they should be familiar with the disposition characteristics of the drugs to be tested before interpreting any results. If interpretation of any given result is outside of the expertise of the physician, assistance from appropriate experts such as a certified medical review officer should be pursued.

(20) RESOLUTION 522 – IMPROVED DEFERRAL PERIODS FOR BLOOD DONORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 522 be amended by addition and deletion to read as follows:

Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence ~~the scientific literature~~; ~~and~~ (3) supports a blood donation deferral period for ~~men who have sex with men~~ those determined to be at risk for transmission of HIV that is representative of current HIV testing technology. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 522 be adopted as amended.

Resolution 522 asks that our American Medical Association amend AMA policy H-50.973, "Blood Donor Deferral Criteria," by addition and deletion to read as follows:

> Our AMA: (1) supports the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on the scientific literature; ~~and~~ (3) supports a blood donation deferral period for men who have sex with men that is representative of current HIV testing technology; and (4) supports research into individual risk assessment criteria for blood donation.

Your Reference Committee heard unanimously supportive testimony for this Resolution with several requests for amending language that singles out men who have sex men and asks for it to be replaced with language that does not single out one group but focuses instead on individual risk factors. Testimony from the GLMA and others supported this change in language. Several commenters noted that the current evidence-base does not support the current deferral period. Others noted that the current deferral period relies on categories rather than assessing an individual's risk for HIV infection and potential transmission. The committee also recommended the use of evidence that includes, but is not limited to, only scientific literature when assessing blood and tissue donation policies. Therefore, your Reference Committee recommends that Resolution 522 be adopted as amended.

(21) RESOLUTION 525 – SUPPORT FOR ROOMING-IN OF NEONATAL ABSTINENCE SYNDROME PATIENTS WITH THEIR PARENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolved of Resolution 525 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association (AMA) supports keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient's health and safety permits, and as supported by validated risk stratification tools for ~~through the implementation of~~ rooming-in programs. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 525 be adopted as amended.

Resolution 525 asks that our American Medical Association (AMA) support keeping patients with neonatal abstinence syndrome with their parents or legal guardians in the hospital throughout their treatment, as the patient's health and safety permits, through the implementation of rooming-in programs and that our AMA support the education of physicians about rooming-in patients with neonatal abstinence syndrome.

Your Reference Committee heard testimony largely in support of the intent of this Resolution. However, several commenters noted that some of the language in the original Resolution was too prescriptive, and others noted that tools are available and should be utilized in the management of patients with NAS. Therefore, your Reference Committee agrees that risk stratification tools can be useful for physicians when managing patients with NAS and recommends that Resolution 525 be adopted as amended.

(22) RESOLUTION 527 – INCREASING THE AVAILABILITY OF BLEEDING CONTROL SUPPLIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 527 be adopted as amended to read as follows:

RESOLVED, That American Medical Association Policy H-130.935, "Support for Hemorrhage Control Training," be amended by addition to read as follows:

H-130.935, "Support for Hemorrhage Control Training"

(1) Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
(2) Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
(3) Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 527 be adopted as amended.

Resolution 527 asks that our American Medical Association Policy H-130.935, "Support for Hemorrhage Control Training," be amended by addition to read as follows:

H-130.935 Support for Hemorrhage Control Training

(4) Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
(5) Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
(6) Our AMA supports the increased availability of bleeding control supplies in schools, places of employment, and public buildings.

Your Reference Committee heard overwhelming supportive testimony for the Resolution. Commenters noted the significant need for relevant civilian preparedness to address bleeding incidences, the "Stop the Bleed" campaign, and the need for adequate education on effective tourniquet usage citing the phrase "turn it til it hurts." The original resolution did not specify the need for adequate education on tourniquet usage. Therefore, your Reference Committee recommends that Resolution 527 be adopted as amended.

(23) RESOLUTION 529 – ADVERSE IMPACTS OF DELAYING THE IMPLEMENTATION OF PUBLIC HEALTH REGULATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 529 be amended by deletion to read as follows:

~~RESOLVED, That our American Medical Association (AMA) urge the Environmental Protection Agency and other federal regulatory agencies to enforce pesticide regulations, particularly of restricted use pesticides, that safeguard human and environmental health, especially in vulnerable populations including but not limited to agricultural workers, immigrant migrant workers, and children (Directive to Take Action); and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 529 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~analyze~~ monitor and evaluate ~~ongoing~~ regulation delays that impact public health, and advocate as ~~deemed~~ appropriate to decrease regulatory delays. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 529 be adopted as amended.

Resolution 529 asks that our American Medical Association (AMA) urge the Environmental Protection Agency and other federal regulatory agencies to enforce pesticide regulations, particularly of restricted use pesticides, that safeguard human and environmental health, especially in vulnerable populations including but not limited to agricultural workers, immigrant migrant workers, and children and that our AMA analyze ongoing regulation delays that impact public health, as deemed appropriate.

Testimony was largely supportive of this resolution and noted that delays in enforcement of environmental and health regulations could have an adverse effect on public health, particularly for vulnerable populations. Testimony proposed an amendment to strike Resolve 1, which was considered much broader, and not reflective of the title of the amendment. In addition, testimony expressed concern over the focus on analysis, and it was pointed out that other groups are already analyzing the impact of these delays. Therefore, your Reference Committee recommends that Resolution 529 be adopted as amended.

(24) RESOLUTION 518 – CHEMICAL VARIABILITY IN PHARMACEUTICAL PRODUCTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 518 be referred for report back at the 2020 Annual Meeting.

Resolution 518 asks that our American Medical Association (AMA) do a study and report back by the 2019 Interim Meeting regarding the pharmaceutical variability, both in active pharmaceutical ingredient and dissolution, the impact on patient care and make recommendations for action from their report findings, that our AMA advocate for legislation requiring independent testing and verification of the chemical content of batches of pharmaceuticals, and that our AMA advocate for the logging of batches at the patient level, so the batches can be traced and connected to patient outcomes or adverse events.

Your Reference Committee heard testimony largely in support of this Resolution. Several commenters noted confusion about some of the concepts detailed in the Resolution. The U.S. Public Health Service provided some clarification on concepts presented and the Council on Science and Public Health noted that there are several issues related to pharmacovigilance, track and trace, and testing and verification of pharmaceuticals that could benefit from further study. Your Reference Committee agrees with the Council and, therefore, recommends that Resolution 518 be referred.

(25) RESOLUTION 507 – REMOVING ETHYLENE OXIDE AS A MEDICAL STERILANT FROM HEALTHCARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 507 be referred for decision.

Resolution 507 asks that our American Medical Association (AMA) adopt as policy and urge, as appropriate, the prevention of ethylene oxide emissions and substitution of ethylene oxide with less toxic sterilization alternatives that are currently available, including hydrogen peroxide, steam, and other safer alternatives, which do not release carcinogens into the workplace or community air and allow no residual exposures to the patient and that our AMA adopt as policy and urge that when health care facilities are evaluating surgical and medical devices that require sterilization, in addition to effectiveness of the device for best patient outcomes, that facilities also be required to prioritize the modes of sterilization for the highest degree of worker and environmental safety.

Mixed testimony was offered for this resolution. It was noted that ethylene oxide is toxic and a group 1 carcinogen and that exposures should be minimized. Incidence of excessive ethylene oxide emissions in an IL sterilization facility are being investigated at the state and federal level; the facility has been shut down during the investigation. Conversely, CA passed a legislation limiting the use of ethylene oxide due to similar public health concerns, but this led to unintended consequences including surgical supply shortage and compromised patient care. The FDA noted in testimony that they are taking a comprehensive approach on this issue and are actively working with sterilization experts, medical device manufacturers, and

other government agencies to advance innovative ways to sterilize medical devices. Given these concerns and conflicting outcomes, your Reference Committee recommends that Resolution 507 be referred for decision.

(26) RESOLUTION 530 – IMPLEMENTING NALOXONE TRAINING INTO THE BASIC LIFE SUPPORT (BLS) CERTIFICATION PROGRAM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 530 not be adopted.

Resolution 530 asks that our American Medical Association collaborate with the Occupational Safety and Health Administration and state medical societies to include naloxone rescue kits in first aid equipment.

Your Reference Committee heard testimony supportive of the concepts noted in this Resolution, but also heard calls for clarification of the ask of the Resolution since the title and text are incongruent. To include naloxone training in BLS, the American Heart Association would need to change their training and certification requirements; currently, many free naloxone training programs exist. It was also noted that logistic issues are associated with the inclusion of naloxone in first-aid kits due to storage and stability issues related to heat and light exposure. Additionally, the need for the FDA to regulate this practice and approve over-the-counter availability of a naloxone product that would be suitable for placement in a public setting or first-aid kit should be addressed. Your Reference Committee commends the intent of this resolution and welcomes future Resolutions with clarified language on this topic. Therefore, your Reference Committee recommends that Resolution 530 not be adopted.

(27) RESOLUTION 505 – GLYPHOSATE STUDIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-135.942 and D-135.997 be reaffirmed in lieu of Resolution 505.

Resolution 505 asks that our American Medical Association advocate for a reduction in the use of glyphosate-based pesticides (the primary chemical in the herbicide branded Roundup), encourage the evaluation of alternatives, and support additional research to determine the long term effects and association between glyphosate and disease.

Your reference committee heard mixed testimony on this controversial topic. It was noted that the scientific literature on the topic has failed to show a consistent connection between agricultural use of glyphosate and cancer, but that some studies have supported the connection resulting in recent multi-billion-dollar liability awards. The issue is emotionally-charged with media suggesting corporate interference in some of the numerous large-scale studies showing no adverse health effects. Existing AMA policy supports research and evidence-based policies that protect the environment and public health, and this certainly applies directly to this issue. Policy H-135.942 supports the assessment of adverse effects of chemicals, and D-135.997 advocates for funding for research into the environmental

contributors to disease. Your Reference Committee felt that Resolution 505 overstates what we can confidently conclude about glyphosate in a way that will certainly be construed politically. We therefore recommend reaffirmation of H-135.942 and D-135.997 in lieu of this resolution.

Policies recommended for reaffirmation:

H-135.942, “Modern Chemicals Policies”

Our AMA supports: (1) the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern; and (2) the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment.

D-135.997, “Research into the Environmental Contributors to Disease”

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Madam Speaker, this concludes the report of Reference Committee E. I would like to thank William Bowman, MD, Wayne C. Hardwick, MD, Shane Hopkins, MD, Shawn C. Jones, MD, Nancy L. Mueller, MD, Raymond Wynn, MD, and all those who testified before the Committee as well as our AMA staff.

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Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)

Report of Reference Committee F

Greg Tarasidis, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 – AMA 2020 Dues

2. Board of Trustees Report 10 – Conduct at AMA Meetings and Events

3. Board of Trustees Report 12 – Data Used to Apportion Delegates

4. Board of Trustees Report 24 – Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion

5. Board of Trustees Report 27 – Advancing Gender Equity in Medicine

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

7. Resolution 602 – Expectations for Behavior at House of Delegates Meetings

8. Resolution 605 – State Societies and the AMA Litigation Center

9. Resolution 607 – Re-establishment of National Guideline Clearinghouse

10. Resolution 609 – Update to AMA Policy H-525.998, “Women in Organized Medicine”

11. Resolution 610 – Mitigating Gender Bias in Medical Research

12. Resolution 616 – TIME’S UP Healthcare

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

13. Resolution 603 – Creation of an AMA Election Reform Committee
    Resolution 611 – Election Reform

14. Resolution 606 – Investigation into Residents, Fellows, and Physician Unions

15. Resolution 614 – Racial and Ethnic Identity Demographic Collection by the AMA

16. Resolution 617 – Disabled Physician Advocacy

17. Resolution 618 – Stakeholder Input to Reports of the House of Delegates

RECOMMENDED FOR REFERRAL

18. Resolution 608 – Financial Protections for Doctors in Training

19. Resolution 612 – Request to AMA for Training in Health Policy and Health Law

20. Resolution 613 – Language Proficiency Data of Physicians in AMA Masterfile

21. Resolution 615 – Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership

RECOMMENDED FOR NOT ADOPTION

22. Resolution 601 – AMA Policy Statement with Editorials

23. Resolution 604 – Engage and Collaborate with the Joint Commission

RECOMMENDED FOR FILING

24. Board of Trustees Report 1 – Annual Report

(1) BOARD OF TRUSTEES REPORT 4 - AMA 2020 DUES

RECOMMENDATION:

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

Board of Trustees Report 4 recommends no changes to our AMA membership dues levels for 2020. The Report further notes that our AMA last raised its dues in 1994.

Regular Members	$420
Physicians in Their Second Year of Practice	$315
Physicians in Military Service	$280
Physicians in Their First Year of Practice	$210
Semi-Retired Physicians	$210
Fully Retired Physicians	$84
Physicians in Residency Training	$45
Medical Students	$20

Your Reference Committee heard limited testimony seeking clarity on the dues pricing structure. The Board of Trustees explained that membership pilot programs are currently being tested and posted on the website, which may result in discrepancies.

Your Reference Committee wishes to highlight the continued stability in the cost of an AMA membership. This year marks the 25th year since the last increase in dues occurred.

(2) BOARD OF TRUSTEES REPORT 10 - CONDUCT AT AMA MEETINGS AND EVENTS

RECOMMENDATION:

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

Board of Trustees Report 10 summarizes the evaluation and joint recommendations provided by the external consultants called for in Policy D-140.954, "Harassment Issues Within the AMA," and recommends the following revisions to the procedures implementing the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities:

1. That Policy D-140.954, "Harassment Issues Within the AMA," be rescinded as having been fulfilled by the report. (Rescind HOD Policy)

2. That Policy H-140.837, "Anti-Harassment Policy," be renamed "Policy on Conduct at AMA Meetings and Events" and further amended by insertion and deletion as follows (Modify Current HOD Policy):

~~**Anti-Harassment Policy Applicable to AMA Entities**~~
Policy on Conduct at AMA Meetings and Events

It is the **policy** of the American Medical Association that all attendees of AMA hosted meetings, events and other activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events and activities, including but not limited to dinners, receptions and social gatherings held in conjunction with such AMA hosted meetings, events and other activities. Attendees should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

~~a~~Any type of harassment of any attendee of an AMA ~~staff, fellow delegates or others by members of the House of Delegates or~~ hosted meeting, event and other ~~attendees at or in connection with HOD meetings, or otherwise~~ activity, including but not limited to dinners, receptions and social gatherings held in conjunction with ~~HOD meetings,~~ an AMA hosted meeting, event or activity, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA ~~delegates and staff are conducting AMA~~ business is conducted. This zero tolerance **policy** also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an "AMA Entity"), as well as other AMA-sponsored events. The purpose of the policy is to protect participants in AMA-sponsored events from harm.

Definition

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise ~~protected group status~~, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

Sexual Harassment

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this **policy**, sexual harassment includes:

- making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and

- creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual's work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual's physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

Operational Guidelines

The AMA shall, through the Office of General Counsel, implement and maintain mechanisms for reporting, investigation, and enforcement of the Policy on Conduct at AMA Meetings and Events in accordance with the following:

1. *Conduct Liaison and Committee on Conduct at AMA Meetings and Events (CCAM)*

   The Office of General Counsel will appoint a "Conduct Liaison" for all AMA House of Delegates meetings and all other AMA hosted meetings or activities (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel, or JAMA Editorial Boards), with responsibility for receiving reports of alleged policy violations, conducting investigations, and initiating both immediate and longer-term consequences for such violations. The Conduct Liaison appointed for any meeting will have the appropriate training and experience to serve in this capacity, and may be a third party or an in-house AMA resource with assigned responsibility for this role. The Conduct Liaison will be (i) on-site at all House of Delegates meetings and other large, national AMA meetings and (ii) on call for smaller meetings and activities. Appointments of the Conduct Liaison for each meeting shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in investigation of alleged policy violations and in decisions on consequences for policy violations.

   The AMA shall establish and maintain a Committee on Conduct at AMA Meetings and Events (CCAM), to be comprised of 5-7 AMA members who are nominated by the Office of General Counsel (or through a nomination process facilitated by the Office of General Counsel) and approved by the Board of Trustees. The CCAM should include one member of the Council on Ethical and Judicial Affairs (CEJA). The remaining members may be appointed from AMA membership generally, with emphasis on maximizing the diversity of membership. Appointments to the CCAM shall ensure appropriate independence and neutrality, and avoid even the appearance of conflict of interest, in decisions on consequences for policy violations. Appointments to the CCAM should be multi-year, with staggered terms.

2. *Reporting Violations of the Policy*

Any persons who believe they have experienced or witnessed conduct in violation of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," during any AMA House of Delegates meeting or other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), CPT Editorial Panel or JAMA Editorial Boards) should promptly notify the (i) Conduct Liaison appointed for such meeting, and/or (ii) the AMA Office of General Counsel and/or (iii) the presiding officer(s) of such meeting or activity.

Alternatively, violations may be reported using an AMA reporting hotline (telephone and online) maintained by a third party on behalf of the AMA. The AMA reporting hotline will provide an option to report anonymously, in which case the name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the Conduct Liaison may investigate.

These reporting mechanisms will be publicized to ensure awareness.

3. *Investigations*

All reported violations of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," pursuant to Section 2 above (irrespective of the reporting mechanism used) will be investigated by the Conduct Liaison. Each reported violation will be promptly and thoroughly investigated. Whenever possible, the Conduct Liaison should conduct incident investigations on-site during the event. This allows for immediate action at the event to protect the safety of event participants. When this is not possible, the Conduct Liaison may continue to investigate incidents following the event to provide recommendations for action to the CCAM. Investigations should consist of structured interviews with the person reporting the incident (the reporter), the person targeted (if they are not the reporter), any witnesses that the reporter or target identify, and the alleged violator.

Based on this investigation, the Conduct Liaison will determine whether a violation of the Policy on Conduct at AMA Meetings and Events has occurred.

All reported violations of the Policy on Conduct at AMA Meetings and Events, and the outcomes of investigations by the Conduct Liaison, will also be promptly transmitted to the AMA's Office of General Counsel (i.e. irrespective of whether the Conduct Liaison determines that a violation has occurred).

4. *Disciplinary Action*

If the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison may take immediate action to protect the safety of event participants, which may include having the violator removed from the AMA meeting, event or activity, without warning or refund.

Additionally, if the Conduct Liaison determines that a violation of the Policy on Conduct at AMA Meetings and Events has occurred, the Conduct Liaison shall report any such violation to the CCAM, together with recommendations as to whether additional commensurate disciplinary and/or corrective actions (beyond those taken on-site at the meeting, event or activity, if any) are appropriate.

The CCAM will review all incident reports, perform further investigation (if needed) and recommend to the Office of General Counsel any additional commensurate disciplinary and/or corrective action, which may include but is not limited to the following:

- Prohibiting the violator from attending future AMA events or activities;
- Removing the violator from leadership or other roles in AMA activities;
- Prohibiting the violator from assuming a leadership or other role in future AMA activities;
- Notifying the violator's employer and/or sponsoring organization of the actions taken by AMA;
- Referral to the Council on Ethical and Judicial Affairs (CEJA) for further review and action;
- Referral to law enforcement.

The CCAM may, but is not required to, confer with the presiding officer(s) of applicable events activities in making its recommendations as to disciplinary and/or corrective actions. Consequence for policy violations will be commensurate with the nature of the violation(s).

5. *Confidentiality*

All proceedings of the CCAM should be kept as confidential as practicable. Reports, investigations, and disciplinary actions under Policy on Conduct at AMA Meetings and Events will be kept confidential to the fullest extent possible, consistent with usual business practices.

6. *Assent to Policy*

As a condition of attending and participating in any meeting of the House of Delegates, or any council, section, or other AMA entities, such as the RVS Update Committee (RUC), CPT Editorial Panel and JAMA Editorial Boards, or other AMA hosted meeting or activity, each attendee will be required to acknowledge and accept (i) AMA policies concerning conduct at AMA HOD meetings, including the Policy on Conduct at AMA Meetings and Events and (ii) applicable adjudication and disciplinary processes for violations of such policies (including those implemented pursuant to these Operational Guidelines), and all attendees are expected to conduct themselves in accordance with these policies.

Additionally, individuals elected or appointed to a leadership role in the AMA or its affiliates will be required to acknowledge and accept the Policy on Conduct at AMA Meetings and Events and these Operational Guidelines.

~~1. Reporting a complaint of harassment~~

~~Any persons who believe they have experienced or witnessed conduct in violation of Anti-Harassment Policy H-140.837 during any AMA House of Delegates meeting or associated functions should promptly notify the Speaker or Vice Speaker of the House or the AMA Office of General Counsel.~~

~~Any persons who believe they have experienced or witnessed conduct in other activities associated with the AMA (such as meetings of AMA councils, sections, the RVS Update Committee (RUC), or CPT Editorial Panel) in violation of Anti-Harassment Policy H-140.837 should promptly notify the presiding officer(s) of such AMA-associated meeting or activity or either the Chair of the Board or the AMA Office of General Counsel.~~

~~Anyone who prefers to register a complaint to an external vendor may do so using an AMA compliance hotline (telephone and online) maintained on behalf of the AMA. The name of the reporting party will be kept confidential by the vendor and not be released to the AMA. The vendor will advise the AMA of any complaint it receives so that the AMA may investigate.~~

~~2. Investigations~~

~~Investigations of harassment complaints will be conducted by AMA Human Resources. Each complaint of harassment or retaliation shall be promptly and thoroughly investigated. Generally, AMA Human Resources will (a) use reasonable efforts to minimize contact between the accuser and the accused during the pendency of an investigation and (b) provide the accused an opportunity to respond to allegations. Based on its investigation, AMA Human Resources will make a determination as to whether a violation of Anti-Harassment Policy H-140.837 has occurred.~~

~~3. Disciplinary Action~~

~~If AMA Human Resources shall determine that a violation of Anti-Harassment Policy H-140.837 has occurred, AMA Human Resources shall (i) notify the Speaker and Vice Speaker of the House or the presiding officer(s) of such other AMA-associated meeting or activity in which such violation occurred, as applicable, of such determination, (ii) refer the matter to the Council on Ethical and Judicial Affairs (CEJA) for disciplinary and/or corrective action, which may include but is not limited to expulsion from the relevant AMA-associated meetings or activities, and (iii) provide CEJA with appropriate training.~~

~~If a Delegate or Alternate Delegate is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the Speaker and Vice Speaker of the House.~~

~~If a member of an AMA council, section, the RVS Update Committee (RUC), or CPT Editorial Panel is determined to have violated Anti-Harassment Policy H-140.837, CEJA shall determine disciplinary and/or corrective action in consultation with the presiding officer(s) of such activities.~~

~~If a nonmember or non-AMA party is the accused, AMA Human Resources shall refer the matter to appropriate AMA management, and when appropriate, may suggest that the complainant contact legal authorities.~~

~~4. Confidentiality~~

~~To the fullest extent possible, the AMA will keep complaints, investigations and resolutions confidential, consistent with usual business practice.~~

Your Reference Committee heard overwhelming support for Board of Trustees Report 10, including accolades for culminating a two-year process with a progressive plan to ensure our AMA is a safe environment for everyone. Concerns were expressed in testimony to the Reference Committee regarding due process, and asked that the Board of Trustees address this issue in the near future. However, the preponderance of testimony was supportive of immediate implementation of Board of Trustees Report 10.

(3) BOARD OF TRUSTEES REPORT 12 - DATA USED TO APPORTION DELEGATES

RECOMMENDATION:

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

Board of Trustees Report 12 is presented in response to Policy G-600.016, "Data Used to Apportion Delegates" and includes an amendment to the current policy, which serves to clarify mid-year reporting of membership counts as follows:

A. That Policy G-600.016, "Data Used to Apportion Delegates," be amended to read as follows:

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review ~~and state medical society~~ of its current AMA membership count ~~status report~~. (New HOD Policy)

2. "Pending members" will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to ~~national medical specialty and~~ state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity. (New HOD Policy)

~~3. Our AMA Physician Engagement department will develop a mechanism to prevent a second counting of those previous "pending members" at the end of the following year until their membership has been renewed. (Directive to Take Action)~~

4. Our AMA will track "pending members" from a given year who are counted towards delegate allocation for the following year and these members will not be counted

again for delegate allocation unless they renew their membership before the end of the following year. (New HOD Policy)

5. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy. (Directive to Take Action)

B. That the Council on Constitution and Bylaws prepare a report for the 2019 Interim Meeting that will allow the implementation of Policy G-600.016, as amended herein.

Your Reference Committee heard only supportive testimony favoring adoption of Board of Trustees Report 12.

(4) BOARD OF TRUSTEES REPORT 24 - DISCOUNTED / WAIVED CPT FEES AS AN AMA MEMBER BENEFIT AND FOR MEMBERSHIP PROMOTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 24 be adopted and the remainder of the Report be filed.

Board of Trustees Report 24 is presented in response to Resolution 607-A-18, which called upon our AMA to investigate mechanisms by which AMA members may receive a discount or waiver on CPT-related fees, including fees associated with using CPT codes within electronic medical billing systems.

Through the analysis that led to this report, an opportunity was identified to improve AMA member benefits for direct licensees with 25 or fewer users by increasing their discount to 30 percent. This change will go into effect for the 2020 CPT data file. The increased discount will enable the AMA to continue to support its mission, while having a positive impact on AMA members in small practices. This is also consistent with other AMA Membership discount programs. Consequently, the Board of Trustees recommends that Resolution 607-A-18 not be adopted and that the remainder of the report be filed.

Your Reference Committee received no testimony in response to Board of Trustees Report 24. Your Reference Committee agrees with the recommendations in the report.

(5) BOARD OF TRUSTEES REPORT 27 - ADVANCING GENDER EQUITY IN MEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 27 be adopted and the remainder of the Report be filed.

Board of Trustees Report 27 is presented in response to Policy D-65.989, "Advancing Gender Equity in Medicine," which directs our AMA to draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers, and other entities that employ physicians.

In this report, the Board of Trustees recognizes gender inequity in medicine as a complex, pervasive issue that requires a multilayered approach. Accordingly, the Board recommends that the following be adopted and that the remainder of the report be filed:

a. That our American Medical Association adopt the following language as policy, "Principles for Advancing Gender Equity in Medicine":

   Our AMA:

   1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);

   2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;

   3. endorses the principle of equal opportunity of employment and practice in the medical field;

   4. affirms its commitment to the full involvement of women in leadership roles throughout the Federation, and encourages all components of the Federation to vigorously continue their efforts to recruit women members into organized medicine;

   5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;

   6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;

   7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;

   8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and

   9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas. (New HOD Policy)

b. That our AMA rescind the following policies, as they have been incorporated into the "Principles for Advancing Gender Equity in Medicine":

   a. D-200.981, "Gender Disparities in Physician Income and Advancement,"
   b. H-525.992, "Women in Medicine," and
   c. H-65.968, "Equal Opportunity" (Rescind HOD Policy)

c. That our AMA rescind AMA Policy D-65.989 (1), "Advancing Gender Equity in Medicine," as this report has fulfilled the request for information on positions and recommendations regarding gender equity in medicine, including the development of clarifying principles. (Rescind HOD Policy)

d. That our AMA encourage state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine. (Directive to Take Action)

e. That our AMA encourage academic medical centers, medical schools, hospitals, group practices, and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. (Directive to Take Action)

f. That our AMA modify Policy D-65.989, "Advancing Gender Equity in Medicine," and continue to: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement. (Modify HOD Policy)

g. That our AMA amend AMA Policy G-600.035, "The Demographics of the House of Delegates," to read as follows:

   a. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

   b. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year.

   c. Future reports on the demographic characteristics of the House of Delegates <u>should, whenever possible,</u> ~~will~~ identify and include information on successful

initiatives and best practices to promote diversity within~~, particularly by age,~~ state and specialty society delegations. (Modify Current HOD Policy)

Your Reference Committee heard overwhelming testimony in favor of this report. Limited testimony was received on language used in the Principles for Advancing Gender Equity in Medicine. It was raised that the term “gender nonconforming members” should be included in the fourth principle. Your Reference Committee wishes to note that this study specifically addressed disparities between female and male physicians. Additionally, it was suggested that “gender” should replace “personal characteristics” in the sixth principle. Your Reference Committee highlights the fact that evaluating compensation can include factors that are indirectly related to gender. Your Reference Committee commends the Board of Trustees for the development of these principles to help advance equity for women physicians and physicians-in-training.

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

RECOMMENDATION:

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

The Report of the House of Delegates Committee on the Compensation of the Officers reminds the House that at the 2018 Interim Meeting a stipend was approved for the President and his/her family when they lose their employer’s health insurance.

In this report, the Compensation Committee recommends amending the definition of eligibility so that President(s) who already have health insurance coverage through Medicare when elected will not be eligible for the stipend for themselves or family members.

Additionally, this report of the Compensation Committee recommends amending the eligibility definition so that if a President becomes Medicare eligible while in office, the President will be expected to enroll in Medicare and the stipend will continue to cover family members who are not Medicare eligible; the amount of the stipend will be adjusted accordingly; and the stipend would be reported as taxable income to the President(s).
Your Reference Committee received no testimony in response to the Report of the House of Delegates Committee on the Compensation of the Officers.

Your Reference Committee extends its appreciation to the members of the House of Delegates Committee on the Compensation of the Officers for this follow-up report and solution that addresses specific concerns about insurance coverage impacting a President who becomes Medicare eligible while in office.

(7) RESOLUTION 602 - EXPECTATIONS FOR BEHAVIOR AT HOUSE OF DELEGATES MEETINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 602 be adopted.

Resolution 602 calls upon our AMA to require every AMA HOD delegate and alternate delegate, as a condition to receiving their credentials for any AMA HOD meeting, to acknowledge and accept during our AMA HOD meeting registration process AMA policies concerning conduct at AMA HOD meetings, and applicable adjudication and disciplinary processes for violations of such policies.

Additionally, Resolution 602 directs that any AMA HOD delegate or alternate delegate who knowingly fails to acknowledge and accept during our AMA HOD meeting registration process AMA policies concerning conduct at AMA HOD meetings, and applicable adjudication and disciplinary processes for violations of such policies shall not be credentialed as a delegate or alternate delegate at that meeting.

Beyond your Speakers' introduction of Resolution 602, your Reference Committee received no on-site testimony and only a supportive online comment. Your Reference Committee appreciates the efforts of our AMA speakers for codifying standards of acceptable behavior within our House of Delegates.

(8) RESOLUTION 605 - STATE SOCIETIES AND THE AMA LITIGATION CENTER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 605 be adopted.

Resolution 605 directs that when seeking a state medical society's support of an amicus brief on a legal matter, especially one pertaining to an issue in that state, the AMA Litigation Center consider the state medical society's point of view in developing the argument, and maintain full disclosure during the drafting of an amicus brief or any change in strategy.

Your Reference Committee heard limited testimony outlining an occurrence in which a state did not feel that our AMA was considerate of its position. Background information provided to your Reference Committee indicated that our AMA makes a strong attempt to be as collaborative as possible with the members of the Federation while maintaining a broad representative voice.

(9) RESOLUTION 607 - RE-ESTABLISHMENT OF NATIONAL GUIDELINE CLEARINGHOUSE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 607 be adopted.

Resolution 607 calls upon our AMA reaffirm Policy H-410.965, “Clinical Practice Guidelines, Performance Measures, and Outcomes Research Activities.”

Additionally, Resolution 607 calls upon our AMA to research possible and existing alternatives for the functions of the National Guidelines Clearinghouse with a report back to the House of Delegates.

Your Reference Committee heard overwhelming support in identifying options for organizations that can make clinical practice guidelines available to physicians that will support patient safety and improve health outcomes. In particular, it was noted that our AMA should provide guidance regarding potential conflicts of interest.

(10) RESOLUTION 609 - UPDATE TO AMA POLICY H-525.998, "WOMEN IN ORGANIZED MEDICINE"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 609 be adopted.

Resolution 609 calls upon our AMA to amend Policy H-525.998, “Women in Organized Medicine,” by deletion to read as follows:

Our AMA:

(1) reaffirms its policy advocating equal opportunities and opposing sex discrimination in the medical profession;

(2) supports the concept of increased tax benefits for working parents;

(3) (a) supports the concept of proper child care for families of working parents; (b) reaffirms its position on child care facilities in or near medical centers and hospitals; (c) encourages business and industry to establish employee child care centers on or near their premises when possible; and (d) encourages local medical societies to survey physicians to determine the interest in clearinghouse activities and in child care services during medical society meetings; and

(4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased availability of such programs.~~; and~~

~~(5) supports that the AMA Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians Congress,~~

~~and forwarded to the House of Delegates for approval, and include not only resources for training programs but also private practice settings. To facilitate wide distribution and easy access, the Guidelines will be placed on the AMA Web site.~~

Your Reference Committee heard limited testimony indicating the purpose of this resolution is to align with ongoing efforts of our AMA to address harassment. Harassment awareness continues to be on the forefront of our AMA's priorities and there is a more detailed process in place, which renders this stricken language obsolete.

(11) RESOLUTION 610 - MITIGATING GENDER BIAS IN MEDICAL RESEARCH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 610 be adopted.

Resolution 610 calls upon our AMA to advocate for the establishment of best practices that remove any gender bias from the review and adjudication of grant applications and submissions for publication in peer-reviewed journals, including removing names and gender identity from the applications or submissions during the review process.

Your Reference Committee heard overwhelming support in favor of establishing best practices to remove gender bias from the review and adjudication of grant applications and submissions for publication in peer-reviewed journals. The resolution called for removal of names and gender identity from such applications and submissions; however, there was limited testimony regarding the validity of complete removal versus minimizing identifying information. Further testimony identified best practices allowing for complete de-identification

(12) RESOLUTION 616 - TIME'S UP HEALTHCARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 616 be adopted.

Resolution 616 calls upon our AMA to evaluate the TIME'S UP Healthcare program and consider participation as a TIME'S UP partner in support of our mutual objectives to eliminate harassment and discrimination in medicine with a report back at the 2019 Interim Meeting.

Your Reference Committee heard supportive testimony encouraging safe and welcoming professional environments for women physicians and physicians-in-training. A relationship with TIME'S UP Healthcare might advance our AMA's efforts to support women in medicine. As with any relationship, consideration needs to be given to preserving the reputation of our AMA. Your Reference Committee heard testimony regarding referral for decision, but felt the resolution accomplished the intent of our AMA Board of Trustees

evaluating the progress in deciding whether to join. Therefore, your Reference Committee recommends adoption so that the requested evaluation of TIME'S UP Healthcare can be conducted and a potential relationship be considered.

(13) RESOLUTION 603 - CREATION OF AN AMA ELECTION REFORM COMMITTEE
RESOLUTION 611 - ELECTION REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternative Resolution 603 be adopted in lieu of Resolutions 603 and 611.

RESOLVED, That our AMA create a Speaker-appointed task force for the purpose of recommending improvements to the current AMA House of Delegates election process with a broad purview to evaluate all aspects. The task force shall present an initial status report at the 2019 Interim Meeting.

Resolution 603 calls upon our AMA to appoint a House of Delegates Election Reform Committee to develop recommendations with which to expedite and streamline the current election and voting process for AMA officers and council positions, and to report back to the House of Delegates at the 2019 Interim Meeting.

Options that should be considered by the Election Reform Committee, include:

- the creation of an interactive election web page;
- candidate video submissions submitted in advance for HOD members to view;
- eliminate all speeches and concession speeches during HOD deliberations, with the exception of the President-Elect, Speaker, and Board of Trustee positions;
- move elections earlier in the meeting to Sunday or Monday;
- conduct voting from HOD seats; and
- reduce and control the cost of campaigns.

Resolution 611 calls upon our AMA to create a Speaker-appointed task force to re-examine election rules and logistics, including social media, emails, mailers, receptions, and parties; the ability of candidates from smaller delegations to compete; electronic balloting; and timing within the meeting. The task force shall report back at the 2019 Interim Meeting recommendations regarding election processes and procedures to accommodate improvements, which allow delegates to focus their efforts and time on policy-making.

Additionally, Resolution 611 calls upon the Speaker-appointed task force to consider addressing the following ideas:

a. elections being held on the Sunday morning of the Annual and Interim meetings of the House of Delegates;
b. coordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously;
c. separating the logistical election process based on the office (e.g., larger interview session for council candidates, more granular process for other offices);
d. an easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail;
e. electronic balloting potentially using delegates' personal devices as an option for initial elections and runoffs to facilitate timely results and minimal interruptions to the business;
f. seeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process; and
g. address the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g., vote trading, block voting, etc.).

Your Reference Committee heard overwhelming support in favor of appointing a committee to look at the current AMA House of Delegates election process. As noted by testimony, the original resolutions proffered were proscriptive. It is believed that a Speaker-appointed task force, comprised of AMA House of Delegates members, will address the ideas outlined in Resolutions 603 and 611. Furthermore, your Reference Committee believes that an initial status report at the 2019 Interim Meeting will include a project timeline established by the task force.

(14) RESOLUTION 606 - INVESTIGATION INTO RESIDENTS, FELLOWS, AND PHYSICIAN UNIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 606 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~to~~ study the ~~feasibility of a national house staff union to represent all interns, residents and fellows~~ risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 606 adopted as amended.

Resolution 606 calls upon our AMA to study the feasibility of a national house-staff union to represent all interns, residents, and fellows.

Your Reference Committee heard testimony indicating that our AMA cannot legally create a union but that an attempt to support unionization was made in 1999 and carried out for three years resulting in a large financial loss to our AMA; however, your Reference Committee heard additional testimony that the changed environment of medicine merits a renewed and expanded examination of whether there is a role for our AMA.

(15) RESOLUTION 614 - RACIAL AND ETHNIC IDENTITY DEMOGRAPHIC COLLECTION BY THE AMA

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 614 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association develop a plan with input from the Minority Affairs Section and the Chief Health Equity Officer to ~~consistently~~ ~~include~~ improve consistency and reliability in the collection of racial and ethnic minority demographic information for physicians and medical students. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 614 be adopted as amended.

Resolution 614 calls upon our AMA to develop a plan, with input from the Minority Affairs Section and the Chief Health Equity Officer, to consistently include racial and ethnic minority demographic information for physicians and medical students.

Your Reference Committee heard overwhelmingly supportive testimony in favor of this resolution and believes that the amended language allows the opportunity to expand outdated racial and ethnic categories; thereby, improving accuracy and supporting workforce diversity.

(16) RESOLUTION 617 - DISABLED PHYSICIAN ADVOCACY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 617 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study and report back on eliminating stigmatization and enhancing inclusion of ~~disabled physicians~~ physicians with disabilities including but not limited to:

1) Enhancing representation of ~~disabled physicians~~ physicians with disabilities within the AMA.

2) Examining support groups, education, legal resources and any other means to increase the inclusion of physicians with disabilities in the AMA; and be it further

RESOLVED, That our AMA identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable ~~disabled physicians~~ physicians with disabilities to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration~~.~~; and be it further

RESOLVED, That our AMA support physicians and physicians-in-training education programs about legal rights related to accommodation and freedom from discrimination for physicians, patients, and employees with disabilities.

RECOMMENDATION B:
Madam Speaker, your Reference Committee recommends that Resolution 617 be adopted as amended.

RECOMMENDATION C:
Madam Speaker, your Reference Committee recommends that the title of Resolution 617 be changed to read as follows:

ADVOCACY FOR PHYSICIANS WITH DISABILITIES

Resolution 617 calls upon our AMA to study and report back on eliminating stigmatization and enhancing inclusion of disabled physicians, including but not limited to: (1) enhancing representation of disabled physicians within the AMA; and (2) examining support groups, education, legal resources, and any other means to increase the inclusion of physicians with disabilities in the AMA.

Additionally, Resolution 617 calls upon our AMA to identify medical, professional and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services, and other services that will enable disabled physicians to develop their capabilities and skills to the maximum and will hasten the processes of their social and professional integration or reintegration.

Your Reference Committee heard supportive testimony; however, there was testimony on using person-first language. Accordingly, your Reference Committee recommends "disabled physicians" be replaced with "physicians with disabilities."

(17) RESOLUTION 618 - STAKEHOLDER INPUT TO REPORTS OF THE HOUSE OF DELEGATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 618 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~study and propose a process for interested stakeholders represented in the House of Delegates to view~~ provide an online list of AMA Council and Board reports under development, including a staff contact ~~and a mechanism~~ for providing stakeholder input. ~~on draft reports, and report back at the 2019 Interim Meeting.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 618 be adopted as amended.

Resolution 618 calls upon our AMA to study and report back at the 2019 Interim Meeting on a proposed process for interested stakeholders represented in the House of Delegates to view an online list of AMA Council and Board reports under development, including a mechanism for on draft reports.

Your Reference Committee heard opposition to Resolution 618 as written because it would place a burden on our AMA Councils and Board of Trustees, as well as could result in delayed reports. Additionally, some reports to be published cannot be placed in the public domain prior to publication. Therefore, your Reference Committee believes the proffered amendment achieves the desired transparency.

(18) RESOLUTION 608 - FINANCIAL PROTECTIONS FOR DOCTORS IN TRAINING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 608 be referred.

Resolution 608 calls upon our AMA to support retirement plans for all residents and fellows, which includes retirement plan matching to further secure the financial stability of physicians and increase financial literacy during training.

Additionally, Resolution 608 calls upon our AMA to support that all programs provide financial advising to resident and fellows.

Your Reference Committee heard limited testimony in support of retirement plans for residents and fellows. However, it was noted that additional financial protections such as adjustment of salaries for cost of living; eliminating interest accrual during training; credit bureau reporting practices; and partnering with preferred lenders for bridge loans are needed. Limited testimony indicated that nuances, such as GME funding, may impact the delivery of a retirement plan and should be studied.

Your Reference Committee heard further testimony acknowledging that physicians-in-training need more robust financial counseling. Factors such as significant medical student debt, delayed start in professional life, and decreased financial literacy may have an impact on retirement planning. Although your Reference Committee heard positive testimony in support of the second Resolve, it believes that an examination of factors related to financial protections is also warranted.

(19) RESOLUTION 612 - REQUEST TO AMA FOR TRAINING IN HEALTH POLICY AND HEALTH LAW

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 612 be referred.

Resolution 612 calls upon our AMA to offer its members training in health policy and health law, and develop a fellowship in health policy and health law.

Your Reference Committee heard mixed testimony. It was noted that understanding and developing health policy and health law is an important skill for physicians to acquire. Testimony supported our AMA sharing resources and opportunities to serve its members, yet there was uncertainty over whether our AMA should implement a fellowship program.

Our AMA Board of Trustees is currently writing a report on this topic to be presented at the 2019 Interim Meeting and referral of this item will allow for consideration of a fellowship program.

(20) RESOLUTION 613 - LANGUAGE PROFICIENCY DATA OF PHYSICIANS IN AMA MASTERFILE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 613 be referred.

Resolution 613 calls upon our AMA to initiate collection of self-reported physician language proficiency data in the Masterfile by asking physicians with the validated

six-point adapted ILR-scale to indicate their level of proficiency for each language besides English in the healthcare settings.

Your Reference Committee heard testimony in support of the spirit of this resolution, but concern was raised as to the challenges of implementation. There was additional testimony indicating that there are other sources recording this data; however, proficiency measures are not always captured. Therefore, your Reference Committee recommends referral to allow our Board of Trustees to examine this complex issue and provide recommendations.

(21) RESOLUTION 615 - IMPLEMENTING AMA CLIMATE CHANGE PRINCIPLES THROUGH JAMA PAPER CONSUMPTION REDUCTION AND GREEN HEALTHCARE LEADERSHIP

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 615 be referred.

Resolution 615 calls upon our AMA to change existing automatic paper JAMA subscriptions to opt-in paper subscriptions by the year 2020, while preserving the option to receive paper JAMA, to support broader climate change efforts.

Your Reference Committee heard extensive testimony acknowledging this is a complex issue that could result in unintended financial consequences. Testimony further reflected that the driver for publishing has shifted from print advertising to institutional digital site licensing; however, the move to digital does not translate into an equal shift in advertising revenue because digital ads are valued less by media managers and generate a fraction of print revenue. For these reasons, your Reference Committee believes that a study is needed to ensure our AMA to preserve the editorial independence and integrity of its publishing operations.

(22) RESOLUTION 601 - AMA POLICY STATEMENT WITH EDITORIALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 601 not be adopted.

Resolution 601 calls upon our AMA to include a policy statement after all editorials in which policy has been established to clarify our position.

Your Reference Committee heard testimony indicating that by longstanding academic tradition and AMA operational policy, oversight and authority for all intellectual content published within the journals is exclusively assigned to the Editor-in-Chief of JAMA and is

explicitly safeguarded by numerous policies and procedures. The published content is directly attributed to the authors of the material.

Your Reference Committee notes that there is a statement on our AMA web site and at the bottom of every print issue on the second page of the mast head that says, *"JAMA does not hold itself responsible for statements made by any contributor. All articles published, including opinion articles, represent the views of the authors and do not reflect the policy of JAMA, the American Medical Association, or the institution with which the author is affiliated unless otherwise indicated."*

Your Reference Committee heard further testimony indicating that viewpoints, editorials, and commentaries in JAMA often address topics at odds with AMA policy and has led the way toward broader thinking.

(23) RESOLUTION 604 - ENGAGE AND COLLABORATE WITH THE JOINT COMMISSION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 604 be <u>not adopted</u>.

Resolution 604 calls upon our AMA to study and report back on the impact, influence, and conflict of interest related to unrestricted grants from pharmaceutical and medical device manufacturers on the development of Joint Commission accreditation standards (especially those that relate to medical prescribing, procedures, and clinical care by licensed physicians).

Your Reference Committee heard extensive testimony in opposition to this resolution. The Chair of The Joint Commission noted that the Commission does not now nor since its inception has it ever accepted money from pharmaceutical or device manufacturers for the development of its standards.

(24) BOARD OF TRUSTEES REPORT 1 - ANNUAL REPORT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 1 be <u>filed</u>.

Board of Trustees Report 1 introduces our AMA's 2017 and 2018 Consolidated Financial Statements and an Independent Auditor's report, which are included in a separate document titled, "2018 Annual Report" that was made available with the Handbook materials.

Your Reference Committee received no testimony in response to the Board of Trustees Report 1. On behalf of our AMA membership, your Reference Committee extends appreciation to the Board of Trustees for executing sound fiscal responsibility throughout this past year, which resulted in the continuation of an ongoing trend of positive operating

results. Additionally, the number of AMA dues paying members increased in 2018 by 3.4 percent, achieving eight years of consecutive growth in membership.

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

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Congress of Neurological Surgeons

Greg Tarasidis, MD
South Carolina
Chair

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)

Report of Reference Committee G

Rodney Trytko, MD, MPH, MBA, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 31 – Non-Payment and Audit Takebacks by CMS
2. Board of Trustees Report 32 – Impact of High Capital Costs of Hospital EHRs on the Medical Staff
3. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2009 AMA House Policies
4. Council on Medical Service Report 8 – Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor
5. Council on Medical Service Report 10 – Alternative Payment Models and Vulnerable Populations
6. Resolution 704 – Prior Authorization Reform
7. Resolution 710 – Council for Affordable Quality Healthcare Attestation

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

8. Board of Trustees Report 13 – Employed Physician Bill of Rights and Basic Practice Professional Standards
9. Board of Trustees Report 15 – Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization
10. Council on Medical Service Report 7 – Hospital Consolidation
11. Council on Medical Service Report 9 – Health Plan Payment of Patient Cost-Sharing
12. Council on Medical Service Report 11 – Corporate Investors
13. Resolution 702 – Peer Support Groups for Second Victims
14. Resolution 706 – Hospital Falls and “Never Events” – A Need for More in Depth Study
15. Resolution 708 – Access to Psychiatric Treatment in Long-Term Care
16. Resolution 711 – Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs
17. Resolution 712 – Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives
18. Resolution 714 – Medicare Advantage Step Therapy
19. Resolution 717 – Military Physician Reintegration into Civilian Practice

RECOMMENDED FOR REFERRAL

20. Resolution 703 – Preservation of the Patient-Physician Relationship

RECOMMENDED FOR REFERRAL FOR DECISION

21. Resolution 719 – Interference with Practice of Medicine by the Nuclear Regulatory Commission

RECOMMENDED FOR NOT ADOPTION

22. Resolution 705 – Physician Requirements for Comprehensive Stroke Center Designation

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

23. Resolution 709 – Promoting Accountability in Prior Authorization
24. Resolution 713 – Selective Application of Prior Authorization
25. Resolution 718 – Economic Discrimination in the Hospital Practice Setting

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

- Resolution 701 – Coding for Prior Authorization Obstacles
- Resolution 707 – Cost of Unpaid Patient Deductibles on Physician Staff Time
- Resolution 715 – Managing Patient-Physician Relations Within Medicare Advantage Plans
- Resolution 716 – Health Plan Claim Auditing Programs

(1) BOARD OF TRUSTEES REPORT 31 - NON-PAYMENT AND AUDIT TAKEBACKS BY CMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that recommendations in Board of Trustees Report 31 be adopted and the remainder of the report be filed.

Board of Trustees Report 31 recommends that our AMA advocate to oppose claim nonpayment, extrapolation of overpayments, and bundled payment denials based on minor wording or clinically insignificant documentation inconsistencies.

Testimony was limited but supportive of Board of Trustees Report 31. A member of the Board of Trustees introduced the report, explaining that although the AMA has extensive policy opposing claim nonpayment for inadvertent, unintentional, or clerical documentation errors, the Board believes that AMA policy could be more specific in addressing minor wording errors or clinically insignificant inconsistencies. Because testimony was supportive, your Reference Committee recommends that the recommendations in Board of Trustees Report 31 be adopted and the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 32 - IMPACT OF HIGH CAPITAL COSTS OF HOSPITAL EHRS ON THE MEDICAL STAFF

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that recommendations in Board of Trustees Report 32 be adopted and the remainder of the report be filed.

Board of Trustees Report 32 recommends that our AMA rescind Policy D-225.974.

A member of the Board of Trustees introduced the report. Testimony overall was supportive of the report. Your Reference Committee thanks the Board of Trustees for its thoughtful and thorough report. Moreover, your Reference Committee highlights that the Board's report was well-researched and based on all available evidence. Accordingly, your Reference Committee recommends that Board of Trustees Report 32 be adopted.

(3) COUNCIL ON MEDICAL SERVICE REPORT 1 - COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2009 AMA HOUSE POLICIES

RECOMMENDATION:

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

Council on Medical Service Report 1 contains recommendations to retain or rescind 2009 AMA socioeconomic policies.

Testimony on Council on Medical Service 1 was provided by a member of the Council on Medical Service who introduced the report which is the result of the Council's review of 81 assigned socioeconomic policies. Because there was no additional testimony, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(4) COUNCIL ON MEDICAL SERVICE REPORT 8 - GROUP PURCHASING ORGANIZATIONS AND PHARMACY BENEFIT MANAGER SAFE HARBOR

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

Council on Medical Service Report 8 recommends that our AMA reaffirm Policies H-125.986, H-110.992, and H-100.956; renew efforts urging the federal government to support greater public transparency and accountability efforts involving the contracting mechanisms and funding structures subject to the Group Purchasing Organization and PBMs anti-kickback safe harbor, including the potential impact on drug pricing and drug shortages; and support efforts to update and modernize the fraud and abuse laws and regulations to address changes in the health care delivery and payment systems including the potential impact on drug pricing and drug shortages.

Testimony on Council on Medical Service Report 8 was unanimously supportive. A member of the Council on Medical Service introduced the report. The Council stated that, although the Council agrees with the sentiment that the GPO safe harbor is flawed, the Council finds little empirical evidence exists to definitively assess the impact of the GPO safe harbor. Moreover, a limited economic model found that, while removal of the safe harbor decreased providers' nominal purchasing price, their total purchasing costs are the same when the safe harbor was present. This means that repeal of the safe harbor would not affect any party's profits or costs.

Additionally, the Council member testified that the Council has numerous concerns should the safe harbor be repealed including that GPOs and PBMs could simply shift fees into other forms, such as rebates or other fees, rather than lose their revenue streams. The Council believes that repeal of the GPO safe harbor could create widespread disruption of the supply chain and administrative challenges for not only hospitals—including physician-owned hospitals—but also clinics, ambulatory surgery centers, and other provider arrangements. As such, physician-owned practice settings could be adversely impacted if the viability of the GPO business model is compromised. Overall, the Council found that, whatever the defects in their funding structure, GPOs serve a function in enabling cost savings and efficiencies in procurement to facilitate patient care. Testimony echoed this statement saying that GPOs can help level the field among smaller sites and practices.

An amendment was offered to state that the GPO safe harbor should not apply to PBMs. However, as the Council on Legislation highlighted, our AMA is already advocating that the Office of the Inspector General (OIG) needs to either eliminate the application of the GPO regulatory safe harbor to PBMs or clarify its application only to administrative fees and define what services are covered. Our AMA's comments stated that PBMs may be able to avail themselves to existing regulatory safe harbors including the GPO safe harbor, the personal services and management contracts safe harbor, managed care safe harbor, and the proposed certain PBM services safe harbor. Our AMA requested that OIG clarify what PBM fees and services apply to both the proposed and existing safe harbors. Otherwise, our AMA is concerned that the lack of clarity may provide further opportunity for exploitation. Taking into account this recent comment letter and advocacy, the Reference Committee does not recognize the need for the proposed amendment.

Moreover, specifically regarding PBMs, testimony highlighted CMS Report 5-A-19, which is before the House of Delegates at this meeting in Reference Committee A. CMS Report 5-A-19 recommends supporting the active regulation of PBMs under state departments of insurance, supporting efforts to ensure that PBMs are subject to federal laws that prevent discrimination against patients, and supporting improved transparency in PBM operations including a list of disclosures.

Your Reference Committee thanks the Council on Medical Service for its thorough report of a complex and nuanced issue. Accordingly, your Reference Committee recommends that the report be adopted and the remainder of the report be filed.

(5) COUNCIL ON MEDICAL SERVICE REPORT 10 - ALTERNATIVE PAYMENT MODELS AND VULNERABLE POPULATIONS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 10 be adopted and the remainder of the report be filed.

Council on Medical Service Report 10 recommends that our AMA reaffirm Policies H-385.913, H-385.908, H-350.974, D-35.985, D-350.995, H-440.828, H-450.924, H-280.945, and H-160.896; support APMs that link quality measures and payments to outcomes specific to vulnerable and high-risk populations; encourage the development and implementation of APMs that provide services to improve the health of vulnerable and high-risk populations; and continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health.

Testimony on Council on Medical Service Report 10 was mixed. A member of the Council introduced the report stating that the report builds upon the AMA's current policy on value-based payment and social determinants of health. In its report, the Council offers a set of recommendations that it hopes mitigates negative outcomes, penalties, and events for both vulnerable populations and the physicians serving them. In doing so, the Council recommended ways in which the health care system can do more to address non-medical factors that often go undetected and untreated among vulnerable populations within the context of a changing payment and delivery system.

The Reference Committee believes that the Council produced a strong report that furthers the health of vulnerable populations and incentivizes physicians to care for them. There was testimony that the report should have included practice costs. However, your Reference Committee believes that this mention is outside of the scope of this report and represents an area of significant and ongoing AMA study and advocacy efforts. Additionally, while there were concerns that the report did not specifically address what risk adjustment methods may be most appropriate to care for vulnerable populations, your Reference Committee highlights that the Council on Medical Service is producing a report specifically on risk adjustment improvements for Interim 2019. Your Reference Committee believes it is imperative to start advocating for the recommendations in Council on Medical Service Report 10 immediately and continue to build upon this work following the Council's upcoming report at Interim and beyond. Your Reference Committee believes the intersection of APMs and vulnerable populations deserves significant attention and believes that the Council's report represents a first step in the right direction. Accordingly, your Reference Committee recommends that Council on Medical Service Report 10 be adopted.

(6) RESOLUTION 704 - PRIOR AUTHORIZATION REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 704 be <u>adopted</u>.

Resolution 704 asks that our AMA explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Your Reference Committee agrees with the uniformly supportive testimony for Resolution 704. Of note, the Council on Medical Services testified on the importance of the evaluation of the efficacy and appropriateness of emerging technological resources

designed to automate the prior authorization process, while also maintaining the AMA's efforts to reduce the overall volume of prior authorizations. Your Reference Committee notes that the AMA's Prior Authorization and Utilization Management Reform Principles, released in 2017, specifically call for the utilization of technology to standardize prior authorization and reduce its patient and physician burdens. Your Reference Committee believes that this resolution represents an appropriate extension of existing AMA efforts and policy and recommends that Resolution 704 be adopted.

(7) RESOLUTION 710 - COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE ATTESTATION

RECOMMENDATION:

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

RESOLVED, That our American Medical Association work with the Council for Affordable Quality Healthcare (CAQH) and any other relevant organizations to reduce the frequency of required CAQH reporting to twelve months or longer unless the physician has a change in relevant information to be updated. (Directive to Take Action)

Resolution 710 asks that our AMA work with the Council for Affordable Quality Healthcare (CAQH) and any other relevant organizations to reduce the frequency of required CAQH reporting to twelve months or longer unless the physician has a change in relevant information to be updated.

Testimony was limited but supportive of Resolution 710. Your Reference Committee concurs with testimony describing CAQH attestation requirements as an administrative burden for physicians. Accordingly, your Reference Committee recommends that Resolution 710 be adopted.

(8) BOARD OF TRUSTEES REPORT 13 - EMPLOYED PHYSICIAN BILL OF RIGHTS AND BASIC PRACTICE PROFESSIONAL STANDARDS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 2 of Board of Trustees Report 13 be amended by addition to read as follows:

2. That our AMA amend policy H-225.955, Protection of Medical Staff Members' Personal Proprietary Financial Information:
"(1)(a) Physicians should be required to disclose relevant personal financial information to the hospital/health system only if they are serving or being considered to serve as a member of the governing body, as a corporate officer, or

as an employee/contractor of the hospital/health system; and such information should be used only so that other individuals understand what conflicts may exist when issues are discussed and when recusal from voting or discussion on an issue may be appropriate." (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 13 be adopted as amended and the remainder of the report be filed.

Board of Trustees Report 13 recommends that our AMA reaffirm Policies H-225.950, H-225.997, H-225.942, H-225.955, H-300.982, and H-383.998; amend Policies H-225.955 and H-225.950; and advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

A member of the Board of Trustees introduced the report stating that the Board's analysis found that most of the concepts set forth in the referred resolutions are already addressed in AMA policy, and the Board recommends reaffirmation of these policies. In some cases, the proposed policies in the resolutions were inconsistent with existing policy. Finally, the Board's analysis identified two themes in Resolutions 701 and 702-A-18 not addressed by existing policy—academic freedom for employed physicians and appropriate levels of administrative and clinical support—and recommends adoption of new policy in these areas.

Testimony on the report was unanimously supportive. There was one amendment presented asking that physicians only need to disclose *relevant* financial information. Your Reference Committee agrees and accepts this amendment. Accordingly, your Reference Committee recommends that Board of Trustees Report 13 be adopted as amended.

(9) BOARD OF TRUSTEES REPORT 15 - PHYSICIAN BURNOUT AND WELLNESS CHALLENGES; PHYSICIAN AND PHYSICIAN ASSISTANT SAFETY NET; IDENTIFICATION AND REDUCTION OF PHYSICIAN DEMORALIZATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 15 be amended by addition to read as follows:

3. That our AMA amend existing Policy D-310.968, "Physician and Medical Student Burnout," to add the following directives (Modify Current HOD Policy):
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.

8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to (1) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows, and regulatory oversight; and (2) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools, and promoting a culture of well-being.

RECOMMENDATION B:

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

Board of Trustees Report 15 recommends that our AMA reaffirm Policies H-170.986, H-405.957, H-405.961, D-405.990, H-95.955, and H-295.858; amend policy H-405.961 to encourage state medical societies to collaborate with state medical boards to develop strategies to destigmatize physician burnout and encourage physicians to participate in the state's physician health program without fear of loss of license or employment; and amend Policy D-310.968 to encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify factors that may lead to physician demoralization; continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being; and continue to address the institutional causes of physician demoralization and burnout, and develop and promote mechanisms by which physicians in all practice settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Testimony strongly supported Board of Trustees Report 15. A member of the Board of Trustees introduced the report, affirming that the AMA fully supports programs to assist physicians in early identification and management of stress and prevention of burnout and demoralization, which is evidenced by the AMA's ongoing development of targeted policies and tools and its recognition of professional satisfaction and practice sustainability as one of its three strategic pillars. Additional testimony was appreciative of the AMA's ongoing work to address physician burnout and demoralization. Your Reference Committee agrees with a minor amendment to Recommendation 3.7, and recommends that the recommendations in Board of Trustees Report 15 be adopted as amended and the remainder of the report be filed.

(10) COUNCIL ON MEDICAL SERVICE REPORT 7 - HOSPITAL CONSOLIDATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 7 be amended by addition and deletion to read as follows:

3. That our AMA ~~encourage~~ work with interested state medical associations to monitor hospital markets and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

Council on Medical Service Report 7 recommends that our AMA affirm that: (a) health care entity mergers should be examined individually, considering case-specific variables of market power and patient needs; (b) our AMA strongly supports and encourages competition in all health care markets; (c) our AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority. The report also recommends that our AMA continue to support actions that promote competition and choice, including: (a) eliminating state CON laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency.

There was supportive testimony on Council on Medical Service Report 7. A member of the Council on Medical Service introduced the report, noting that our AMA's own research has found that most hospital markets are highly concentrated, and that this concentration is largely due to consolidation. The Council member explained that addressing hospital mergers with the same vigor that our AMA has addressed major health insurance mergers would place an undue burden on the association's resources and could alienate some AMA members. Additional testimony affirmed that the consolidation trend is worrisome but that it would be difficult for our AMA to address these mergers. Your Reference Committee agrees with an amendment to Recommendation 3 asking our AMA to work with interested state medical associations to monitor hospital markets and review the impact of health system integration. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted and the remainder of the report be filed.

(11) COUNCIL ON MEDICAL SERVICE REPORT 9 - HEALTH PLAN PAYMENT OF PATIENT COST-SHARING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be amended by addition of a new Recommendation to read as follows:

7. That our AMA advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be amended by addition of a new Recommendation to read as follows:

8. That our AMA support health plan and insurer programs that collect patient co-payments and deductibles only if such programs allow physicians to opt out, are transparent about all program specifics, and do not penalize physicians who elect not to participate. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be amended by addition of a new Recommendation to read as follows:

9. That our AMA monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

Council on Medical Service Report 9 recommends that our AMA reaffirm Policies H-165.985, H-165.838, H-165.849, and H-165.828; amend Policy D-190.974 to prioritize efforts to determine patient financial responsibility at the point of care, especially for

patients in high-deductibles plans; and support the development of IT systems to enable physicians and patients to better understand financial obligations and to encourage states and others to monitor the growth of high deductible health plans and other forms of cost-sharing to assess their impacts on access to care, health outcomes, medical debt, and physician practice sustainability.

Testimony on Council on Medical Service Report 9 was generally supportive. A member of the Council introduced the report. The Council noted that it has concerns over asking insurance companies to get further entrenched in the health care system and patient care by taking over collection of co-payments and deductibles. Additionally, the Council does not believe that it is feasible that insurers will agree to assume the financial risk of taking over patient payments for physicians, which could end up as insurer bad debt. And, if insurers do assume this risk, the Council doubts the insurer's motives. Inevitably, the Council believes that the insurer will profit off of this arrangement, and, when a patient does not pay the insurer, the Council doubts that insurers will pay physicians their contracted rate. Moreover, the Council is concerned that, if patients do not pay the insurer, they may lose coverage, which is neither helpful for physician practices nor is it in the best interest of the patient.

Your Reference Committee offers several new recommendations to address testimony that stated that the Council did not call for sufficient action in its report. First, your Reference Committee recommends advocating for the inclusion of health insurance contract provisions that permit physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service. Your Reference Committee believes that it is imperative that all physicians, other than those prohibited by EMTALA, should be legally permitted to collect patient financial obligations at the point of care. Your Reference Committee highlights that report recommendations 4 and 5 are also directly aimed at simplifying and expediting patient collections at the point of care.

Moreover, your Reference Committee offers a new recommendation consistent with our AMA's long-standing policy on freedom of choice to support health plan and insurer programs that collect patient co-payments and deductibles only if the program allows physicians to opt-out, is transparent about all program specifics, and does not penalize physicians who elect not to participate. Your Reference Committee believes that our AMA must support physicians who choose to utilize insurer programs and subsequently be paid directly by the insurer rather than the patient. However, your Reference Committee recognizes the need for safe-guarding such insurer policies, particularly to protect physicians who wish not to participate in such arrangements and to ensure that they are not penalized for their non-participation.

Finally, your Reference Committee recommends a new recommendation calling on our AMA to monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles. Your committee recognizes the benefits and downsides of participating in such arrangements and calls on the AMA to monitor these programs and how they affect physician practices, including practice sustainability.

Your Reference Committee believes its recommended amendments represent a politically viable solution to the issue of insurers collecting co-payments and deductibles and also offers a balanced approach recognizing varying physician preferences on how

to collect, or be paid, patient financial obligations. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 9 be adopted as amended and the remainder of the report be filed.

(12) COUNCIL ON MEDICAL SERVICE REPORT 11 - CORPORATE INVESTORS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 11 be amended by addition of a new recommendation to read as follows:

9. That our AMA support consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 11 be adopted as amended and the remainder of the report be filed.

Council on Medical Service Report 11 recommends that our AMA adopt a series of guidelines that should be considered by physicians contemplating corporate investor partnerships. Additionally, the report recommends supporting improved transparency regarding corporate investment in physician practices, and encourages further study by affected national medical specialty societies.

Testimony was supportive of Council on Medical Service 11. A member of the Council on Medical Service introduced the report, explaining that growing numbers of physicians are employed by corporations, although the extent of corporate investment in physician practices is not known. The Council member highlighted longstanding AMA policy on the corporate practice of medicine and also policy affirming that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit. Additional testimony described the challenges of obtaining data on corporate investment in physician practices which is frequently not disclosed. Your Reference Committee heard testimony asking our AMA to solicit feedback on corporate investors, and supports the addition of a new recommendation asking our AMA to support consideration of options for gathering information on this important and rapidly evolving issue. Your Reference Committee also notes that our AMA will continue to monitor corporate investment in physician practices and its impact on patients and physicians. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 11 be adopted as amended and the remainder of the report be filed.

(13) RESOLUTION 702 - PEER SUPPORT GROUPS FOR SECOND VICTIMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 702 be amended by addition to read as follows:

RESOLVED, That our American Medical Association encourage institutional, local, and state physician wellness programs to consider developing voluntary, confidential, and non-discoverable peer support groups to address the "second victim phenomenon" (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 702 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with other interested organizations to encourage that any future surveys of physician burnout should incorporate questions about the prevalence and potential impact of the "second victim phenomenon" ~~develop a survey of all physicians in the United States to quantitate the effects of stress and burnout on them, and its potential impact~~ on our physician workforce. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 702 be adopted as amended.

Resolution 702 asks that our AMA encourage institutional, local, and state physician wellness programs to consider developing peer support groups to address the "second victim phenomenon"; and work with other interested organizations to develop a survey of all physicians in the United States to quantitate the effects of stress and burnout on them, and its potential impact on our physician workforce.

Testimony was generally supportive of Resolution 702. Several speakers noted the value of peer support groups centered around "second victim" experiences. One speaker expressed concerns regarding legal issues that could impact peer support groups, although others stated that these legal issues, such as discoverability, had not been problematic. Testimony on the second Resolve clause questioned whether physician surveys on this issue are needed, and an amended version was offered. Your Reference Committee incorporated amendments to the first and second Resolve clauses and recommends that Resolution 702 be adopted as amended.

(14) RESOLUTION 706 - HOSPITAL FALLS AND "NEVER EVENTS" - A NEED FOR MORE IN DEPTH STUDY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 706:

RESOLVED, That our American Medical Association work with interested state medical associations and national medical specialty societies to support research regarding the feasibility and impact of removing patient falls with injury from Medicare's list of "never events." (New HOD Policy)

Resolution 706 asks that our AMA study the merits of recommending that "Patient death or serious injury associated with a fall while being cared for in a health care setting" be removed from the list of "Never Events" for which a hospital may face an adverse payment decision by third-party payors or an adverse accreditation decision by The Joint Commission; and study the merits of recommending that a pay-for-performance measure be added which would reward health care organizations for taking steps resulting in patients' improved ability to participate in self-care, improved functional status, and improved mobility for seniors who have been admitted to a facility for a condition resulting in a temporary need for bed rest.

Testimony was generally supportive of Resolution 706. Testimony was also supportive of alternate language offered by a member of the Council on Medical Service that asks the AMA to work with interested state medical associations and national medical specialty societies to support research regarding the feasibility and impact of removing patient falls with injury from Medicare's list of "never events." Your Reference Committee supports this language and recommends that the alternate resolution be adopted in lieu of Resolution 706.

(15) RESOLUTION 708 - ACCESS TO PSYCHIATRIC TREATMENT IN LONG-TERM CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve in Resolution 708 be amended by deletion to read as follows:

~~RESOLVED, That our American Medical Association ask the Centers for Medicare and Medicaid Services (CMS) to acknowledge that psychotropic medications can be an appropriate long-term care treatment for patients with chronic mental illness (Directive to Take Action)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve in Resolution 708 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ask CMS to discontinue the use of antipsychotic ~~psychotropic~~ medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications (Directive to Take Action); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve in Resolution 708 be amended by deletion to read as follows:

~~RESOLVED, That our AMA ask the CMS to acknowledge that antipsychotic medication can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed (Directive to Take Action)~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve in Resolution 708 be amended by deletion to read as follows:

~~RESOLVED, That our AMA ask CMS to refrain from issuing citations or imposing financial penalties for the medically necessary and appropriate use of antipsychotic medication for the treatment of dementia-related psychosis. (Directive to Take Action)~~

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 708 be adopted as amended and Policy D-120.951 be reaffirmed.

Resolution 708 asks that our AMA ask the Centers for Medicare and Medicaid Services (CMS) to acknowledge that psychotropic medications can be an appropriate long-term care treatment for patients with chronic mental illness; ask CMS to discontinue the use of psychotropic medication as a factor contributing to the Nursing Home Compare rankings, unless the data utilized is limited to medically inappropriate administration of these medications; ask the CMS to acknowledge that antipsychotic medication can be an appropriate treatment for dementia-related psychosis if non-pharmacologic

approaches have failed; and ask CMS to refrain from issuing citations or imposing financial penalties for the medically necessary and appropriate use of antipsychotic medication for the treatment of dementia-related psychosis.

Testimony on Resolution 708 was unanimously supportive. A member of the Council on Medical Service called for an amendment to adopt the second Resolve and reaffirm Policy D-120.951 in lieu of the other Resolve clauses. In its testimony, the Council noted that Policy D-120.951 not only addresses the first, third, and fourth Resolve clauses but also is nearly identical language. However, the Council supports adoption of the second Resolve and recognizes our AMA's lack of policy on the use of antipsychotic medication as a factor in Nursing Home Compare rankings. Testimony noted that current CMS policies on the use of antipsychotic medications may cause patient harm and urged AMA action on this issue. Your Reference Committee agrees and therefore recommends that Resolution 708 be adopted as amended and Policy D-120.951 be reaffirmed.

> Appropriate Use of Antipsychotic Medications in Nursing Home Patients D-120.951
> Our AMA will meet with the Centers for Medicare & Medicaid Services (CMS) for a determination that acknowledges that antipsychotics can be an appropriate treatment for dementia-related psychosis if non-pharmacologic approaches have failed and will ask CMS to cease and desist in issuing citations or financial penalties for medically necessary and appropriate use of antipsychotics for the treatment of dementia-related psychosis. (Res. 523, A-12)

(16) RESOLUTION 711 - IMPACT ON THE MEDICAL STAFF OF THE SUCCESS OR FAILURE IN GENERATING SAVINGS OF HOSPITAL INTEGRATED SYSTEM ACOS

> RECOMMENDATION:
>
> Madam Speaker, your Reference Committee recommends that the following alternate Resolution <u>be adopted in lieu of Resolution 711</u>:
>
> EFFECTS OF HOSPITAL INTEGRATED SYSTEM ACCOUNTABLE CARE ORGANIZATIONS
>
> RESOLVED, That our American Medical Association encourage studies into the effect of hospital integrated system Accountable Care Organizations' (ACOs) ability to generate savings and the effect of these ACOs on medical staffs and potential consolidation of medical practices. (New HOD Policy)

Resolution 711 asks that our AMA study the effect of hospital integrated system ACOs' failure to generate savings on downsizing of the medical staff and further consolidation of medical practices and the root causes for failure to generate savings in hospital integrated ACOs, as compared to physician-owned ACOs, and report back at the 2019 Interim Meeting.

There was generally supportive testimony on Resolution 711. The Council on Medical Service called for adoption of an alternate resolution to support studies into how to improve ACO performance and physician satisfaction with ACOs. In its testimony, the Council stated that it believes that the request of Resolution 711 is not best directed at our AMA but rather that the request is more appropriate for ACO organizations or the American Hospital Association. In particular, the Council noted that, though well-intentioned, our AMA simply does not have the necessary data to complete this study. Your Reference Committee agrees and therefore recommends an alternate resolution encouraging other organizations to study hospital integrated system ACOs.

(17) RESOLUTION 712 - PROMOTION OF EARLY RECOGNITION AND TREATMENT OF SEPSIS BY OUT-OF-HOSPITAL HEALTHCARE PROVIDERS TO SAVE LIVES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 712:

RESOLVED, That our American Medical Association work with interested national medical specialty societies to promote the importance of early detection and treatment of sepsis by physicians. (New AMA Policy)

Resolution 712 asks that our AMA collaborate with interested medical organizations such as the Centers for Disease Control and Prevention and the Society of Critical Care Medicine to promote the importance of early detection and expedited intervention of sepsis by healthcare providers who work in out-of-hospital settings to improve patient outcomes and save lives.

There was limited but supportive testimony on Resolution 712. An amended version of Resolution 712 was offered by the resolution's sponsor to address concerns regarding early antibiotic use among emergency medical technicians. Your Reference Committee crafted an simpler alternate resolution which achieves the intent of Resolution 712 and is inclusive of physicians in all settings. Accordingly, your Reference Committee recommends that the alternate resolution be adopted in lieu of Resolution 712.

(18) RESOLUTION 714 - MEDICARE ADVANTAGE STEP THERAPY

RECOMMENDATION:

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

RESOLVED, That our AMA believes that step therapy programs create barriers to patient care and encourages

health plans to instead focus utilization management protocol on review of statistical outliers; and be it further

RESOLVED, That our AMA advocate that the Medicare Advantage step therapy protocol, if not repealed, should feature the following patient protections:

1. Enable the treating physician, rather than another entity such as the insurance company, to determine if a patient "fails" a treatment;
2. Exempt patients from the step therapy protocol when the physician believes the required step therapy treatments would be ineffective, harmful, or otherwise against the patients' best interests;
3. Permit a physician to override the step therapy process when patients are stable on a prescribed medication;
4. Permit a physician to override the step therapy if the physician expects the treatment to be ineffective based on the known relevant medical characteristics of the patient and the known characteristics of the drug regimen; if patient comorbidities will cause, or will likely cause, an adverse reaction or physical harm to the patient; or is not in the best interest of the patient, based on medical necessity;
5. Include an exemption from step therapy for emergency care;
6. Require health insurance plans to process step therapy approval and override request processes electronically;
7. Not require a person changing health insurance plans to repeat step therapy that was completed under a prior plan; and
8. Consider a patient with recurrence of the same systematic disease or condition to be considered an established patient and therefore not subject to duplicative step therapy policies for that disease or condition.

Resolution 714 asks that our AMA our AMA work with the Centers for Medicare and Medicaid Services (CMS) to immediately publish guidance to plans that lays out, at minimum, the patient safeguards proposed/finalized in the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses proposed rule so that beneficiaries have some protections in 2019, and asks that CMS does not respond to stakeholder input and publish guidance according to these and other principles, our AMA support and actively work to advance Congressional action to provide patients safeguards in the 2019 plan year.

Your Reference Committee agreed with the significant testimony in support of Resolution 714. In order to adequately protect patients from the problematic aspects of

step therapy, your Reference Committee believes that the AMA needs to further weigh in on this issue. As highlighted in testimony from the Council on Legislation, the AMA has been extremely active in attempting to prevent the expansion of step therapy to Medicare Part B drugs. Unfortunately, as noted by several commenters, these efforts have failed to prevent implementation of this problematic program, making further action at this time appropriate. The Committee notes that it received an alternate resolution submitted by the Council on Legislation, which called for the AMA to adopt policy consistent with both the current AMA compendium and ongoing federal and state legislative bills and regulatory developments. Although the Council's language was useful, we believe it fell short of adequately calling for direct action while also failing to adequately address the recurrence of a systematic disease event. As a result, the Committee crafted and recommends adoption of the alternate resolution in lieu of Resolution 714.

(19) RESOLUTION 717 - MILITARY PHYSICIAN REINTEGRATION INTO CIVILIAN PRACTICE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 717:

REENTRY INTO PHYSICIAN PRACTICE

RESOLVED, That our American Medical Association encourage hospitals to establish alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges; and be it further

RESOLVED, That our AMA encourage The Joint Commission and other accrediting organizations to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to obtain and maintain credentials and privileges.

Resolution 717 asks that our AMA develop recommendations to inform local credentialing bodies of pathways to facilitate the process of military veteran physicians and surgeons to return to civilian practice without compromising patient care.

Testimony on Resolution 717 was mixed. An alternate resolution was offered to broaden the resolution to include all physicians attempting to reenter the physician workforce. This alternate received overwhelming supportive testimony and highlights that all physicians who, for whatever reason, stepped away from medicine for a period of time need assistance transitioning back to practice. Your Reference Committee wholeheartedly agrees and therefore recommends adoption of the alternate resolution.

(20) RESOLUTION 703 - PRESERVATION OF THE PATIENT-PHYSICIAN RELATIONSHIP

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 703 be referred.

Resolution 703 asks that our AMA, in an effort to improve professional satisfaction among physicians while also enhancing patient care, conduct a study to identify perceived barriers to optimal patient-physician communication from the perspective of both the patient and the physician, as well as identify healthcare work environment factors that impact a physician's ability to deliver high quality patient care, including but not limited to: (1) the use versus non-use of electronic devices during the clinical encounter; and (2) the presence or absence of a scribe during the patient-physician encounter, and report back at the 2020 Interim Meeting.

Testimony on Resolution 703 was supportive of the study called for in Resolution 703. Your Reference Committee received an alternative resolution from the author to study, from the perspective of both the patient and physician, the adequacy of the time allotted to or spent in direct patient-physician contact, with a goal of establishing a minimum time required for a clinical encounter that is effective and satisfactory to both parties. As such, your Reference Committee recommends that Resolution 703 be referred for study and requests that the proposed alternative resolution be considered with the referral.

(21) RESOLUTION 719 - INTERFERENCE WITH PRACTICE OF MEDICINE BY THE NUCLEAR REGULATORY COMMISSION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 719 be referred for decision.

Resolution 719 asks that our AMA advocate for a follow-up review by the Institute of Medicine of the Nuclear Regulatory Commission's medical use program, specifically evaluating effects of the Nuclear Regulatory Commission's regulatory policy in the last 25 years on the current state of nuclear medicine in the U.S. and patients' access to care.

Testimony was supportive of Resolution 719. An additional Resolve clause offered very specific instructions to the AMA to oppose a proposed rule open for comment until July 3, 2019. Given the complexity and timeliness of the issues raised in Resolution 719 and the proposed amendment, your Reference Committee recommends that the item be referred for decision.

(22) RESOLUTION 705 - PHYSICIAN REQUIREMENTS FOR COMPREHENSIVE STROKE CENTER DESIGNATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 705 be not adopted.

Resolution 705 asks that our AMA advocate for changing the following two provisions from The Joint Commission Stroke Center Requirements: (1) Stroke procedurists should not be required to perform 15 mechanical thrombectomies per year to qualify for taking endovascular call at designated stroke hospitals; and (2) Stroke procedurists should be able to take call at more than one hospital at a time.

There was considerable and mixed testimony on Resolution 705. Your Reference Committee heard varying testimony on the use of volume requirements, the levels of stroke center designation, and patient care and safety. Importantly, your Reference Committee heard testimony from relevant specialty societies that this resolution is highly specific and complex, and best dealt with by the relevant specialty societies not our AMA. Your Reference Committee strongly agrees and therefore recommends that Resolution 705 not be adopted.

(23) RESOLUTION 709 - PROMOTING ACCOUNTABILITY IN PRIOR AUTHORIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-285.987 and H-285.939 be reaffirmed in lieu of Resolution 709.

Resolution 709 asks that our AMA amend Policy H-320.968 to advocate that any physician who recommends a denial as to the medical necessity of services on behalf of a utilization review entity or health plan be of the same specialty and have expertise to treat the medical condition or disease as the practitioner who provided the services under review; and that our AMA and its Council on Judicial and Ethical Affairs study the ethical and medicolegal responsibilities of physicians who participate in the prior authorization process on behalf of utilization review entities or health plans, particularly with regard to determinations of medical necessity, and report back to the HOD at the 2020 Annual Meeting with guidance for physicians who provide utilization review services.

Your Reference Committee heard a significant amount of testimony for Resolution 709 recognizing the importance of health plan decision-makers having the appropriate level of education and experience when making prior authorization denials. Of note, the Committee recognizes the importance of the amendment seeking to explicitly require all denials to be made by a physician, and when possible, that the physician be of the same specialty and have expertise in the condition under review. Your Reference Committee agrees with this sentiment and the largely supportive testimony received on the resolution. However, as invoked by the Council on Legislation's testimony, we believe

that current policy and ongoing AMA advocacy initiatives already accomplish this Resolution's intent.

The AMA has been extremely active in advocating to reduce physician and patient harms caused by prior authorization. This work includes the development of physician surveys on negative impacts of prior authorization, an AMA Grassroots website (www.fixpriorauth.org) enabling physicians to provide testimonials to be used in AMA advocacy, the development and promotion of state legislative efforts, and collaboration amongst the healthcare industry to improve prior authorization processes. Amongst the most common aspects of these efforts has been the need to ensure that health plans utilize properly trained physician experts when denying care. For example, the Prior Authorization and Utilization Management Reform Principles explicitly call for any physician making a decision on a prior authorization appeal to be of the same specialty, and subspecialty whenever possible, as the prescribing/ordering physician. Additionally, as highlighted in testimony, the Council on Legislation has model legislation requiring an adverse decision on a prior authorization to be made by a physician with a current and valid non-restricted license to practice medicine and must be board certified in the same specialty as the health care provider who typically manages the denied medical condition.

In addition to these active advocacy efforts, the AMA has relevant and overlapping policy and ethical opinions on the issues raised in Resolution 709. Policy H-285.987 establishes detailed guidelines for physicians to follow when serving as medical directors/decision-makers for managed care plans, with requirements that they be licensed and credentialed in the same state as network physicians over whose care they are making decisions. Policy H-285.939 calls on the AMA to undertake federal and state legislative and regulatory measures necessary to hold health plan medical directors liable for medical decisions regarding contractually covered medical services. Additionally, this resolution is extensively addressed by the AMA Code of Medical Ethics Policy 10.1.1 "Ethical Obligations of Medical Directors," which explicitly details the ethical considerations that physicians must take into account when making benefit determinations on behalf of health plans.

As a result of these policies and the ongoing initiatives, your Reference Committee recommends that H-285.987 and H-285.939 be reaffirmed in lieu of Resolution 709.

> Guidelines for Qualifications of Managed Care Medical Directors H-285.987
> The AMA has adopted the following "Guidelines for Qualifications of Medical Directors of Managed Care Organizations:"
> To the greatest extent possible, physicians who are employed as medical directors of managed care organizations shall:
> (1) hold an unlimited current license to practice medicine in one of the states served by the managed care organization, and where that Medical Director will be making clinical decisions or be involved in peer review that Medical Director should have a current license in each applicable state;
> (2) meet credentialing requirements equivalent to those met by plan providers;
> (3) be familiar with local medical practices and standards in the plan's service area;

(4) be knowledgeable concerning the applicable accreditation or "program approval" standards for preferred provider organizations and health maintenance organizations;
(5) possess good interpersonal and communications skills;
(6) demonstrate knowledge of risk management standards;
(7) be experienced in and capable of overseeing the commonly used processes and techniques of peer review, quality assurance, and utilization management;
(8) demonstrate knowledge of due process procedures for resolving issues between the participating physicians and the health plan administration, including those related to medical decision-making and utilization review;
(9) be able to establish fair and effective grievance resolution mechanisms for enrollees;
(10) be able to review, advise, and take action on questionable hospital admissions, medically unnecessary days, and all other medical care cost issues; and
(11) be willing to interact with physicians on denied authorizations.
The AMA strongly encourages managed care organizations and payer groups to utilize these guidelines in their recruitment and retention of medical directors.

Managed Care Medical Director Liability H-285.939
AMA policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. (1) Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions; (2) that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and (3) that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.

(24) RESOLUTION 713 - SELECTIVE APPLICATION OF PRIOR AUTHORIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-320.939 be reaffirmed in lieu of Resolution 713.

Resolution 713 asks that our AMA support policies such that prior authorization requirements will not be applied to items or services ordered by physicians and other health care practitioners: (i) whose prescribing or ordering practices align with an evidence-based guideline established or approved by a national professional medical association; or (ii) who meet quality (eg gold standard) criteria; or (iii) whose orders or prescriptions are routinely approved; or (iv) who adhere to a high quality clinical care pathway; or (v) who participate in an alternative payment model or care delivery model that aims to improve health care quality.

Testimony on Resolution 713 was significantly supportive of pursuing ways of eliminating prior authorization requirements for physicians whose conduct does not

warrant their application, a belief with which your Reference Committee agrees. The committee notes that both the resolution and the author's testimony referred to the Consensus Statement on Improving the Prior Authorization Process as a particularly relevant resource in the development of Resolution 713. This resource, which was spearheaded and co-authored by the AMA, specifically calls for the selective application of prior authorization and calls for programmatic exemptions for physicians in risk-based contracts. Your Reference Committee notes that the creation of this resource was directly spurred by advocacy efforts coordinated with the release of the AMA Prior Authorization and Utilization Management Reform Principles.

Policy H-320.939 establishes that the AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles. As highlighted in testimony from the Council on Medical Service, these principles call for health plans to restrict prior authorization programs to physicians whose prescribing patterns routinely deviate from protocol (Principle 19), call for gold-carding exemptions and non-application to physicians using clinical decision support systems or pathways (Principle 20), and does not apply to physicians in risk-based contracts (Principle 21).

Because these Principles already address the concepts, your Reference Committee recommends reaffirmation of H-320.939 in lieu of Resolution 713.

> Prior Authorization and Utilization Management Reform H-320.939
> 1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
> 2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
> 3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.

(25) RESOLUTION 718 - ECONOMIC DISCRIMINATION IN THE HOSPITAL PRACTICE SETTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-180.963, H-230.971, H-230.975, and H-230.976 be reaffirmed in lieu of Resolution 718.

Resolution 718 asks that our AMA actively oppose policies that limit a physician's access to hospital services based upon the number of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation.

Testimony on Resolution 718 was limited to the resolution's author. Your Reference Committee takes issue with use of the term "referrals," and believes that the intent of the resolution is addressed by existing AMA policy. Accordingly, your Reference Committee recommends that Policies H-180.963, H-230.971, H-230.975, and H-230.976 be reaffirmed in lieu of Resolution 718.

H-180.963 Volume Discrimination Against Physicians
The AMA recommends that volume indicators should be applied only to those treatments where outcomes have been shown by valid statistical methods to be significantly influenced by frequency of performance; and affirms that volume indicators should not be used as the sole criteria for credentialing and reimbursement and that, when volume indicators are used, allowances should be made for physicians starting practice. (Res. 101, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: BOT Rep. 3, A-09; Reaffirmed: Res. 703, A-18)

H-230.971 Economic Credentialing
Our AMA will work with The Joint Commission to assure, through the survey process, that any criteria used in the credentialing process are directly related to the quality of patient care. (BOT Rep. 15, I-93; Reaffirmed: CLRPD Rep. 1, A-05; Modified: CMS Rep. 1, A-15)

H-230.975 Economic Credentialing
The AMA (1) adopts the following definition of economic credentialing: economic credentialing is defined as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges; (2) strongly opposes the practice of economic credentialing; (3) believes that physicians should continue to work with their hospital boards and administrators to develop appropriate educational uses of physician hospital utilization and related financial data and that any such data collected be reviewed by professional peers and shared with the individual physicians from whom it was collected; (4) believes that physicians should attempt to assure provision in their hospital medical staff bylaws of an appropriate role for the medical staff in decisions to grant or maintain exclusive contracts or to close medical staff departments; (5) will communicate its policy and concerns on economic credentialing on a continuing basis to the American Hospital Association, Federation of American Health Systems, and other appropriate organizations; (6) encourages state medical societies to review their respective state statutes with regard to economic credentialing and, as appropriate, to seek modifications therein; (7) will explore the development of draft model legislation that would acknowledge the role of the medical staff in the hospital medical staff credentialing process and assure various elements of medical staff self-governance; and (8) will study and address the issues posed by the use of economic credentialing in other health care settings and delivery systems. (CMS Rep. B, I-91; Reaffirmed by BOT Rep. 14, A-98; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17)

H-230.976 Economic Credentialing
The AMA opposes the use of economic criteria not related to quality to determine an individual physician's qualifications for the granting or renewal of medical staff membership or privileges. (Res. 2, A-91; Reaffirmed: CME Rep. 8, I-93;

Reaffirmed by BOT Rep. 14, A-98; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17)

Madam Speaker, this concludes the report of Reference Committee G. I would like to thank Michael Bishop, MD, Jayne Courts, MD, Sterling Ransone Jr., MD, Stephen Tharp, MD, Brett Youngerman, MD, and all those who testified before the Committee.

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