

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002  
(A-19)

Introduced by: American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Family Physicians, American Society for Gastrointestinal Endoscopy, American Society of Neuroimaging, American Urological Association, North American Spine Society, Society for Cardiovascular Angiography and Interventions, American Academy of Orthopedic Surgeons

Subject: Sensible Appropriate Use Criteria in Medicare

Referred to: Reference Committee B  
(Charles Rothberg, MD, Chair)

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1 Whereas, The Protecting Access to Medicare Act (PAMA) of 2014 (P.L. 113-93) established a  
2 program promoting the use of Appropriate Use Criteria (AUC) for advanced imaging services;  
3 and  
4

5 Whereas, The number of clinicians affected by the program is vast, crossing almost every  
6 medical specialty, including primary care, and for which the Centers for Medicare & Medicaid  
7 Services (CMS) estimates 579,687 ordering professionals will be subject to this program; and  
8

9 Whereas, While clinicians have embraced AUC, the law sets up an unnecessarily rigid system  
10 for consulting AUC, a complex exchange of information between the health care professional  
11 who orders an advanced imaging test and the health care professional who furnishes the test,  
12 and onerous documentation requirements; and  
13

14 Whereas, All health care professionals who order advanced diagnostic imaging tests will be  
15 required to acquire and consult a qualified Clinical Decision Support Mechanism (CDSM) for  
16 every advanced diagnostic test unless an exception applies; and  
17

18 Whereas, Health care professionals who furnish advanced diagnostic imaging tests will be  
19 required to include detailed information received from the ordering professional on the claim  
20 form to receive payment for the test; and  
21

22 Whereas, Clinicians are required only to use CDSMs that are qualified by CMS, which, in many  
23 cases, will force clinicians to abandon long-standing methods of AUC consultation, as well as  
24 the consultation of specialty-specific AUC; and  
25

26 Whereas, Various CMS-approved AUC guidelines are in conflict and not aligned; and  
27

28 Whereas, The AUC Program, designed to curtail inappropriate imaging, is outdated and  
29 unnecessary in the environment of evolving payment and delivery models in which providers are  
30 at financial risk; and  
31

32 Whereas, The AUC Program diverts provider resources away from quality improvement as  
33 providers are struggling to assign adequate resources for IT infrastructure and Quality Payment  
34 Program participation; and

1 Whereas, The Medicare's Merit-based Incentive Payment System and Alternative Payment  
2 Models already incentivize appropriate use of health care resources, including advanced  
3 diagnostic imaging; and  
4

5 Whereas, CMS has stated it will implement the AUC consultation and reporting requirements on  
6 January 1, 2020, as an education and operations testing year during which CMS has said AUC  
7 consultation and some level of claims documentation will be required; and  
8

9 Whereas, Time is of the essence to pass legislation that will resolve the complex technical and  
10 workflow challenges associated with the AUC Program and remove any barriers to modifying  
11 and aligning the AUC Program with Medicare's Quality Payment Program; therefore be it  
12

13 RESOLVED, That our AMA policy H-320.940, "Medicare's Appropriate Use Criteria Program,"  
14 be amended by addition to read as follows:  
15

16 Our AMA will continue to advocate to delay the effective date of the Medicare AUC  
17 Program until the Centers for Medicare & Medicaid Services can adequately address  
18 technical and workflow challenges with its implementation and any interaction between  
19 the Quality Payment Program (QPP) and the use of advanced diagnostic imaging  
20 appropriate use criteria, and support legislation that resolves technical and workflow  
21 challenges and/or removes barriers to modifying or aligning the AUC Program and the  
22 QPP. (Modify HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 06/06/19

## RELEVANT AMA POLICY

### Medicare's Appropriate Use Criteria Program H-320.940

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 and the use of advanced diagnostic imaging appropriate use criteria.

Citation: Res. 229, A-17

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1003  
(A-19)

Introduced by: Charles Rothberg, MD, Delegate  
Thomas J. Madejski, MD, Delegate

Subject: Site of Service Differential

Referred to: Reference Committee A  
(John Montgomery, MD, Chair)

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1 Whereas, The site of service differential is a long standing payment policy that arose from the  
2 use of separate rate setting systems in CMS reimbursement calculations; and  
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4 Whereas, Our nation (and its patients) cannot afford to pay double for services just because the  
5 doctors happen to be employed by a hospital; and  
6

7 Whereas, Under CMS proposal to pay the same rate for services delivered at off-campus  
8 hospital outpatient departments and independent doctors' offices there will be financial winners  
9 and financial losers; and  
10

11 Whereas, Indexes utilized to determine hospital costs and those utilized to determine physician  
12 practice costs are flawed; and  
13

14 Whereas, Insurance, including Medicare, ought to cover the true costs of doing business—the  
15 costs should be determined objectively rather than by the hospitals as is currently the case  
16 (although change should not occur in a manner that unfairly penalizes safety net organizations  
17 for example); and  
18

19 Whereas, For example, the MEI still utilizes apartment rent and non-farm labor for as the basis  
20 for practice costs; and  
21

22 Whereas, MedPac still grants increases to hospitals, but not physicians; therefore be it  
23

24 RESOLVED, That our American Medical Association advocate for site of service payment  
25 equalization to be calculated in a manner that both enhances physician reimbursement while  
26 maintaining hospital rates for physician services at an objectively justifiable level, including but  
27 not limited to the filing of amicus briefs in relevant lawsuits as determined appropriate by the  
28 Office of General Counsel. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 06/07/19

## REFERRAL CHANGES AND OTHER REVISIONS (A-19)

WAS	IS NOW
Res. 429 – Support for Children of Incarcerated Parents	Res. 531 (Ref Comm E)

### RESOLUTIONS WITH ADDITIONAL SPONSORS\*

- 020 - Request to the AMA Council on Ethical and Judicial Affairs (CEJA) to Consider Specific Changes to the Code of Medical Ethics Opinion E-5.7, “Physician-Assisted Suicide”, in Order to Remove Inherent Conflicts Within the Code, to Delete Pejorative, Stigmatizing Language, and to Adopt an Ethical Position of Engaged Neutrality  
**(New Mexico, Vermont, Oregon, Colorado, California, Medical Student Section)**
- 113 – Ensuring Access to Statewide Commercial Health Plans  
**(Washington, Connecticut, Rhode Island, Massachusetts, Vermont, Maine, New Hampshire)**
- 221 - Extending Medicaid Coverage to 12-Months Postpartum  
**(American College of Obstetricians and Gynecologists, American Psychiatric Association, New Jersey, Illinois, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, Texas, Delaware, Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming, American Academy of Family Physicians, American College of Physicians, Massachusetts, Maine, Connecticut, Rhode Island, New Hampshire, Vermont, Michigan, American Medical Women’s Association)**
- 228 - Truth in Advertising  
**(American Society of Anesthesiologists, Texas, Virginia, Illinois, Arizona, Mississippi, Oklahoma, South Carolina, Washington, American Society of Interventional Pain Physicians)**
- 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  
**(American Psychiatric Association, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Clinical Neurophysiology Society, American College of Physicians, Colorado, Vermont, Washington, Wisconsin, Illinois)**
- 404 – Shade Structures in Public and Private Planning and Zoning Matters  
**(Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, American Academy of Dermatology, Society for Investigative Dermatology, American Society of Dermatopathology, American Society for Dermatologic Surgery Association)**

## REFERRAL CHANGES AND OTHER REVISIONS (A-19)

### RESOLUTIONS WITH ADDITIONAL SPONSORS\* (continued)

- 501 – USP 800  
~~Virginia; American Association of Clinical Urologists;~~ American College of Allergy, Asthma and Immunology; Kansas; South Carolina; Louisiana; Maryland
- 517 – Compounding  
(American Academy of Dermatology, American Academy of Cosmetic Surgery, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology, American Society of Dermatopathology, Missouri, Florida, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society for Aesthetic Plastic Surgery, American Academy of Facial Plastic and Reconstructive Surgery, Wisconsin, South Carolina, American Vein and Lymphatic Society, New York, Utah, International Society of Hair Restoration Surgery, American College of Allergy, Asthma, and Immunology, American Society of Plastic Surgeons)

\* Additional sponsors underlined.  
Sponsors ~~stricken~~.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

### Supplementary Report of Committee on Rules and Credentials (A-19)

Presented by: H. Tim Pearce, Jr., MD, Chair

Sunday, June 9, 2019

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1 Madam Speaker, Members of the House of Delegates:

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3 (1) LATE RESOLUTION(S)

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5 The Committee on Rules and Credentials met Saturday, June 8, to discuss Late Resolution(s)  
6 1002 - 1003. Sponsors of the late resolutions met with the committee to consider late  
7 resolutions, and were given the opportunity to present for the committee's consideration the  
8 reason the resolution could not be submitted in a timely fashion and the urgency of  
9 consideration by the House of Delegates at this meeting.

10  
11 Recommended for acceptance:

- 12  
13 • Late 1002 – Sensible Appropriate Use Criteria in Medicare  
14 • Late 1003 – Site of Service Differential

15  
16 (2) REAFFIRMATION RESOLUTIONS

17  
18 The Speakers asked the Committee on Rules and Credentials to review the recommendations  
19 for placing resolutions introduced at this meeting of the House of Delegates on the  
20 Reaffirmation Calendar. Reaffirmation of existing policy means that the policies reaffirmed  
21 remain active policies within the AMA policy database and therefore are part of the body of  
22 policy that can be used in setting the AMA's agenda. It also resets the sunset clock, so such  
23 policies will remain viable for 10 years from the date of reaffirmation. The Committee  
24 recommends that current policy be reaffirmed in lieu of the following resolutions (current policy  
25 and AMA activities are listed in the Appendix to this report):

- 26  
27 • Resolution 102 – Use of HSAs for Direct Primary Care  
28 • Resolution 103 – Health System Improvement Standards  
29 • Resolution 104 – Adverse Impacts of Single Specialty Independent Practice Associations  
30 • Resolution 106 – Raising Medicare Rates for Physicians  
31 • Resolution 108 – Congressional Healthcare Proposals  
32 • Resolution 109 – Part A Medicare Payment to Physicians  
33 • Resolution 110 – Establishing Fair Medicare Payer Rates  
34 • Resolution 111 – Practice Overhead Expense and the Site-of-Service Differential  
35 • Resolution 112 – Health Care Fee Transparency  
36 • Resolution 114 – Ensuring Access to Nationwide Commercial Health Plans  
37 • Resolution 115 – Safety of Drugs Approved by Other Countries  
38 • Resolution 117 – Support for Medicare Disability Coverage of Contraception for Non-  
39 Contraceptive Use  
40 • Resolution 118 – Pharmaceutical Pricing Transparency  
41 • Resolution 120 – Medicare Coverage of Hearing Aids

- 1 • Resolution 121 – Maintenance Hemodialysis for Undocumented Persons
- 2 • Resolution 122 – Reimbursement for Telemedicine Visits
- 3 • Resolution 123 – Standardizing Coverage of Applied Behavioral Analysis Therapy for
- 4 Persons with Autism Spectrum Disorder
- 5 • Resolution 124 – Increased Affordability and Access to Hearing Aids and Related Care
- 6 • Resolution 127 – Eliminating the CMS Observation Status
- 7 • Resolution 128 – Elimination of CMS Hospital Readmission Penalties
- 8 • Resolution 129 – The Benefits of Importation of International Pharmaceutical Medications
- 9 • Resolution 130 – Notification of Generic Drug Manufacturing Changes
- 10 • Resolution 201 – Assuring Patient Access to Kidney Transplantation
- 11 • Resolution 202 – Reducing the Hassle Factor in Quality Improvement Programs
- 12 • Resolution 205 – Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to
- 13 Employed Physician Salary
- 14 • Resolution 206 – Changing the Paradigm: Opposing Present and Obvious Restraint of
- 15 Trade
- 16 • Resolution 209 – Mandates by ACOs Regarding Specific EMR Use
- 17 • Resolution 210 – Air Ambulances
- 18 • Resolution 213 – Financial Penalties and Clinical Decision-Making
- 19 • Resolution 214 – The Term Physician
- 20 • Resolution 215 – Reimbursement for Health Information Technology
- 21 • Resolution 216 – Eliminate the Word Provider from Healthcare Contracts
- 22 • Resolution 222 – Protecting Patients from Misleading and Potentially Harmful Bad Drug
- 23 Ads
- 24 • Resolution 225 – DACA in GME
- 25 • Resolution 226 – Physician Access to Their Medical and Billing Records
- 26 • Resolution 228 – Truth in Advertising
- 27 • Resolution 229 – Clarification of CDC Opioid Prescribing Guidelines
- 28 • Resolution 230 – State Legislation Mandating Electrocardiogram (ECG) and/or
- 29 Echocardiogram Screening of Scholastic Athletes
- 30 • Resolution 234 – Improved Access to Non-Opioid Therapies
- 31 • Resolution 236 – Support for Universal Basic Income Pilot Studies
- 32 • Resolution 238 – Coverage Limitations and Non-Coverage of Interventional Pain
- 33 Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis
- 34 • Resolution 240 – Formation of Collective Bargaining Workgroup
- 35 • Resolution 241 – Facilitation of Research with Medicare Claims Data
- 36 • Resolution 305 – Lack of Support for Maintenance of Certification
- 37 • Resolution 306 – Interest Rates and Medical Education
- 38 • Resolution 309 – Promoting Addiction Medicine During a Time of Crisis
- 39 • Resolution 318 – Rural Health Physician Workforce Disparities
- 40 • Resolution 320 – Opioid Education in Medical Schools
- 41 • Resolution 412 – Regulating Liquid Nicotine and E-cigarettes
- 42 • Resolution 413 - End the Epidemic of HIV Nationally
- 43 • Resolution 416 – Non-Medical Exemptions from Immunizations
- 44 • Resolution 422 – Promoting Nutrition Education Among Healthcare Providers
- 45 • Resolution 428 – Dangers of Vaping
- 46 • Resolution 434 – Change in Marijuana Classification to Allow Research
- 47 • Resolution 506 – Clarify Advertising and Contents of Herbal Remedies and Dietary
- 48 Supplements



- 1 • Resolution 509 – Addressing Depression to Prevent Suicide
- 2 • Resolution 511 – Mandating Critical Congenital Heart Defect Screening in Newborns
- 3 • Resolution 516 – Alcohol Consumption and Health
- 4 • Resolution 521 – Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter
- 5 • Resolution 523 – Availability and Use of Low Starting Opioid Doses
- 6 • Resolution 525 – Support for Rooming-in of Neonatal Abstinence Syndrome Patients with
- 7 their Parents
- 8 • Resolution 701 – Coding for Prior Authorization Obstacles
- 9 • Resolution 702 – Peer Support Groups for Second Victims
- 10 • Resolution 703 – Preservation of the Patient-Physician Relationship
- 11 • Resolution 707 – Cost of Unpaid Patient Deductibles on Physician Staff Time
- 12 • Resolution 709 – Promoting Accountability in Prior Authorization
- 13 • Resolution 712 – Promotion of Early Recognition and Treatment of Sepsis by Out-of-
- 14 Hospital Healthcare Providers to Save Lives
- 15 • Resolution 713 – Selective Application of Prior Authorization
- 16 • Resolution 715 – Managing Patient-Physician Relations within Medicare Advantage Plan
- 17 • Resolution 716 - Health Plan Claim Auditing Programs



Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Patricia L. Austin, MD; Oran Lee Berkenstock, MD; Jenny Boyer, MD; Madelyn E. Butler, MD; Kenneth M. Certa, MD; and Robert H. Emmick, Jr., MD; and on behalf of the committee those who appeared before the committee.

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Patricia L. Austin, MD  
California

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Kenneth M. Certa, MD  
American Psychiatric Association

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Oran Lee Berkenstock, MD\*  
Tennessee

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Robert H. Emmick, Jr., MD\*  
Texas

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Jenny Boyer, MD\*  
Oklahoma

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H. Tim Pearce, Jr., MD, Chair  
South Carolina

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Madelyn E. Butler, MD  
Florida

\* Alternate Delegate

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

- Resolution 102 – Use of HSAs for Direct Primary Care
  - The Role of Cash Payments in All Physician Practices H-380.984
  - Direct Primary Care H-385.912
  - In addition, the AMA submitted letters in support of legislation that would have achieved the objectives of Resolution 102: H.R. 6317, the Primary Care Enhancement Act of 2018; and H.R. 365, the Primary Care Enhancement Act of 2017.
- Resolution 103 – Health System Improvement Standards
  - Health System Reform Legislation H-165.838
  - Adequacy of Health Insurance Coverage Options H-165.846
  - Unfunded Mandates H-270.962
  - Out-of-Network Care H-285.904
  - Network Adequacy H-285.908
  - Collective Bargaining for Physicians H-385.946
- Resolution 104 – Adverse Impacts of Single Specialty Independent Practice Associations
  - Tiered, Narrow, or Restricted Physician Networks D-285.972
  - Access to Specialists and Subspecialists in Managed Care Plans H-285.973
  - Any Willing Provider Provisions and Laws H-285.984
  - Exclusion of Physicians by Managed Care Health Plans H-285.992
  - In addition, the AMA was party to a sign-on letter highlighting priority provisions for incorporation into the final National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act. The AMA also developed model state legislation, Physician Fair Process Protections Act.
- Resolution 106 – Raising Medicare Rates for Physicians
  - Sustainable Growth Rate Repeal D-390.953
- Resolution 108 – Congressional Healthcare Proposals
  - Health System Reform Legislation H-165.838
  - Expanding Choice in the Private Sector H-165.881
  - Opposition to Nationalized Health Care H-165.985
  - Patient Information and Choice H-373.998
- Resolution 109 – Part A Medicare Payment to Physicians
  - Parity in Medicare Reimbursement D-390.969
  - The Site-of-Service Differential D-330.902
- Resolution 110 – Establishing Fair Medicare Payer Rates
  - Uncoupling Commercial Fee Schedules from Medicare Conversion Factors D-400.990
- Resolution 111 – Practice Overhead Expense and the Site-of-Service Differential
  - The Site-of-Service Differential D-330.902
  - Parity in Medicare Reimbursement D-390.969
  - Discontinuance of Federal Funding for Ambulatory Care Centers H-240.993
  - Medicare Reimbursement of Office-Based Procedures H-400.957

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

- CMS Report 4-I-18, The Site-of-Service Differential, addresses the intent of Resolution 111. In addition, the AMA submitted 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.
- Resolution 112 – Health Care Fee Transparency
  - Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988
  - Price Transparency D-155.987
  - Patient Information and Choice H-373.998
  - In addition, 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. AMA policy recommendations addressing hospital charge transparency were included in the letter. 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.
- Resolution 114 – Ensuring Access to Nationwide Commercial Health Plans
  - Ensuring Marketplace Competition and Health Plan Choice H-165.825
  - Health System Reform Legislation H-165.838
  - Health Insurance Exchange Authority and Operation H-165.839
  - In addition, at the 2018 Annual Meeting, the Council on Medical Service presented Report 3, Ensuring Marketplace Competition and Health Plan Choice. This report responded to the concerns of many physicians regarding insufficient competition in the ACA marketplaces, and recommended that our AMA support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.
- Resolution 115 – Safety of Drugs Approved by Other Countries
  - Prescription Drug Importation and Patient Safety D-100.983
- Resolution 117 – Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use
  - Patient Access to Treatments Prescribed by Their Physicians H-120.988
  - Coverage of Contraceptives by Insurance H-180.958
- Resolution 118 – Pharmaceutical Pricing Transparency
  - Pharmaceutical Costs H-110.987
  - Price of Medicine H-110.991
  - Private Health Insurance Formulary Transparency H-125.979
  - Pharmaceutical Benefits Management Companies H-125.986
  - In addition, to expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, TruthinRx.org, in 2016. Nearly 350,000 individuals have signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

also generating more than one million messages sent to Congress demanding drug price transparency.

- PBM transparency has also been a key theme highlighted in federal advocacy efforts related to drug pricing. In a 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 comments in response to the proposed rule Removal of Safe Harbor Protections for Rebates Involving Prescription Pharmaceuticals and Creation of a New Safe Harbor Protection for Certain Point-Of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees in April 2019, the AMA supported applying manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale, and requiring PBMs to disclose a wide range of information, including additional information about their fee arrangements. In a 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 supported requiring PBMs to apply manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale to ensure that patients benefit from discounts as well as eliminate some incentives for higher drug list prices; requiring increased transparency in formularies, prescription drug cost-sharing, and utilization management requirements for patients and physicians at the point-of-prescribing as well as when beneficiaries make annual enrollment elections; and prohibiting removal of drugs from a formulary or moving to a higher cost tier during the duration of the patient's plan year unless a change is made for safety reasons. These concerns were echoed in 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.
- In addition, in August 2018, the AMA submitted a letter in support of S 2554, the Patient Right to Know Drug Prices Act, which has since become law. The law prohibits health insurers and PBMs from using gag clauses that prevent pharmacists from sharing with patients the lower cost options when patients are purchasing medically necessary medication. In addition, the law will ensure that the FTC will have the necessary authorities to combat anti-competitive pay-for-delay settlement agreements between manufacturers of biological reference products and follow-on biologicals.
- In March 2019, the AMA submitted a letter that supported HR 1781, the Payment Commission Data Act of 2019. If enacted into law, the bill would provide access to essential data that the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) need to evaluate the practices of various entities within the pharmaceutical supply chain that are either not readily available or not available at all for independent analysis, including drug pricing and rebate data. In its letter, the AMA noted that the lack of independent, data driven, third-party analysis of drug pricing and rebate data continues to hamstring additional efforts needed to combat anti-competitive business practices that undermine affordability and harm patients.
- Concerning state-level advocacy, the AMA developed model state legislation entitled, An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year (AMA Model Act), which addresses the issues of stabilized formularies and cost transparency. In particular, the AMA Model Act requires PBMs operating in the state to disclose any discounts or other financial consideration

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

they received that affect the price and cost-sharing of covered medicines placed on a formulary.

- Resolution 120 – Medicare Coverage of Hearing Aids
  - Hearing Aid Coverage H-185.929
  - In addition, Council on Medical Service Report 6-I-15, Hearing Aid Coverage, responded to a referred resolution that was similar to Resolution 120.
- Resolution 121 – Maintenance Hemodialysis for Undocumented Persons
  - Health Care Payment for Undocumented Persons D-440.985
  - Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
  - Addressing Immigrant Health Disparities H-350.957
  - In addition, the AMA continues to advocate on behalf of the health care needs of undocumented persons. For example, in a December 2018 letter to the US Department of Homeland Security, the AMA expressed concerns regarding access to health care services for individuals and families who are seeking admission into the U.S., an extension of stay, or change in immigration status.
- Resolution 122 – Reimbursement for Telemedicine Visits
  - Coverage of and Payment for Telemedicine H-480.946
  - As outlined in an AMA Advocacy Resource Center issue brief, the AMA has model state legislation addressing the coverage of and payment for telemedicine. During the 2018 state legislative session, 44 states introduced over 160 telehealth-related pieces of legislation – many of which were consistent with the AMA Telemedicine Act, or were amended to incorporate language from the model bill. In addition, the AMA has supported historic telemedicine victories in Congress – provisions in the following bills will improve access to, payment for and coverage of telemedicine services: H.R. 1892, The Bipartisan Budget Act of 2018; S. 2372, the VA MISSION Act of 2018; and H.R. 6, The SUPPORT for Patient and Communities Act of 2018. Finally, AMA advocacy in this arena was reflected in the 2019 Medicare Physician Fee Schedule final rule, which included changes that will profoundly impact the delivery of telehealth services and connected care models that improve access, quality, lower costs and increase patient engagement.
- Resolution 123 – Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder
  - Medical Care of Persons with Developmental Disabilities H-90.968
  - In addition, the AMA has engaged in advocacy efforts to advance access to care for individuals with developmental disabilities, such as autism. For example, in an October 2018 letter to the Health Resources and Services Administration, the AMA urged consideration of a rulemaking process to allow persons with intellectual and developmental disabilities to be included as a medically underserved population.
- Resolution 124 – Increased Affordability and Access to Hearing Aids and Related Care
  - Hearing Aid Coverage H-185.929
  - In addition, Council on Medical Service Report 6-I-15, Hearing Aid Coverage, examined hearing aid coverage for children, adults, and Medicare beneficiaries.

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- Resolution 127 – Eliminating the CMS Observation Status
  - Medicare's Two-Midnight Rule D-160.932
  - Observation Status and Medicare Part A Qualification D-280.988
  - Inclusion of Observation Status in Mandatory Three Day Inpatient Stay D-280.989
  - Patient Cost-Sharing Requirements for Hospital Inpatient and Observation Services H-185.941
  - In addition, recent AMA comment letters to the Centers for Medicare & Medicaid Services advocated repeal of the two-midnight policy. Also, Council on Medical Service Report 4-A-14, Analysis of Place-of-Service Code for Observation Services, examined the issue outlined in Resolution 127.
- Resolution 128 – Elimination of CMS Hospital Readmission Penalties
  - PRO Readmission Review H-340.989
  - In addition, the AMA has recently engaged in significant advocacy regarding readmission penalties. In a February 2018 letter to CMS, the AMA recommended that CMS work in conjunction with the Agency for Healthcare Research and Quality (AHRQ) to respond to an initial set of issues to better ensure that readmission penalties are not contributing to negative patient outcomes. The AMA reiterated these concerns in two additional comment letters: (1) June 2018 comments on the Fiscal Year (FY) 2019 Proposed Rule for the Hospital Inpatient Prospective Payment System for Acute Care Hospitals (IPPS) and the Long-Term Care Hospital Prospective Payment System, and (2) the September 2018 comments on the 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule.
- Resolution 129 – The Benefits of Importation of International Pharmaceutical Medications
  - Prescription Drug Importation and Patient Safety D-100.983
  - Federal Regulation and Computerized Tracking of Pharmaceuticals During Shipping and Handling from Manufacture Until Ultimately Received by Patient D-100.985
  - In addition, at the 2018 Interim Meeting, the Council on Medical Service presented Report 1, “Canadian Prescription Drug Importation for Personal Use.”
- Resolution 130 – Notification of Generic Drug Manufacturing Changes
  - Prescription Labeling H-115.974
- Resolution 201 – Assuring Patient Access to Kidney Transplantation
  - Advancing Quality Coordinated Care for Patients with End Stage Renal Disease H-370.957
- Resolution 202 – Reducing the Hassle Factor in Quality Improvement Programs
  - Reducing MIPS Reporting Burden D-395.999
  - Maintenance of Certification and Osteopathic Continuous Certification D-275.954
- Resolution 205 – Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary
  - Patient Satisfaction and Quality of Care H-450.982
  - Patient Satisfaction Surveys and Quality Parameters as Criteria for Physician Payment D-385.958



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- Maintenance of Certification H-275.924
- Resolution 206 – Changing the Paradigm: Opposing Present and Obvious Restraint of Trade
  - AMA’s Aggressive Pursuit of Antitrust Reform D-383.990
  - A Level Playing Field in Negotiations Between Health Insurance Companies and Physicians D-383.982
  - Collective Bargaining: Antitrust Immunity D-383.983
  - Fair Valuation of Physician Services in Third Party Payer Contracting with Hospitals and Health Care Systems D-383.985
  - Amend the Patient Protection and Affordable Care Act (PPACA) H-165.833
  - Insurance Industry Antitrust Exemption H-180.975
  - Antitrust Relief as a Priority of the AMA H-380.987
  - Physicians’ Ability to Negotiate and Undergo Practice Consolidation H-383.988
  - Antitrust Relief for Physicians Through Federal Legislation H-383.990
  - Negotiations Issue H-383.993
- Resolution 209 – Mandates by ACOs Regarding Specific EMR Use
  - Accountable Care Organization Principles H-160.915
  - EHR Interoperability D-478.972
  - National Health Information Technology D-478.995
- Resolution 210 – Air Ambulances
  - Out-of-Network Care H-285.904
- Resolution 213 – Financial Penalties and Clinical Decision-Making
  - Volume Discrimination Against Physicians H-180.963
  - Clinical Practice Guidelines and Clinical Quality Improvement Activities H-320.949
  - Utilization Review by Physicians H-320.973
  - Prior Authorization and Utilization Management Reform H-320.939
- Resolution 214 – The Term Physician
  - Definition of a Physician H-405.976
  - Definition of a Physician D-405.989
  - Definition of a Physician H-405.969
- Resolution 215 – Reimbursement for Health Information Technology
  - Health Information Technology Principles H-478.981
  - Information Technology Standards and Costs D-478.996
- Resolution 216 – Eliminate the Word Provider from Healthcare Contracts
  - Clarification of the Term Provider in Advertising, Contracts and Other Communications H-405.968
  - Physician-Patient Relationship H-405.997
  - Physician (Doctors) Services Costs as Reported by HHS and Medicare H-330.986
- Resolution 222 – Protecting Patients from Misleading and Potentially Harmful Bad Drug Ads



**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

- Attorney Ads on Drug Side Effects H-105.985
- Privacy and Confidentiality H-315.978
- AMA model legislation Safety in Advertising for Lawsuits against Drug and Medical Device Manufacturers Act
- Resolution 225 – DACA in GME
  - Visa Complications for IMGs in GME D-255.991
  - Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986
  - AMA Principles on International Medical Graduates H-255.988
  - Strategies for Enhancing Diversity in the Physician Workforce D-200.985
  - Impact of Immigration Barriers on the Nation's Health D-255.980
- Resolution 226 – Physician Access to Their Medical and Billing Records
  - AMA Principles for Physician Employment H-225.950
  - Model State Physician Employment Patient Notification and Records Act
- Resolution 228 – Truth in Advertising
  - Anesthesiology is the Practice of Medicine H-160.929
  - Definition of Physician H-405.969
  - The AMA's Truth in Advertising (TIA) model bill requires health care providers to clearly and honestly state their level of training, licensing and what procedures they may legally perform in all their advertising and marketing materials. Advertising is broadly defined in the model legislation to include any communication or statement, including oral communication with patients. Based on this existing policy, the AMA sent a letter in March, 2019 to the New Hampshire Board of Nursing urging them to reconsider a position statement allowing CRNAs to refer to themselves as nurse anesthesiologists.
- Resolution 229 – Clarification of CDC Opioid Prescribing Guidelines
  - Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level H-410.980
  - Practice Parameters - Their Relevance to Physician Credentialing H-410.987
  - Support an Independent Clinical Practice Guideline Development Process H-410.954
- Resolution 230 – State legislation mandating electrocardiogram (ECG) and/or echocardiogram screening of scholastic athletes
  - Government Interference in Patient Counseling H-373.995
- Resolution 234 – Improved Access to Non-Opioid Therapies
  - Workforce and Coverage for Pain Management H-185.931
  - Pain as the Fifth Vital Sign D-450.956
  - Promotion of Better Pain Care D-160.981
  - Legislative Pain Care Restrictions H-95.930
- Resolution 236 – Support for Universal Basic Income Pilot Studies
  - Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

- Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896
- Discriminatory Policies that Create Inequities in Health Care H-65.963
- Giving States New Options to Improve Coverage for the Poor D-165.966
- Resolution 238 – Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis
  - Workforce and Coverage for Pain Management H-185.931
  - Pain as the Fifth Vital Sign D-450.956
  - Promotion of Better Pain Care D-160.981
  - Legislative Pain Care Restrictions H-95.930
- Resolution 240 – Formation of Collective Bargaining Workgroup
  - Physician Collective Bargaining H-385.976
  - Employee Associations and Collective Bargaining for Physicians D-383.981
  - Collective Bargaining and the Definition of Supervisors D-383.988
  - Collective Bargaining for Physicians H-385.946
  - Collective Negotiations H-385.973
- Resolution 241 – Facilitation of Research with Medicare Claims Data
  - Medicare Claims Data Release D-406.993
  - Sharing Demographic Medicare Data with Other Public Entities by CMS H-330.934
  - Medicare Physician Payment Reform D-390.961
- Resolution 305 – Lack of Support for Maintenance of Certification
  - D-275.954, Maintenance of Certification and Osteopathic Continuous Certification
  - H-275.924, Maintenance of Certification
- Resolution 306 – Interest Rates and Medical Education
  - H-305.925, Principles of and Actions to Address Medical Education Costs and Student Debt
- Resolution 309 – Promoting Addiction Medicine During a Time of Crisis
  - D-120.985, Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone
  - H-310.906, Improving Residency Training in the Treatment of Opioid Dependence
  - H-120.960, Protection for Physicians Who Prescribe Pain Medication
- Resolution 318 – Rural Health Physician Workforce Disparities
  - H-465.988, Educational Strategies for Meeting Rural Health Physician Shortage
  - H-400.988, Medicare Reimbursement, Geographical Differences
  - H-465.981, Enhancing Rural Physician Practices
- Resolution 320 – Opioid Education in Medical Schools
  - D-120.985, Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone
  - H-120.960, Protection for Physicians Who Prescribe Pain Medication

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

- Resolution 412 – Regulating Liquid Nicotine and E-cigarettes
  - FDA Regulation of Tobacco Products H-495.988
  - H-495.986 Tobacco Product Sales and Distribution
- Resolution 413 - End the Epidemic of HIV Nationally
  - Global HIV/AIDS Prevention H-20.898
  - HIV/AIDS as a Global Public Health Priority H-20.922
- Resolution 416 – Non-Medical Exemptions from Immunizations
  - Nonmedical Exemptions from Immunizations H-440.970
- Resolution 422 – Promoting Nutrition Education Among Healthcare Providers
  - Basic Courses in Nutrition H-150.995
  - Obesity as a Major Public Health Problem H-150.953
- Resolution 428 – Dangers of Vaping
  - Tobacco Product Labeling H-495.989
- Resolution 434 – Change in Marijuana Classification to Allow Research
  - Cannabis and Cannabinoid Research H-95.952
- Resolution 506 – Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements
  - H-150.954, Dietary Supplements and Herbal Remedies
  - H-150.946, Advertising for Herbal Supplements
  - H-115.988, Qualitative Labeling of All Drugs
  - D-150.991, Herbal Products and Drug Interactions
- Resolution 509 – Addressing Depression to Prevent Suicide
  - H-345.984, Awareness, Diagnosis, and Treatment of Depression and other Mental Illnesses
- Resolution 511 – Mandating Critical Congenital Heart Defect Screening in Newborns
  - H-245.973, Standardization of Newborn Screening Programs
- Resolution 516 – Alcohol Consumption and Health
  - H-30.937, Setting Domestic and International Public Health Prevention Targets for Per Capita Alcohol Consumption as a Means of Reducing the Burden on Non-Communicable Diseases on Health Status
  - H-170.992, Alcohol and Drug Abuse Education
  - H-425.993, Health Promotion and Disease Prevention
- Resolution 521 – Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter
  - H-115.972, Over-the-Counter Inhalers in Asthma
- Resolution 523 – Availability and Use of Low Starting Opioid Doses

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

- D-160.981, Promotion of Better Pain Care
- D-120.947, More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief
- D-120.976, Pain Management
- D-120.971, Promoting Pain Relief and Preventing Abuse of Controlled Substances
- Resolution 525 – Support for Rooming-in of Neonatal Abstinence Syndrome Patients with their Parents
  - H-245.982, AMA Support for Breastfeeding
  - H-420.971, Infant Victims of Substance Abuse
  - H-420.962, Perinatal Addiction - Issues in Care and Prevention
  - H-95.976, Drug Abuse in the United States - the Next Generation
- Resolution 701 – Coding for Prior Authorization Obstacles
  - Prior Authorization and Utilization Management Reform H-320.939
  - Approaches to Increase Payer Accountability H-320.968
  - Managed Care H-285.998
  - In addition, the House considered a resolution on this same topic at the 2018 Interim Meeting, Resolution 812, resulting in the modification of Policy H-320.939. The AMA has been extremely active in supporting efforts to illuminate the patient impacts of prior authorization. This work includes the 2018 AMA physician survey, which featured questions focused on assessing patient impact of prior authorization, the AMA Grassroots website ([www.fixpriorauth.org](http://www.fixpriorauth.org)), which captures first-hand patient stories about the hardships they have endured due to prior authorization, and state advocacy efforts requiring health plans to publicly report data on the results of prior authorization, including patient impact statistics.
- Resolution 702 – Peer Support Groups for Second Victims
  - Physician and Medical Student Burnout D-310.968
  - Programs on Managing Physician Stress and Burnout H-405.957
  - Physician Health Programs H-405.961
  - Educating Physicians About Physician Health Programs D-405.990
  - In addition, the AMA's commitment to physician satisfaction and well-being is evidenced by the AMA's ongoing development of policies and tools to help physicians; support for programs to assist physicians in early identification and management of stress; education of physicians about physician health programs; publication of peer-reviewed research to build the evidence base regarding factors that cause physician dissatisfaction and burnout; and the launch of the online STEPS Forward™ practice transformation platform.
- Resolution 703 – Preservation of the Patient-Physician Relationship
  - Patient Safety Incidents Related to Use of Electronic Health Records H-478.985
  - Study of Minimum Competencies and Scope of Medical Scribe Utilization D-478.967
  - Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records D-478.966
  - Protecting the Patient-Physician Relationship H-165.837

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

- In addition, there is a wealth of literature on this topic. The use versus non-use of electronic devices during the clinical encounter and the use or non-use of scribes during the clinical encounter are well-researched areas with significant primary research available. Notably, studies address time spent in indirect patient care (i.e. interacting with the patient's medical record) versus direct patient care and the use of scribes in the physician workflow and patient experience. Additionally, Board of Trustees Report 20-A-17 researched the use of scribes during the clinical encounter.
- Resolution 707 – Cost of Unpaid Patient Deductibles on Physician Staff Time
  - Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans H-165.849
  - Administrative Simplification in the Physician Practice D-190.974
  - Health Insurance Affordability H-165.828
  - In addition, at Interim 2016, Resolution 805 was referred for decision. Resolution 805-I-16 similarly requested that health insurers collect any patient financial responsibility, including deductibles and co-insurance, directly from the patient. As a result of Resolution 805-I-16, the AMA Board of Trustees agreed to engage in ongoing dialogue with health insurers and health insurance representatives about the increasing difficulty of practices in collecting co-payments and deductibles. The AMA continues to hold such meetings with insurers to address this issue as well as other issues relating to physician burden and practice sustainability.
  - Moreover, the AMA has developed a comprehensive point-of-care pricing toolkit to help practices with patient collections ([ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/managing-patient-payments.page](http://ama-assn.org/ama/pub/advocacy/topics/administrative-simplification-initiatives/managing-patient-payments.page)). The toolkit recognizes the issue of uncollected patient financial responsibility that can result in physician practices taking on debt and contains varied resources to help mitigate the problem.
  - Importantly, Council on Medical Service Report 9-A-19 responds to referred Resolution 707-A-18 that asked that our AMA urge health plans and insurers to bear the responsibility of ensuring physicians promptly receive full payment for patient copayments, coinsurance, and deductibles. This Council report makes recommendations directly related to the issue of physician resources expended collecting patient deductibles.
- Resolution 709 – Promoting Accountability in Prior Authorization
  - Guidelines for Qualifications of Managed Care Medical Directors H-285.987
  - Managed Care Medical Director Liability H-285.939
  - Additionally, this resolution is addressed by the AMA Code of Medical Ethics Policy 10.1.1 Ethical Obligations of Medical Directors, which details the ethical considerations that physicians must consider when making benefit determinations on behalf of health plans.
- Resolution 712 – Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives
  - Improved Treatment of Sepsis H-160.898
- Resolution 713 – Selective Application of Prior Authorization
  - Prior Authorization and Utilization Management Reform H-320.939
  - Eliminating Precertification H-320.950

**APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES**

- Resolution 715 – Managing Patient-Physician Relations within Medicare Advantage Plans
  - Retroactive Assignment of Patients by Managed Care Entities H-285.947
  - Physician Payment Reform H-390.849
  - Work of the Task Force on the Release of Physician Data H-406.991
- Resolution 716 - Health Plan Claim Auditing Programs
  - Uses and Abuses of CPT Modifier -25 D-70.971
  - Managed Care H-285.998
  - Physicians' Experiences with Retrospective Denial of Payment and Down-Coding by Managed Care Plans H-320.948
  - Prior Authorization and Utilization Management Reform H-320.939
  - Medicare Prepayment and Postpayment Audits H-330.921

## SUMMARY OF FISCAL NOTES (A-19)

### **BOT Report(s)**

- 01 Annual Report: Info Report
- 02 New Specialty Organizations Representation in the House of Delegates: Minimal
- 03 2018 Grants and Donations: Info Report
- 04 AMA 2020 Dues: no significant fiscal impact
- 05 Update on Corporate Relationships: Info Report
- 06 Redefining AMA's Position on ACA and Healthcare Reform: Info Report
- 07 AMA Performance, Activities and Status in 2018: Info Report
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2018 Through February 2019: Info Report
- 09 Council on Legislation Sunset Review of 2009 House Policies: n/a
- 10 Conduct at AMA Meetings and Events: Estimated cost between \$75,000 - \$100,000 for Conduct Liaison fees and travel expenses, as well as potential meeting costs for the Committee on Conduct at AMA Meetings and Events
- 11 Policy and Economic Support for Early Child Care: Minimal
- 12 Data Used to Apportion Delegates:
- 13 Employed Physician Bill of Rights and Basic Practice Professional Standards: Minimal
- 14 Reforming the Orphan Drug Act; An Optional National Prescription Drug Formulary; Reform of Pharmaceutical Pricing; Negotiated Payment Schedules: Minimal
- 15 Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization: Minimal
- 16 Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients: Modest
- 17 Ban on Medicare Advantage "No Cause" Network Terminations: Modest
- 18 Increased Use of Body-Worn Cameras by Law Enforcement Officers: Modest
- 19 FDA Conflict of Interest: Minimal
- 20 Safe and Efficient E-Prescribing: Minimal
- 21 Augmented Intelligence in Health Care: Modest
- 22 Inappropriate Use of CDC Guidelines for Prescribing Opioids: Minimal
- 23 Prior Authorization Requirements for Post-Operative Opioids: Minimal
- 24 Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion: 0
- 25 All Payer Graduate Medical Education Funding: Minimal
- 26 Research Handling of De-Identified Patient Information: Minimal
- 27 Advancing Gender Equity in Medicine: Modest
- 28 Opposition to Measures that Criminalize Homelessness: Minimal
- 29 Improving Safety and Health Code Compliance in School Facilities: Minimal
- 30 Opioid Treatment Programs Reporting to Prescription Monitoring Programs: Minimal
- 31 Non-Payment and Audit Takebacks by CMS: Minimal
- 32 Impact of High Capital Costs of Hospital EHRs on the Medical Staff: n/a
- 33\* Specialty Society Representation in the House of Delegates - Five Year Review: n/a

### **CC&B Report(s)**

- 01 Clarification to the Bylaws: Delegate Representation, Registration and Credentialing: n/a
- 02 Section Internal Operating Procedures and Council Rules: Roles of the House of Delegates, Board of Trustees and the Council on Constitution and Bylaws: Info. Report

### **CEJA Opinion(s)**

- 01 Amendment to E-2.2.1, "Pediatric Decision Making": Info. Report



## **SUMMARY OF FISCAL NOTES (A-19)**

### **CEJA Report(s)**

- 01 Competence, Self-Assessment and Self-Awareness: Minimal
- 02 Physician Assisted Suicide: n/a
- 03 CEJA's Sunset Review of 2009 House Policies: Minimal
- 04 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report: Info. Report
- 05 Discrimination Against Physicians by Patients: Info. Report

### **CLRPD Report(s)**

- 01 Demographic Characteristics of the House of Delegates and AMA Leadership: Info. Report

### **CME Report(s)**

- 01 Council on Medical Education Sunset Review of 2009 House Policies: Minimal
- 02 Update on Maintenance of Certification and Osteopathic Continuous Certification: Modest
- 03 Standardizing the Residency Match System and Timeline: Minimal
- 04 Augmented Intelligence in Medical Education:
- 05 Accelerating Change in Medical Education Consortium Outcomes: Info. Report
- 06 Study of Medical Student, Resident, and Physician Suicide: \$81,500
- 07 For-Profit Medical Schools or Colleges: Info. Report

### **CMS Report(s)**

- 01 Council on Medical Service Sunset Review of 2009 AMA House Policies: Minimal
- 02 Covering the Uninsured Under the AMA Proposal for Reform: Minimal
- 03 Medicare Coverage for Dental Services: Minimal
- 04 Reclassification of Complex Rehabilitation Technology: Minimal
- 05 The Impact of Pharmacy Benefit Managers on Patients and Physicians: Minimal
- 06 Preventive Prostate Cancer Screening: Minimal
- 07 Hospital Consolidation: Minimal
- 08 Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor: Minimal
- 09 Health Plan Payment of Patient Cost-Sharing: Minimal
- 10 Alternative Payment Models and Vulnerable Populations: Minimal
- 11 Corporate Investors: Minimal

### **CSAPH Report(s)**

- 01 CSAPH Sunset Review of 2009 House of Delegates Policies: Minimal
- 02 Drug Shortages: 2019 Update: Info. Report
- 03 Low Nicotine Product Standard: Minimal
- 04 Vector-Borne Diseases: Minimal

### **HOD Comm on Compensation of the Officers**

- 01# Report of the House of Delegates Committee on Compensation of the Officers: Maximum annual stipend is \$87K.

## SUMMARY OF FISCAL NOTES (A-19)

### **Joint Report(s)**

- 01 CME/CSAPH Joint Report - Protecting Medical Trainees from Hazardous Exposure: Minimal

### **Report of the Speakers**

- 01 Recommendations for Policy Reconciliation: Minimal

### **Resolution(s)**

- 001 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations: minimal
- 002 Addressing Existential Suffering in End-of-Life Care: Moderate
- 003 Conforming Sex and Gender Designation on Government IDs and Other Documents: Minimal
- 004 Reimbursement for Care of Practice Partner Relatives: Modest
- 005 Right for Gamete Preservation Therapies: Moderate
- 006 Use of Person-Centered Language: Minimal
- 007 Delegation of Informed Consent: Modest
- 008# Preventing Anti-Transgender Violence: Modest
- 009# References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment: Modest
- 010# Covenants not to Compete: Minimal
- 011# Mature Minor Consent to Vaccinations: Minimal
- 012# Improving Body Donation Regulation: Minimal
- 013# Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court: Modest
- 014# Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations: Minimal
- 015# Opposing Mandated Reporting of People Who Question Their Gender Identity: Minimal
- 016# Sexual and Gender Minority Populations in Medical Research: Minimal
- 017# National Guidelines for Guardianship: Modest
- 018# Support for Requiring Investigations into Deaths of Children in Foster Care: Minimal
- 019# Opposition to Requirements for Gender-Based Medical Treatments for Athletes: Modest
- 020# Changes to E-5.7, "Physician-Assisted Suicide": Minimal
- 021# Health, In All Its Dimensions, Is a Basic Right: Modest
- 022# Opposition to Involuntary Civil Commitment for Substance Use Disorder: Modest
- 023\* Distribution and Display of Human Trafficking Aid Information in Public Places: Minimal
- 024\* Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings: Minimal
- 025\* Gender Equity in Hospital Medical Staff Bylaws: Modest
- 026\* Restrictive Covenants of Large Health Care Systems: Moderate
- 027\* Model Legislation for "Mature Minor" Consent to Vaccinations: Modest
- 101 Health Hazards of High Deductible Insurance: minimal
- 102 Use of HSAs for Direct Primary Care: Modest
- 103 Health System Improvement Standards: Modest
- 104 Adverse Impacts of Single Specialty Independent Practice Associations: Minimal
- 105 Payment for Brand Medications When the Generic Medication is Recalled: Modest
- 106 Raising Medicare Rates for Physicians: Modest
- 107 Investigate Medicare Part D - Insurance Company Upcharge: Minimal

## SUMMARY OF FISCAL NOTES (A-19)

### **Resolution(s)**

- 108 Congressional Healthcare Proposals: Modest
- 109 Part A Medicare Payment to Physicians: Modest
- 110 Establishing Fair Medicare Payer Rates: Modest
- 111 Practice Overhead Expense and the Site-of-Service Differential: Modest
- 112 Health Care Fee Transparency: Modest
- 113 Ensuring Access to Statewide Commercial Health Plans: Modest
- 114 Ensuring Access to Nationwide Commercial Health Plans: Modest
- 115 Safety of Drugs Approved by Other Countries: Modest
- 116 Medicare for All: Modest
- 117 Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use: Modest
- 118 Pharmaceutical Pricing Transparency: Modest
- 119# Returning Liquid Oxygen to Fee Schedule Payment: Modest
- 120# Medicare Coverage of Hearing Aids: Modest
- 121# Maintenance Hemodialysis for Undocumented Persons: Modest
- 122# Reimbursement for Telemedicine Visits: Modest
- 123# Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder: Minimal
- 124# Increased Affordability and Access to Hearing Aids and Related Care: Modest
- 125# Mitigating the Negative Effects of High-Deductible Health Plans: Modest
- 126# Ensuring Prescription Drug Price Transparency from Retail Pharmacies: Modest
- 127# Eliminating the CMS Observation Status: Modest
- 128\* Elimination of CMS Hospital Readmission Penalties: Modest
- 129\* The Benefits of Importation of International Pharmaceutical Medications: Modest
- 130\* Notification of Generic Drug Manufacturing Changes: Modest
- 131\* Update Practice Expense Component of Relative Value Units: Estimate \$5M to replicate 2007/2008 Physician Practice Information Survey that gathered detailed practice expense data on 8,000 physician practices (2007/2008 PPIS survey cost \$2.4 million). Total cost includes new survey project manager; existing staff salaries; professional fees to survey vendor for survey development, testing, implementation and completion of 8,000 surveys; travel and meetings; and other related costs.
- 201 Assuring Patient Access to Kidney Transplantation: Modest
- 202 Reducing the Hassle Factor in Quality Improvement Programs: Modest
- 203 Medicare Part B and Part D Drug Price Negotiation: Modest
- 204 Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs: Modest
- 205 Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary: Minimal
- 206 Changing the Paradigm: Opposing Present and Obvious Restraint of Trade: Modest
- 207 Direct-to-Consumer Genetic Tests: Modest
- 208 Repeal or Modification of the Sunshine Act: Minimal
- 209 Mandates by ACOs Regarding Specific EMR Use: Modest
- 210 Air Ambulances: Minimal
- 211 Use of FAIR Health: Modest
- 212 Pharmacy Benefit Managers: Modest
- 213 Financial Penalties and Clinical Decision-Making: Minimal
- 214 The Term Physician: Modest

## SUMMARY OF FISCAL NOTES (A-19)

### **Resolution(s)**

- 215 Reimbursement for Health Information Technology: Modest
- 216 Eliminate the Word Provider from Healthcare Contracts: Minimal
- 217 Medicare Vaccine Billing: Modest
- 218 Payment for Medications Used Off Label for Treatment of Pain: Modest
- 219 Medical Marijuana License Safety: Modest
- 220 Study of Confidentiality and Privacy Protection in the Treatment of Substance Disorders: Modest
- 221 Extending Medicaid Coverage to 12-Months Postpartum: Modest
- 222 Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads: Modest
- 223 Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record: Minimal
- 224 Extending Pregnancy Medicaid to One Year Postpartum: Modest
- 225 DACA in GME: Minimal
- 226 Physician Access to Their Medical and Billing Records: Modest
- 227 Controlled Substance Management: Modest
- 228 Truth in Advertising: Modest
- 229 Clarification of CDC Opioid Prescribing Guidelines: Modest
- 230# State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes: Modest
- 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: Minimal
- 232# COPD National Action Plan: Modest
- 233# GME Cap Flexibility: Modest
- 234# Improved Access to Non-Opioid Therapies: Modest
- 235# Prescription Coverage of the Lidocaine Transdermal Patch: Modest
- 236# Support for Universal Basic Income Pilot Studies: Minimal
- 237# Opportunities in Blockchain for Healthcare: Modest
- 238# Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis: Modest
- 239# Improving Access to Medical Care Through Tax Treatment of Physicians: Modest
- 240# Formation of Collective Bargaining Workgroup: Modest
- 241# Facilitation of Research with Medicare Claims Data: Modest
- 242\* Improving Health Information Technology Products to Properly Care for LGBTQ Patients: Minimal
- 243\* Improving the Quality Payment Program and Preserving Patient Access: Modest
- 244\* EHR-Integrated Prescription Drug Monitoring Program Rapid Access: Modest
- 245\* Sensible Appropriate Use Criteria in Medicare: Modest
- 246\* Call for Transparency Regarding the Announcement of 17,000 Cuts to Military Health Providers: Modest
- 301 American Board of Medical Specialties Advertising: minimal
- 302 The Climate Change Lecture for US Medical Schools: Estimated cost of \$50,000 includes one FTE, management review, and in house designer
- 303 Graduate Medical Education and the Corporate Practice of Medicine: Minimal
- 304 Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs: Modest
- 305 Lack of Support for Maintenance of Certification: Minimal
- 306 Interest Rates and Medical Education: Minimal
- 307 Mental Health Services for Medical Students: Minimal

## SUMMARY OF FISCAL NOTES (A-19)

### **Resolution(s)**

- 308 MOC Moratorium: Minimal
- 309 Promoting Addiction Medicine During a Time of Crisis: Minimal
- 310 Mental Health Care for Medical Students: Minimal
- 311 Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure: Modest
- 312 Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians: Modest
- 313 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows: Modest
- 314 Evaluation of Changes to Residency and Fellowship Application and Matching Processes: Minimal
- 315 Scholarly Activity by Resident and Fellow Physicians: Modest
- 316 Medical Student Debt: Modest
- 317 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities: Modest
- 318 Rural Health Physician Workforce Disparities: Modest
- 319# Adding Pipeline Program Participation Questions to Medical School Applications: Modest
- 320# Opioid Education in Medical Schools: Modest
- 321# Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical Profession: Modest
- 322# Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools: Minimal
- 323\* Improving Access to Care in Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model: Modest
- 324\* Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary Reimbursement: Minimal
- 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: Minimal
- 402 Bullying in the Practice of Medicine: Minimal
- 403 White House Initiative on Asian Americans and Pacific Islanders: Modest
- 404 Shade Structures in Public and Private Planning and Zoning Matters: Minimal
- 405 Gun Violence Prevention: Safety Features: Minimal
- 406 Reduction in Consumption of Processed Meats: Minimal
- 407 Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents: Modest
- 408 Banning Edible Cannabis Products: Modest
- 409 Addressing the Vaping Crisis: Minimal
- 410 Reducing Health Disparities Through Education: Modest
- 411 AMA to Analyze Benefits / Harms of Legalization of Marijuana: Modest
- 412 Regulating Liquid Nicotine and E-Cigarettes: Modest
- 413 End the Epidemic of HIV Nationally: Minimal
- 414 Patient Medical Marijuana Use in Hospitals: Modest
- 415 Distracted Driving Legislation: Modest
- 416 Non-Medical Exemptions from Immunizations: Modest
- 417 Improved Health in the United States Prison System Through Hygiene and Health Educational Programming for Inmates and Prison Staff: Modest
- 418 Eliminating the Death Toll from Combustible Cigarettes: Modest
- 419 Universal Access for Essential Public Health Services: Modest
- 420 Coordinating Correctional and Community Healthcare: Minimal
- 421 Contraception for Incarcerated Women: Minimal
- 422 Promoting Nutrition Education Among Healthcare Providers: Minimal

## SUMMARY OF FISCAL NOTES (A-19)

### **Resolution(s)**

- 423# Mandatory Immunizations for Asylum Seekers: Modest
- 424# Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury: Modest
- 425# Distracted Driver Education and Advocacy: Estimated cost of \$65K includes formulation of campaign, development of module and implementation of web based campaign,
- 426# Health Care Accreditation of Correctional, Detention and Juvenile Facilities: Modest
- 427# Utility of Autonomous Vehicles for Individuals Who are Visually Impaired or Developmentally Disabled: Modest
- 428# Dangers of Vaping: Minimal
- 429# Support for Children of Incarcerated Parents (MOVED TO REF COMM E - now Resolution 531): Minimal
- 430# Compassionate Release for Incarcerated Patients: Modest
- 431# Eliminating Recommendations to Restrict Dietary Cholesterol and Fat: Minimal
- 432# Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals: Minimal
- 433# Transformation of Rural Community Public Health Systems: Modest
- 434# Change in Marijuana Classification to Allow Research: Modest
- 501 USP 800: minimal
- 502 Destigmatizing the Language of Addiction: Modest
- 503 Addressing Healthcare Needs of Children of Incarcerated Parents: Minimal
- 504 Screening, Intervention, and Treatment for Adverse Childhood Experiences: Minimal
- 505 Glyphosate Studies: Minimal
- 506 Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements: Minimal
- 507 Removing Ethylene Oxide as a Medical Sterilant from Healthcare: Minimal
- 508 Benzodiazepine and Opioid Warning: Minimal
- 509 Addressing Depression to Prevent Suicide Epidemic: Minimal
- 510 The Intracranial Hemorrhage Anticoagulation Reversal Initiative: Minimal
- 511 Mandating Critical Congenital Heart Defect Screening in Newborns: Minimal
- 512 Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients: Minimal
- 513 Determining Why Infertility Rates Differ Between Military and Civilian Women: Minimal
- 514 Opioid Addiction: Modest
- 515 Reversing Opioid Epidemic: Modest
- 516 Alcohol Consumption and Health: Minimal
- 517# Compounding: Modest
- 518# Chemical Variability in Pharmaceutical Products: Modest
- 519# Childcare Availability for Persons Receiving Substance Use Disorder Treatment: Minimal
- 520# Substance Use During Pregnancy: Minimal
- 521# Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter: Modest
- 522# Improved Deferral Periods for Blood Donors: Minimal
- 523# Availability and Use of Low Starting Opioid Doses: Minimal
- 524# Availability of Naloxone Boxes: Minimal
- 525# Support for Rooming-in of Neonatal Abstinence Syndrome Patients with Their Parents: Minimal
- 526# Trauma-Informed Care Resources and Settings: Minimal
- 527# Increasing the Availability of Bleeding Control Supplies: Minimal
- 528# Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing: Minimal

## SUMMARY OF FISCAL NOTES (A-19)

### **Resolution(s)**

- 529# Adverse Impacts of Delaying the Implementation of Public Health Regulations: Modest
- 530# Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program: Minimal
- 531\* Support for Children of Incarcerated Parents: Minimal
- 532\* Dispelling Myths of Bystander Opioid Overdoes: Modest
- 601 AMA Policy Statement with Editorials: indeterminate - the cost of implementing this resolution is varied given the large volume of content across the 13 journals in the JAMA Network as well as the wealth of AMA policy. At a minimum implementation would require the addition of 3 full time staff and would result in increased operational costs associated with extra paper, printing, binding, mailing, and layout of larger print issues.
- 602 Expectations for Behavior at House of Delegates Meetings: Minimal
- 603 Creation of an AMA Election Reform Committee: Estimated cost of \$15,000 to \$25,000 to study.
- 604 Engage and Collaborate with The Joint Commission: Minimal
- 605 State Societies and the AMA Litigation Center: Minimal
- 606 Investigation into Residents, Fellows and Physician Unions: Modest
- 607 Re-establishment of National Guideline Clearinghouse: Modest
- 608 Financial Protections for Doctors in Training: Indeterminate
- 609 Update to AMA Policy H-525.998, "Women in Organized Medicine": Minimal
- 610 Mitigating Gender Bias in Medical Research: Minimal
- 611# Election Reform: Estimated cost to implement the resolution is between \$15K-\$25K to convene a task force.
- 612# Request to AMA for Training in Health Policy and Health Law: Est cost of \$200,000 to establish curriculum, host event, start fellowship, host fellow. Fellow expenses at least 150K annually
- 613# Language Proficiency Data of Physicians in the AMA Masterfile: Estimated cost of \$35,000, development, project management and quality assurance.
- 614# Racial and Ethnic Identity Demographic Collection by the AMA: Modest
- 615# Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership: Indeterminate. A move to digital would not translate into an equal shift in ad revenue as digital generate a fraction of print revenue.
- 616# TIME'S UP Healthcare: Minimal
- 617# Disabled Physician Advocacy: Modest
- 618\* Stakeholder Input to Reports of the House of Delegates: Minimal
- 701 Coding for Prior Authorization Obstacles: minimal
- 702 Peer Support Groups for Second Victims: Estimated cost of \$465K to determine appropriate collaborative partners, develop survey instrument with input from organizational partners, program survey into online survey platform, print and mail post-cards with survey URL information to all living physician records in AMA Masterfile, analyze data and report findings.
- 703 Preservation of the Patient-Physician Relationship: Modest
- 704 Prior Authorization Reform: Modest
- 705 Physician Requirements for Comprehensive Stroke Center Designation: Minimal
- 706 Hospital Falls and "Never Events" - A Need for More in Depth Study: Modest
- 707 Cost of Unpaid Patient Deductibles on Physician Staff Time: Modest
- 708# Access to Psychiatric Treatment in Long Term Care: Modest
- 709# Promoting Accountability in Prior Authorization: Modest
- 710# Council for Affordable Quality Healthcare Attestation: Modest
- 711# Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs: Modest
- 712# Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives: Modest
- 713\* Selective Application of Prior Authorization: Minimal



## SUMMARY OF FISCAL NOTES (A-19)

### **Resolution(s)**

- 714\* Medicare Advantage Step Therapy: Modest
- 715\* Managing Patient-Physician Relations Within Medicare Advantage Plans: Modest
- 716\* Health Plan Claim Auditing Programs: Modest
- 717\* Military Physician Reintegration into Civilian Practice: Modest
- 718\* Economic Discrimination in the Hospital Practice Setting: Modest
- 719\* Interference with Practice of Medicine by the Nuclear Regulatory Commission: Modest

**Minimal - less than \$1,000**

**Modest - between \$1,000 - \$5,000**

**Moderate - between \$5,000 - \$10,000**

**# Contained in the Handbook Addendum**

**\* Contained in Sunday Tote**

## REPORT OF THE BOARD OF TRUSTEES

B of T Report -A-19

Subject: Distinguished Service Award

Presented by: Jack Resneck, Jr., MD, Chair

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1 The Board of Trustees is pleased to nominate Otis Webb Brawley, MD, Atlanta, Georgia, for the  
2 2019 Distinguished Service Award.

3  
4 Throughout his career, Dr. Brawley has made substantial contributions to the care of cancer  
5 patients and is considered a global leader in the field of cancer health disparities. At the National  
6 Cancer Institute, Dr. Brawley was appointed to direct the office of healthcare disparities and went  
7 on to a leadership position at the Emory University Cancer Center. In 2007 he assumed the role of  
8 Chief Medical and Scientific Officer at the American Cancer Society where he was heavily  
9 involved in cancer prevention, early detection and quality treatment through cancer research and  
10 education. He continues to champion efforts to decrease smoking, improve diet, detect cancer at the  
11 earliest stage, and provide the critical support cancer patients need.

12  
13 Dr. Brawley's 2012 book, "How We Do Harm: A Doctor Breaks Ranks About Being Sick in  
14 America," describes the challenges some ordinary Americans experience while trying to get quality  
15 health care. The book has become a classic in the field of evidence-based practice.

16  
17 Dr. Brawley is currently Bloomberg Distinguished Professor at Johns Hopkins University Schools  
18 of Medicine and Public Health. He is a Fellow of the American Society of Clinical Oncology, a  
19 Fellow of the American College of Epidemiology, and a Master of the American College of  
20 Physicians. He is also an elected member of the National Academy of Medicine.

21  
22 The Distinguished Service Award may be made to a member of the Association for meritorious  
23 service in the science and art of medicine, and your Board believes that Dr. Brawley's career-long  
24 dedication to the science and art of medicine for the benefit of patients and the practice of medicine  
25 exemplifies what it means to be distinguished in our profession.

**ORDER OF BUSINESS  
SECOND SESSION**

**Sunday, June 9, 2019  
8:00 AM**

- 1. Report of the Committee on Rules and Credentials - H. Tim Pearce, Jr., MD, Chair**
- 2. Presentation, Correction and Adoption of Minutes of 2018 Interim Meeting**
- 3. Remarks of the Speaker - Susan R. Bailey, MD**
- 4. Announcement of Changes in Reference Committees**
- 5. Report(s) of the Board of Trustees - Jack Resneck, Jr., MD, Chair**
  - 01 Annual Report (F)
  - 02 New Specialty Organizations Representation in the House of Delegates (Amendments to C&B)
  - 03 2018 Grants and Donations (Info. Report)
  - 04 AMA 2020 Dues (F)
  - 05 Update on Corporate Relationships (Info. Report)
  - 06 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
  - 07 AMA Performance, Activities and Status in 2018 (Info. Report)
  - 08 Annual Update on Activities and Progress in Tobacco Control: March 2018 Through February 2019 (Info. Report)
  - 09 Council on Legislation Sunset Review of 2009 House Policies (B)
  - 10 Conduct at AMA Meetings and Events (F)
  - 11 Policy and Economic Support for Early Child Care (D)
  - 12 Data Used to Apportion Delegates (F)
  - 13 Employed Physician Bill of Rights and Basic Practice Professional Standards (G)
  - 14 Reforming the Orphan Drug Act; An Optional National Prescription Drug Formulary; Reform of Pharmaceutical Pricing; Negotiated Payment Schedules (B)
  - 15 Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization (G)
  - 16 Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients (D)
  - 17 Ban on Medicare Advantage "No Cause" Network Terminations (B)
  - 18 Increased Use of Body-Worn Cameras by Law Enforcement Officers (B)
  - 19 FDA Conflict of Interest (B)
  - 20 Safe and Efficient E-Prescribing (B)
  - 21 Augmented Intelligence in Health Care (B)
  - 22 Inappropriate Use of CDC Guidelines for Prescribing Opioids (B)
  - 23 Prior Authorization Requirements for Post-Operative Opioids (B)
  - 24 Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion (F)
  - 25 All Payer Graduate Medical Education Funding (C)
  - 26 Research Handling of De-Identified Patient Information (Amendments to C&B)
  - 27 Advancing Gender Equity in Medicine (F)
  - 28 Opposition to Measures that Criminalize Homelessness (D)

- 29 Improving Safety and Health Code Compliance in School Facilities (D)
- 30 Opioid Treatment Programs Reporting to Prescription Monitoring Programs (B)
- 31 Non-Payment and Audit Takebacks by CMS (G)
- 32 Impact of High Capital Costs of Hospital EHRs on the Medical Staff (G)
- 33\* Specialty Society Representation in the House of Delegates - Five Year Review (Amendments to C&B)

**6. Report(s) of the Council on Constitution and Bylaws - Jerome C. Cohen, MD, Chair**

- 01 Clarification to the Bylaws: Delegate Representation, Registration and Credentialing (Amendments to C&B)
- 02 Section Internal Operating Procedures and Council Rules: Roles of the House of Delegates, Board of Trustees and the Council on Constitution and Bylaws (Info. Report)

**7. Report(s) of the Council on Ethical and Judicial Affairs - James E. Sabin, MD, Chair**

- 01 Competence, Self-Assessment and Self-Awareness (Amendments to C&B)
- 02 Physician Assisted Suicide (Amendments to C&B)
- 03 CEJA's Sunset Review of 2009 House Policies (Amendments to C&B)
- 04 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report (Info. Report)
- 05 Discrimination Against Physicians by Patients (Info. Report)

**8. Opinion(s) of the Council on Ethical and Judicial Affairs - James E. Sabin, MD, Chair**

- 01 Amendment to E-2.2.1, "Pediatric Decision Making" (Info. Report)

**9. Report(s) of the Council on Long Range Planning and Development - Alfred Herzog, MD, Chair**

- 01 Demographic Characteristics of the House of Delegates and AMA Leadership (Info. Report)

**10. Report(s) of the Council on Medical Education - Carol D. Berkowitz, MD, Chair**

- 01 Council on Medical Education Sunset Review of 2009 House Policies (C)
- 02 Update on Maintenance of Certification and Osteopathic Continuous Certification (C)
- 03 Standardizing the Residency Match System and Timeline (C)
- 04 Augmented Intelligence in Medical Education (C)
- 05 Accelerating Change in Medical Education Consortium Outcomes (Info. Report)
- 06 Study of Medical Student, Resident, and Physician Suicide (C)
- 07 For-Profit Medical Schools or Colleges (Info. Report)

**11. Report(s) of the Council on Medical Service - James G. Hinsdale, MD, Chair**

- 01 Council on Medical Service Sunset Review of 2009 AMA House Policies (G)
- 02 Covering the Uninsured Under the AMA Proposal for Reform (A)
- 03 Medicare Coverage for Dental Services (A)
- 04 Reclassification of Complex Rehabilitation Technology (A)
- 05 The Impact of Pharmacy Benefit Managers on Patients and Physicians (A)
- 06 Preventive Prostate Cancer Screening (A)
- 07 Hospital Consolidation (G)
- 08 Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor (G)
- 09 Health Plan Payment of Patient Cost-Sharing (G)
- 10 Alternative Payment Models and Vulnerable Populations (G)
- 11 Corporate Investors (G)

**12. Report(s) of the Council on Science and Public Health - Robyn F. Chatman, MD, Chair**

- 01 CSAPH Sunset Review of 2009 House of Delegates Policies (E)
- 02 Drug Shortages: 2019 Update (Info. Report)
- 03 Low Nicotine Product Standard (D)
- 04 Vector-Borne Diseases (D)

**13. Report(s) of the HOD Committee on Compensation of the Officers - Marta J. Van Beek, MD, Chair**

- 01# Report of the House of Delegates Committee on Compensation of the Officers (F)

**14. Joint Report(s)**

- 01 CME/CSAPH Joint Report - Protecting Medical Trainees from Hazardous Exposure (C)

**15. Report(s) of the Speakers - Susan R. Bailey, MD, Speaker; Bruce A. Scott, MD, Vice Speaker**

- 01 Recommendations for Policy Reconciliation (Info. Report)

**--EXTRACTION OF INFORMATIONAL REPORTS--**

**16. Unfinished business**

**17. New Business (Introduction of Resolutions)**

- 001 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations (Amendments to C&B)
- 002 Addressing Existential Suffering in End-of-Life Care (Amendments to C&B)
- 003 Conforming Sex and Gender Designation on Government IDs and Other Documents (Amendments to C&B)
- 004 Reimbursement for Care of Practice Partner Relatives (Amendments to C&B)
- 005 Right for Gamete Preservation Therapies (Amendments to C&B)
- 006 Use of Person-Centered Language (Amendments to C&B)
- 007 Delegation of Informed Consent (Amendments to C&B)
- 008# Preventing Anti-Transgender Violence (Amendments to C&B)
- 009# References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment (Amendments to C&B)
- 010# Covenants not to Compete (Amendments to C&B)
- 011# Mature Minor Consent to Vaccinations (Amendments to C&B)
- 012# Improving Body Donation Regulation (Amendments to C&B)
- 013# Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court (Amendments to C&B)
- 014# Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations (Amendments to C&B)
- 015# Opposing Mandated Reporting of People Who Question Their Gender Identity (Amendments to C&B)
- 016# Sexual and Gender Minority Populations in Medical Research (Amendments to C&B)
- 017# National Guidelines for Guardianship (Amendments to C&B)
- 018# Support for Requiring Investigations into Deaths of Children in Foster Care (Amendments to C&B)
- 019# Opposition to Requirements for Gender-Based Medical Treatments for Athletes (Amendments to C&B)
- 020# Changes to E-5.7, "Physician-Assisted Suicide" (Amendments to C&B)

021# Health, In All Its Dimensions, Is a Basic Right (Amendments to C&B)

022# Opposition to Involuntary Civil Commitment for Substance Use Disorder (Amendments to C&B)

023\* Distribution and Display of Human Trafficking Aid Information in Public Places (Amendments to C&B)

024\* Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings (Amendments to C&B)

025\* Gender Equity in Hospital Medical Staff Bylaws (Amendments to C&B)

026\* Restrictive Covenants of Large Health Care Systems (Amendments to C&B)

027\* Model Legislation for "Mature Minor" Consent to Vaccinations (Amendments to C&B)

101 Health Hazards of High Deductible Insurance (A)

102 Use of HSAs for Direct Primary Care (A)

103 Health System Improvement Standards (A)

104 Adverse Impacts of Single Specialty Independent Practice Associations (A)

105 Payment for Brand Medications When the Generic Medication is Recalled (A)

106 Raising Medicare Rates for Physicians (A)

107 Investigate Medicare Part D - Insurance Company Upcharge (A)

108 Congressional Healthcare Proposals (A)

109 Part A Medicare Payment to Physicians (A)

110 Establishing Fair Medicare Payer Rates (A)

111 Practice Overhead Expense and the Site-of-Service Differential (A)

112 Health Care Fee Transparency (A)

113 Ensuring Access to Statewide Commercial Health Plans (A)

114 Ensuring Access to Nationwide Commercial Health Plans (A)

115 Safety of Drugs Approved by Other Countries (A)

116 Medicare for All (A)

117 Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use (A)

118 Pharmaceutical Pricing Transparency (A)

119# Returning Liquid Oxygen to Fee Schedule Payment (A)

120# Medicare Coverage of Hearing Aids (A)

121# Maintenance Hemodialysis for Undocumented Persons (A)

122# Reimbursement for Telemedicine Visits (A)

123# Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder (A)

124# Increased Affordability and Access to Hearing Aids and Related Care (A)

125# Mitigating the Negative Effects of High-Deductible Health Plans (A)

126# Ensuring Prescription Drug Price Transparency from Retail Pharmacies (A)

127# Eliminating the CMS Observation Status (A)

128\* Elimination of CMS Hospital Readmission Penalties (A)

129\* The Benefits of Importation of International Pharmaceutical Medications (A)

130\* Notification of Generic Drug Manufacturing Changes (A)

131\* Update Practice Expense Component of Relative Value Units (A)

201 Assuring Patient Access to Kidney Transplantation (B)

202 Reducing the Hassle Factor in Quality Improvement Programs (B)

203 Medicare Part B and Part D Drug Price Negotiation (B)

204 Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs (B)

205 Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary (B)

206 Changing the Paradigm: Opposing Present and Obvious Restraint of Trade (B)

207 Direct-to-Consumer Genetic Tests (B)

208 Repeal or Modification of the Sunshine Act (B)

209 Mandates by ACOs Regarding Specific EMR Use (B)

210 Air Ambulances (B)

211 Use of FAIR Health (B)

212 Pharmacy Benefit Managers (B)

213 Financial Penalties and Clinical Decision-Making (B)

214 The Term Physician (B)

215 Reimbursement for Health Information Technology (B)

216 Eliminate the Word Provider from Healthcare Contracts (B)

217 Medicare Vaccine Billing (B)

218 Payment for Medications Used Off Label for Treatment of Pain (B)

219 Medical Marijuana License Safety (B)

220 Study of Confidentiality and Privacy Protection in the Treatment of Substance Disorders (B)

221 Extending Medicaid Coverage to 12-Months Postpartum (B)

222 Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads (B)

223 Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record (B)

224 Extending Pregnancy Medicaid to One Year Postpartum (B)

225 DACA in GME (B)

226 Physician Access to Their Medical and Billing Records (B)

227 Controlled Substance Management (B)

228 Truth in Advertising (B)

229 Clarification of CDC Opioid Prescribing Guidelines (B)

230# State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes (B)

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 (B)

232# COPD National Action Plan (B)

233# GME Cap Flexibility (B)

234# Improved Access to Non-Opioid Therapies (B)

235# Prescription Coverage of the Lidocaine Transdermal Patch (B)

236# Support for Universal Basic Income Pilot Studies (B)

237# Opportunities in Blockchain for Healthcare (B)

238# Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis (B)

239# Improving Access to Medical Care Through Tax Treatment of Physicians (B)

240# Formation of Collective Bargaining Workgroup (B)

241# Facilitation of Research with Medicare Claims Data (B)

242\* Improving Health Information Technology Products to Properly Care for LGBTQ Patients (B)

243\* Improving the Quality Payment Program and Preserving Patient Access (B)

244\* EHR-Integrated Prescription Drug Monitoring Program Rapid Access (B)



245\* Sensible Appropriate Use Criteria in Medicare (B)

246\* Call for Transparency Regarding the Announcement of 17,000 Cuts to Military Health Providers (B)

301 American Board of Medical Specialties Advertising (C)

302 The Climate Change Lecture for US Medical Schools (C)

303 Graduate Medical Education and the Corporate Practice of Medicine (C)

304 Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs (C)

305 Lack of Support for Maintenance of Certification (C)

306 Interest Rates and Medical Education (C)

307 Mental Health Services for Medical Students (C)

308 MOC Moratorium (C)

309 Promoting Addiction Medicine During a Time of Crisis (C)

310 Mental Health Care for Medical Students (C)

311 Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure (C)

312 Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians (C)

313 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows (C)

314 Evaluation of Changes to Residency and Fellowship Application and Matching Processes (C)

315 Scholarly Activity by Resident and Fellow Physicians (C)

316 Medical Student Debt (C)

317 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities (C)

318 Rural Health Physician Workforce Disparities (C)

319# Adding Pipeline Program Participation Questions to Medical School Applications (C)

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322# Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools (C)

323\* Improving Access to Care in Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model (C)

324\* Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary Reimbursement (C)

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 (D)

402 Bullying in the Practice of Medicine (D)

403 White House Initiative on Asian Americans and Pacific Islanders (D)

404 Shade Structures in Public and Private Planning and Zoning Matters (D)

405 Gun Violence Prevention: Safety Features (D)

406 Reduction in Consumption of Processed Meats (D)

407 Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents (D)

408 Banning Edible Cannabis Products (D)

409 Addressing the Vaping Crisis (D)

410 Reducing Health Disparities Through Education (D)

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506 Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements (E)  
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511 Mandating Critical Congenital Heart Defect Screening in Newborns (E)  
512 Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients (E)  
513 Determining Why Infertility Rates Differ Between Military and Civilian Women (E)  
514 Opioid Addiction (E)  
515 Reversing Opioid Epidemic (E)  
516 Alcohol Consumption and Health (E)  
517# Compounding (E)

518# Chemical Variability in Pharmaceutical Products (E)  
519# Childcare Availability for Persons Receiving Substance Use Disorder Treatment (E)  
520# Substance Use During Pregnancy (E)  
521# Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter (E)  
522# Improved Deferral Periods for Blood Donors (E)  
523# Availability and Use of Low Starting Opioid Doses (E)  
524# Availability of Naloxone Boxes (E)  
525# Support for Rooming-in of Neonatal Abstinence Syndrome Patients with Their Parents (E)  
526# Trauma-Informed Care Resources and Settings (E)  
527# Increasing the Availability of Bleeding Control Supplies (E)  
528# Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing (E)  
529# Adverse Impacts of Delaying the Implementation of Public Health Regulations (E)  
530# Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program (E)  
531\* Support for Children of Incarcerated Parents (E)  
532\* Dispelling Myths of Bystander Opioid Overdoes (E)  
601 AMA Policy Statement with Editorials (F)  
602 Expectations for Behavior at House of Delegates Meetings (F)  
603 Creation of an AMA Election Reform Committee (F)  
604 Engage and Collaborate with The Joint Commission (F)  
605 State Societies and the AMA Litigation Center (F)  
606 Investigation into Residents, Fellows and Physician Unions (F)  
607 Re-establishment of National Guideline Clearinghouse (F)  
608 Financial Protections for Doctors in Training (F)  
609 Update to AMA Policy H-525.998, "Women in Organized Medicine" (F)  
610 Mitigating Gender Bias in Medical Research (F)  
611# Election Reform (F)  
612# Request to AMA for Training in Health Policy and Health Law (F)  
613# Language Proficiency Data of Physicians in the AMA Masterfile (F)  
614# Racial and Ethnic Identity Demographic Collection by the AMA (F)  
615# Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership (F)  
616# TIME'S UP Healthcare (F)  
617# Disabled Physician Advocacy (F)  
618\* Stakeholder Input to Reports of the House of Delegates (F)  
701 Coding for Prior Authorization Obstacles (G)  
702 Peer Support Groups for Second Victims (G)  
703 Preservation of the Patient-Physician Relationship (G)  
704 Prior Authorization Reform (G)  
705 Physician Requirements for Comprehensive Stroke Center Designation (G)  
706 Hospital Falls and "Never Events" - A Need for More in Depth Study (G)  
707 Cost of Unpaid Patient Deductibles on Physician Staff Time (G)  
708# Access to Psychiatric Treatment in Long Term Care (G)  
709# Promoting Accountability in Prior Authorization (G)

- 710# Council for Affordable Quality Healthcare Attestation (G)
- 711# Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs (G)
- 712# Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives (G)
- 713\* Selective Application of Prior Authorization (G)
- 714\* Medicare Advantage Step Therapy (G)
- 715\* Managing Patient-Physician Relations Within Medicare Advantage Plans (G)
- 716\* Health Plan Claim Auditing Programs (G)
- 717\* Military Physician Reintegration into Civilian Practice (G)
- 718\* Economic Discrimination in the Hospital Practice Setting (G)
- 719\* Interference with Practice of Medicine by the Nuclear Regulatory Commission (G)

## **18. Information Statement**

- 01\* A New Podcast Series: The Original Guide to Men's Health (Information Statement)

## **19. Report of the Committee on Rules and Credentials - H. Tim Pearce, Jr., MD, Chair**

*# contained in the Handbook Addendum*

*\* contained in the Sunday Tote*

**ORDER OF BUSINESS**

Reference Committee on Amendments to Constitution and Bylaws (A-19)  
William Reha, MD, Chair

June 8, 2019  
Regency C

Hyatt Regency Chicago  
Chicago

1. Board of Trustees Report 02 – New Specialty Organizations Representation in the House of Delegates.
2. Board of Trustees Report 26 – Research Handling of De-Identified Patient Information
3. Board of Trustees Report 33 – Specialty Society Representation in the House of Delegates – Five-Year Review
4. Council on Constitution and Bylaws Report 01 – Clarification to the Bylaws: Delegate Representation, Registration and Credentialing
5. Council on Ethical and Judicial Affairs Report 03 – CEJA's Sunset Review of 2009 House Policies
6. Council on Ethical and Judicial Affairs Report 01 – Competence, Self-Assessment and Self-Awareness
7. Resolution 001 – Opposing Attorney Presence at and/or Recording of Independent Medical Examinations
8. Resolution 006 – Use of Person-Centered Language
9. Resolution 024 – Eliminating Use of the Term “Mental Retardation” by Physicians in Clinical Settings
10. Resolution 003 – Conforming Sex and Gender Designation on Government IDs and Other Documents
11. Resolution 015 – Opposing Mandated Reporting of People Who Question Their Gender Identity
12. Resolution 008 – Preventing Anti-Transgender Violence
13. Resolution 016 – Sexual and Gender Minority Populations in Medical Research
14. Resolution 019 – Opposition to Requirements for Gender-Based Medical Treatments for Athletes

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15. Resolution 005 – Right for Gamete Preservation Therapies
16. Resolution 009 – References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment
17. Resolution 025 – Gender Equity in Hospital Medical Staff Bylaws
18. Resolution 007 – Delegation of Informed Consent
19. Resolution 004 – Reimbursement for Care of Practice Partner Relatives
20. Resolution 010 – Covenants Not to Compete
21. Resolution 026 – Restrictive Covenants of Large Health Care Systems
22. Resolution 014 – Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations
23. Resolution 011 – Mature Minor Consent to Vaccinations
24. Resolution 027 – Model Legislation for “Mature Minor” Consent to Vaccinations
25. Resolution 012 – Improving Body Donations Regulations
26. Resolution 018 – Support for Requiring Investigations into Deaths of Children in Foster Care
27. Resolution 017 – National Guidelines for Guardianship
28. Resolution 013 – Opposing Office of Refugee Resettlement’s Use of Medical and Psychiatric Records for Evidence in Immigration Court
29. Resolution 022 – Opposition to Involuntary Civil Commitment for Substance Use Disorder
30. Resolution 023 – Distribution and Display of Human Trafficking Aid Information in Public Places
31. Resolution 021 – Health, In All Its Dimensions, Is a Basic Right
32. Council on Ethical and Judicial Affairs Report 02 – Physician Assisted Suicide
33. Resolution 020 – Changes to E-5.7, “Physician-Assisted Suicide”
34. Resolution 002 – Addressing Existential Suffering in End-of-Life Care

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**ORDER OF BUSINESS**

Reference Committee A (A-19)

John Montgomery, MD, Chair

June 9, 2019  
Regency Ballroom A

Hyatt Regency Chicago  
Chicago

1. Council on Medical Service Report 2 - Covering the Uninsured under the AMA  
Proposal for Reform  
*Resolution 103 - Health System Improvement Standards*  
*Resolution 108 - Congressional Healthcare Proposals*  
Resolution 116 - Medicare for All
2. Resolution 113 - Ensuring Access to Statewide Commercial Health Plans  
*Resolution 114 - Ensuring Access to Nationwide Commercial Health Plans*
3. Council on Medical Service Report 3 - Medicare Coverage for Dental Services
4. Council on Medical Service Report 4 - Reclassification of Complex Rehabilitation Technology
5. Resolution 119 - Returning Liquid Oxygen to Fee Schedule Payment
6. Council on Medical Service Report 5 - The Impact of Pharmacy Benefit Managers on Patients and Physicians  
*Resolution 118 - Pharmaceutical Pricing Transparency*
7. Resolution 126 - Ensuring Prescription Drug Price Transparency from Retail Pharmacies
8. Council on Medical Service Report 6 - Preventive Prostate Cancer Screening
9. *Resolution 115 - Safety of Drugs Approved by Other Countries*  
*Resolution 129 - The Benefits of Importation of International Pharmaceutical Medications*
10. *Resolution 122 - Reimbursement for Telemedicine Visits*
11. *Resolution 127 - Eliminating the CMS Observation Status*
12. *Resolution 128 - Elimination of CMS Hospital Readmission Penalties*
13. *Resolution 109 - Part A Medicare Payment to Physicians*

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During the reference committee hearing, supplemental materials may be sent to RC@ama-assn.org or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee. This address is only operational for the duration of the reference committee hearings.

14. *Resolution 111 - Practice Overhead Expense and the Site-of-Service Differential*  
*Late Resolution 1003 - Site of Service Differential*
15. Resolution 131 - Update Practice Expense Component of Relative Value Units
16. Resolution 101 - Health Hazards of High Deductible Insurance  
Resolution 125 - Mitigating the Negative Effects of High-Deductible Health Plans
17. *Resolution 102 - Use of HSAs for Direct Primary Care*
18. *Resolution 104 - Adverse Impacts of Single Specialty Independent Practice Associations*
19. Resolution 105 - Payment for Brand Medications When the Generic Medication is Recalled
20. *Resolution 130 - Notification of Generic Drug Manufacturing Changes*
21. *Resolution 120 - Medicare Coverage of Hearing Aids*  
*Resolution 124 - Increased Affordability and Access to Hearing Aids and Related Care*
22. *Resolution 117 - Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use*
23. Resolution 107 - Investigate Medicare Part D – Insurance Company Upcharge
24. *Resolution 112 - Health Care Fee Transparency*
25. *Resolution 121 - Maintenance Hemodialysis for Undocumented Persons*
26. *Resolution 123 - Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder*
27. *Resolution 106 - Raising Medicare Rates for Physicians*
28. *Resolution 110 - Establishing Fair Medicare Payer Rates*

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## **ORDER OF BUSINESS**

Reference Committee B (A-19)  
Charles Rothberg, MD, Chair

June 9, 2019  
Regency Ballroom B

Grand Hyatt  
Chicago, IL

1. Board of Trustees Report 9—Council on Legislation Sunset Report
2. 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)
3. Board of Trustees Report 17—Ban on Medicare Advantage "No Cause" Network Terminations
4. Board of Trustees Report 18— Increased Use of Body-Worn Cameras by Law Enforcement Officers (Resolution 208-I-17)
5. Board of Trustees Report 19—FDA Conflict of Interest (Resolution 216-A-18)
6. Board of Trustees Report 20—Safe and Efficient e-Prescribing
7. Board of Trustees Report 21—Augmented Intelligence in Health Care
8. Board of Trustees Report 22—Inappropriate Use of CDC Guidelines for Prescribing Opioids (Resolution 235-I-18)
9. Board of Trustees Report 23—Prior Authorization Requirements for Post-Operative Opioids (Resolution 208-A-18)
10. Board of Trustees Report 30—Opioid Treatment Programs Reporting to Prescription Monitoring Programs (Resolution 507-A-18)
11. 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
12. Resolution 204—Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs
13. Resolution 212—Pharmacy Benefit Managers
14. Resolution 218—Payment for Medications Used Off Label for Treatment of Pain  
*Resolution 234—Improved Access to Non-Opioid Therapies*  
Resolution 235—Prescription Coverage of the Lidocaine Transdermal Patch  
*Resolution 238—Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis*
15. Resolution 219—Medical Marijuana License Safety
16. Resolution 227—Controlled Substance Management
17. *Resolution 229—Clarification of CDC Opioid Prescribing Guidelines*
18. *Resolution 201—Assuring Patient Access to Kidney Transplantation*
19. *Resolution 202—Reducing the Hassle Factor in Quality Improvement Programs*
20. *Resolution 209—Mandates by ACOs Regarding Specific EMR Use*
21. *Resolution 241—Facilitation of Research with Medicare Claims Data*
22. Resolution 243—Improving the Quality Payment Program and Preserving Patient Access
23. Resolution 203—Medicare Part B and Part D Drug Price Negotiation

- Resolution 217—Medicare Vaccine Billing
- 24. *Resolution 205—Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary*
- 25. *Resolution 213—Financial Penalties and Clinical Decision-Making*
- 26. *Resolution 226—Physician Access to Their Medical and Billing Records*
- 27. *Resolution 206—Changing the Paradigm: Opposing Present and Obvious Restraint of Trade*  
*Resolution 240—Formation of Collective Bargaining Workgroup*
- 28. Resolution 207—Direct-to-Consumer Genetic Tests
- 29. Resolution 208—Repeal or Modification of the Sunshine Act
- 30. *Resolution 210—Air Ambulances*
- 31. Resolution 211—Use of Fair Health
- 32. *Resolution 214—The Term Physician*  
*Resolution 216—Eliminate the Word Provider from Healthcare Contracts*
- 33. *Resolution 215—Reimbursement for Health Information Technology*
- 34. Resolution 223—Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record
- 35. Resolution 242—Improving Health Information Technology Products to Properly Care for LGBTQ Patients
- 36. Resolution 244—EHR-Integrated Prescription Drug Monitoring Program Rapid Access
- 37. Resolution 237—Opportunities in Blockchain for Healthcare
- 38. 221—Extending Medicaid Coverage to 12-Months Postpartum  
224—Extending Pregnancy Medicaid to One Year Postpartum
- 39. *Resolution 222—Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads*
- 40. *Resolution 225—DACA in GME*
- 41. *Resolution 228—Truth in Advertising*
- 42. *Resolution 230—State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes*
- 43. Resolution 232—COPD National Action Plan
- 44. Resolution 233—GME Cap Flexibility
- 45. *Resolution 236—Support for Universal Basic Income Pilot Studies*
- 46. Resolution 239—Improving Access to Medical Care Through Tax Treatment of Physicians
- 47. Resolution 245—Sensible Appropriate Use Criteria in Medicare  
*Late Resolution 1002—Sensible Appropriate Use Criteria in Medicare*
- 48. Resolution 246—Call for Transparency Regarding the Announcement of 17,000 Cuts to Military Health Providers

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**ORDER OF BUSINESS**

Reference Committee C (A-19)  
Nicole D. Riddle, MD, Chair

June 9, 2019  
Regency Ballroom C

Hyatt Regency  
Chicago

1. Council on Medical Education Report 1, Council on Medical Education Sunset Review of 2009 House Policies
2. Council on Medical Education Report 4, Augmented Intelligence in Medical Education
3. Resolution 302, The Climate Change Lecture for US Medical Schools
4. Resolution 304, Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs
5. Resolution 319, Adding Pipeline Program Participation Questions to Medical School Applications
6. *Resolution 306, Interest Rates and Medical Education*
7. Resolution 316, Medical Student Debt
8. Resolution 322, Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools
9. *Resolution 320, Opioid Education in Medical Schools*
10. *Resolution 309, Promoting Addiction Medicine During a Time of Crisis*
11. Council on Medical Education - Council on Science and Public Health Report 1, Protecting Medical Trainees from Hazardous Exposure
12. Resolution 313, Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows
13. Resolution 315, Scholarly Activity by Resident and Fellow Physicians
14. Resolution 303, Graduate Medical Education and the Corporate Practice of Medicine
15. Resolution 324, Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary Reimbursement

16. Council on Medical Education Report 3, Standardizing the Residency Match System and Timeline
17. Resolution 314, Evaluation of Changes to Residency and Fellowship Application and Matching Processes
18. Resolution 312, Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians
19. Board of Trustees Report 25, All Payer Graduate Medical Education Funding
20. Resolution 311, Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure
21. *Resolution 318, Rural Health Physician Workforce Disparities*
22. Resolution 323, Improving Access to Care in Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model
23. Council on Medical Education Report 6, Study of Medical Student, Resident, and Physician Suicide
24. Resolution 307, Mental Health Services for Medical Students
25. Resolution 310, Mental Health Care for Medical Students
26. Resolution 317, A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
27. Council on Medical Education Report 2, Update on Maintenance of Certification and Osteopathic Continuous Certification
28. *Resolution 305, Lack of Support for Maintenance of Certification*
29. Resolution 308, Maintenance of Certification Moratorium
30. Resolution 301, American Board of Medical Specialties Advertising
31. Resolution 321, Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical Profession

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## **ORDER OF BUSINESS**

Reference Committee D (A-19)  
Diana Ramos, MD, MPH, Chair

June 9, 2019  
Regency Ballroom D

Hyatt Regency  
Chicago

1. Board of Trustees Report 11 – Policy and Economic Support for Early Child Care
2. Board of Trustees Report 29 – Improving Safety and Health Code Compliance in School Facilities
3. 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
4. Resolution 404 – Shade Structures in Public and Private Planning and Zoning Matters
5. Resolution 425 – Distracted Driver Education and Advocacy  
Resolution 415 – Distracted Driving Legislation
6. Resolution 427 – Utility of Autonomous Vehicles for Individuals Who Are Visually Impaired or Developmentally Disabled  
Resolution 407 – Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents
7. Resolution 405 – Gun Violence Prevention: Safety Features
8. 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
9. Board of Trustees Report 16 – Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients
10. Board of Trustees Report 28 – Opposition to Measures that Criminalize Homelessness
11. Council on Science and Public Health Report 4 – Vector-borne Diseases
12. *Resolution 413 – End the Epidemic of HIV Nationally*
13. Resolution 432 – Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals
14. Resolution 423 – Mandatory Immunizations for Asylum Seekers
15. *Resolution 416 – Non-Medical Exemptions from Immunizations*
16. Resolution 402 – Bullying in the Practice of Medicine
17. Resolution 403 – White House Initiative on Asian Americans and Pacific Islanders
18. Resolution 410 – Reducing Health Disparities Through Education
19. Council on Science and Public Health Report 3 – Low Nicotine Product Standard
20. Resolution 418 – Eliminating the Death Toll from Combustible Cigarettes
21. Resolution 409 – Addressing the Vaping Crisis

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22. *Resolution 428 – Dangers of Vaping*
23. *Resolution 412 – Regulating Liquid Nicotine and E-Cigarettes*
24. Resolution 411 – AMA to Analyze Benefits/Harms of Legalization of Marijuana
25. Resolution 408 – Banning Edible Cannabis Products
26. Resolution 414 – Patient Medical Marijuana Use in Hospitals
27. *Resolution 434 – Change in Marijuana Classification to Allow Research*
28. Resolution 433 – Transformation of Rural Community Public Health Systems
29. Resolution 419 – Universal Access for Essential Public Health Services
30. Resolution 417 – Improved Health in the United States Prison System through Hygiene and Health Educational Programming for Inmates and Prison Staff
31. Resolution 420 – Coordinating Correctional and Community Healthcare
32. Resolution 426 – Health Care Accreditation of Correctional, Detention, and Juvenile Facilities
33. Resolution 421 – Contraception for Incarcerated Women
34. Resolution 430 – Compassionate Release for Incarcerated Patients
35. *Resolution 422 – Promoting Nutrition Among Healthcare Providers*
36. Resolution 431 – Eliminating Recommendations to Restrict Dietary Cholesterol and Fat
37. Resolution 406 – Reduction in Consumption of Processed Meats

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**ORDER OF BUSINESS**

Reference Committee E (A-19)  
Leslie H. Secrest, MD, Chair

June 9, 2019  
Regency Ballroom D

Hyatt Regency Chicago  
Chicago

1. CSAPH Report 1, CSAPH Sunset Review of 2009 House of Delegates Policies
2. *CSAPH Report 2, Drug Shortages: 2019 Update*
3. Resolution 503, Addressing Healthcare Needs of Children of Incarcerated Parents  
Resolution 531, Support for Children of Incarcerated Parents
4. Resolution 528, Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing
5. Resolution 510, The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) Initiative
6. Resolution 522, Improved Deferral Periods for Blood Donors
7. Resolution 527, Increasing the Availability of Bleeding Control Supplies
8. *Resolution 506, Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements*
9. *Resolution 511, Mandating Critical Congenital Heart Defect Screening in Newborns*
10. Resolution 512, Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients
11. Resolution 513, Determining Why Infertility Rates Differ Between Military and Civilian Women
12. *Resolution 516, Alcohol Consumption and Health*
13. Resolution 507, Removing Ethylene Oxide as a Medical Sterilant from Healthcare
14. Resolution 501, USP 800
15. Resolution 517, Compounding
16. Resolution 504, Screening, Intervention, and Treatment for Adverse Childhood Experiences  
Resolution 526, Trauma-Informed Care Resources and Settings
17. *Resolution 509, Addressing Depression to Prevent Suicide Epidemic*
18. Resolution 502, Destigmatizing the Language of Addiction
19. Resolution 508, Benzodiazepine and Opioid Warning
20. Resolution 514, Opioid Addiction
21. Resolution 515, Reversing Opioid Epidemic
22. Resolution 519, Childcare Availability for Persons Receiving Substance Use Disorder Treatment
23. Resolution 520, Substance Use During Pregnancy
24. *Resolution 523, Availability and Use of Low Starting Opioid Doses*

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25. Resolution 532, Dispelling Myths of Bystander Opioid Overdose
26. Resolution 524, Availability of Naloxone Boxes
27. Resolution 530, Implementing Naloxone Training into the Basic Life Support Certification Program
28. *Resolution 525, Support for Rooming-in of Neonatal Abstinence Syndrome Patients with Their Parents*
29. Resolution 518, Chemical variability in pharmaceutical products
30. *Resolution 521, Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter*
31. Resolution 529, Adverse Impacts of Delaying the Implementation of Public Health Regulations
32. Resolution 505, Glyphosate Studies

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## **ORDER OF BUSINESS**

Reference Committee F (A-19)  
Greg Tarasidis, MD, Chair

June 9, 2019  
Grand Ballroom

Hyatt Regency Chicago  
Chicago

### **Financial**

1. Board of Trustees Report 1 – Annual Report
2. Board of Trustees Report 4 – AMA 2020 Dues
3. Report of the House of Delegates Committee on the Compensation of the Officers

### **Governance**

4. Resolution 605 – State Societies and the AMA Litigation Center
5. Resolution 606 – Investigation into Residents, Fellows, and Physician Unions
6. Resolution 613 – Language Proficiency Data of Physicians in AMA Masterfile
7. Resolution 614 – Racial and Ethnic Identity Demographic Collection by the AMA
8. Resolution 616 – TIME’S UP Healthcare
9. Resolution 617 – Disabled Physician Advocacy

### **House of Delegates**

10. Board of Trustees Report 10 – Conduct at AMA Meetings and Events
11. Resolution 602 – Expectations for Behavior at House of Delegates Meetings
12. Resolution 609 – Update to AMA Policy H-525.998, “Women in Organized Medicine”
13. Board of Trustees Report 12 – Data Used to Apportion Delegates
14. Resolution 603 – Creation of an AMA Election Reform Committee
15. Resolution 611 – Election Reform
16. Resolution 618 – Stakeholder Input to Reports of the House of Delegates

### **Membership**

17. Board of Trustees Report 24 – Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion

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During the reference committee hearing, supplemental materials may be sent to [steve.currier@ama-assn.org](mailto:steve.currier@ama-assn.org) or provided to the staff. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents, and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee, and will only accept supplemental material for the duration of the reference committee hearing.

### Publishing

18. Resolution 601 – AMA Policy Statement with Editorials
19. Resolution 610 – Mitigating Gender Bias in Medical Research
20. Resolution 615 – Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership

### Miscellaneous

21. Board of Trustees Report 27 – Advancing Gender Equity in Medicine
22. Resolution 604 – Engage and Collaborate with the Joint Commission
23. Resolution 607 – Re-establishment of National Guideline Clearinghouse
24. Resolution 608 – Financial Protections for Doctors in Training
25. Resolution 612 – Request to AMA for Training in Health Policy and Health Law

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## **ORDER OF BUSINESS**

Reference Committee G (A-19)  
Rodney Trytko, MD, Chair

June 9, 2019  
Regency Ballroom A

Hyatt Regency Chicago  
Chicago

1. Board of Trustees Report 13 – Employed Physician Bill of Rights and Basic Practice Professional Standards
2. Board of Trustees Report 32 – Impact of High Capital Costs of Hospital EHRs on the Medical Staff
3. Board of Trustees Report 31 – Non-Payment and Audit Takebacks by CMS
4. Board of Trustees Report 15 – Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization
5. *Resolution 702 – Peer Support Groups for Second Victims*
6. Council on Medical Service Report 8 – Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor
7. Council on Medical Service Report 9 – Health Plan Payment of Patient Cost-Sharing  
*Resolution 707 – Cost of Unpaid Patient Deductibles on Physician Staff Time*
8. Council on Medical Service Report 10 – Alternative Payment Models and Vulnerable Populations
9. Council on Medical Service Report 1 – Council on Medical Service Sunset Review of 2009 AMA House Policies
10. Council on Medical Service Report 7 – Hospital Consolidation
11. Council on Medical Service Report 11 – Corporate Investors
12. *Resolution 701 – Coding for Prior Authorization Obstacles*
13. *Resolution 716 – Health Plan Claim Auditing Programs*
14. Resolution 704 – Prior Authorization Reform

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15. *Resolution 703 – Preservation of the Patient-Physician Relationship*
16. Resolution 705 – Physician Requirements for Comprehensive Stroke Center Designation
17. Resolution 708 – Access to Psychiatric Treatment in Long-Term Care
18. Resolution 711 – Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs
19. Resolution 717 – Military Physician Reintegration into Civilian Practice
20. *Resolution 715 – Managing Patient-Physician Relations Within Medicare Advantage Plans*
21. Resolution 706 – Hospital Falls and “Never Events” – A Need for More in Depth Study
22. Resolution 718 – Economic Discrimination in the Hospital Practice Setting
23. Resolution 710 – Council for Affordable Quality Healthcare Attestation
24. *Resolution 712 – Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives*
25. Resolution 719 – Interference with Practice of Medicine by the Nuclear Regulatory Commission
26. *Resolution 709 – Promoting Accountability in Prior Authorization*
27. *Resolution 713 – Selective Application of Prior Authorization*
28. Resolution 714 – Medicare Advantage Step Therapy

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## **Reference Committee on Amendments to Constitution and Bylaws**

### **BOT Report(s)**

- 02 New Specialty Organizations Representation in the House of Delegates
- 26 Research Handling of De-Identified Patient Information
- 33\* Specialty Society Representation in the House of Delegates - Five Year Review

### **CC&B Report(s)**

- 01 Clarification to the Bylaws: Delegate Representation, Registration and Credentialing

### **CEJA Report(s)**

- 01 Competence, Self-Assessment and Self-Awareness
- 02 Physician Assisted Suicide
- 03 CEJA's Sunset Review of 2009 House Policies

### **Resolution(s)**

- 001 Opposing Attorney Presence at and/or Recording of Independent Medical Examinations
- 002 Addressing Existential Suffering in End-of-Life Care
- 003 Conforming Sex and Gender Designation on Government IDs and Other Documents
- 004 Reimbursement for Care of Practice Partner Relatives
- 005 Right for Gamete Preservation Therapies
- 006 Use of Person-Centered Language
- 007 Delegation of Informed Consent
- 008# Preventing Anti-Transgender Violence
- 009# References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment
- 010# Covenants not to Compete
- 011# Mature Minor Consent to Vaccinations
- 012# Improving Body Donation Regulation
- 013# Opposing Office of Refugee Resettlement's Use of Medical and Psychiatric Records for Evidence in Immigration Court
- 014# Disclosure of Funding Sources and Industry Ties of Professional Medical Associations and Patient Advocacy Organizations
- 015# Opposing Mandated Reporting of People Who Question Their Gender Identity
- 016# Sexual and Gender Minority Populations in Medical Research
- 017# National Guidelines for Guardianship
- 018# Support for Requiring Investigations into Deaths of Children in Foster Care
- 019# Opposition to Requirements for Gender-Based Medical Treatments for Athletes
- 020# Changes to E-5.7, "Physician-Assisted Suicide"
- 021# Health, In All Its Dimensions, Is a Basic Right
- 022# Opposition to Involuntary Civil Commitment for Substance Use Disorder
- 023\* Distribution and Display of Human Trafficking Aid Information in Public Places
- 024\* Eliminating Use of the Term "Mental Retardation" by Physicians in Clinical Settings
- 025\* Gender Equity in Hospital Medical Staff Bylaws
- 026\* Restrictive Covenants of Large Health Care Systems
- 027\* Model Legislation for "Mature Minor" Consent to Vaccinations

# Contained in the Handbook Addendum

\* Contained in the Sunday Tote

## Reference Committee A

### CMS Report(s)

- 02 Covering the Uninsured Under the AMA Proposal for Reform
- 03 Medicare Coverage for Dental Services
- 04 Reclassification of Complex Rehabilitation Technology
- 05 The Impact of Pharmacy Benefit Managers on Patients and Physicians
- 06 Preventive Prostate Cancer Screening

### Resolution(s)

- 101 Health Hazards of High Deductible Insurance
- 102 Use of HSAs for Direct Primary Care
- 103 Health System Improvement Standards
- 104 Adverse Impacts of Single Specialty Independent Practice Associations
- 105 Payment for Brand Medications When the Generic Medication is Recalled
- 106 Raising Medicare Rates for Physicians
- 107 Investigate Medicare Part D - Insurance Company Upcharge
- 108 Congressional Healthcare Proposals
- 109 Part A Medicare Payment to Physicians
- 110 Establishing Fair Medicare Payer Rates
- 111 Practice Overhead Expense and the Site-of-Service Differential
- 112 Health Care Fee Transparency
- 113 Ensuring Access to Statewide Commercial Health Plans
- 114 Ensuring Access to Nationwide Commercial Health Plans
- 115 Safety of Drugs Approved by Other Countries
- 116 Medicare for All
- 117 Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use
- 118 Pharmaceutical Pricing Transparency
- 119# Returning Liquid Oxygen to Fee Schedule Payment
- 120# Medicare Coverage of Hearing Aids
- 121# Maintenance Hemodialysis for Undocumented Persons
- 122# Reimbursement for Telemedicine Visits
- 123# Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder
- 124# Increased Affordability and Access to Hearing Aids and Related Care
- 125# Mitigating the Negative Effects of High-Deductible Health Plans
- 126# Ensuring Prescription Drug Price Transparency from Retail Pharmacies
- 127# Eliminating the CMS Observation Status
- 128\* Elimination of CMS Hospital Readmission Penalties
- 129\* The Benefits of Importation of International Pharmaceutical Medications
- 130\* Notification of Generic Drug Manufacturing Changes
- 131\* Update Practice Expense Component of Relative Value Units

# Contained in the Handbook Addendum

\* Contained in the Sunday Tote

## Reference Committee B

### **BOT Report(s)**

- 09 Council on Legislation Sunset Review of 2009 House Policies
- 14 Reforming the Orphan Drug Act; An Optional National Prescription Drug Formulary; Reform of Pharmaceutical Pricing; Negotiated Payment Schedules
- 17 Ban on Medicare Advantage "No Cause" Network Terminations
- 18 Increased Use of Body-Worn Cameras by Law Enforcement Officers
- 19 FDA Conflict of Interest
- 20 Safe and Efficient E-Prescribing
- 21 Augmented Intelligence in Health Care
- 22 Inappropriate Use of CDC Guidelines for Prescribing Opioids
- 23 Prior Authorization Requirements for Post-Operative Opioids
- 30 Opioid Treatment Programs Reporting to Prescription Monitoring Programs

### **Resolution(s)**

- 201 Assuring Patient Access to Kidney Transplantation
- 202 Reducing the Hassle Factor in Quality Improvement Programs
- 203 Medicare Part B and Part D Drug Price Negotiation
- 204 Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs
- 205 Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary
- 206 Changing the Paradigm: Opposing Present and Obvious Restraint of Trade
- 207 Direct-to-Consumer Genetic Tests
- 208 Repeal or Modification of the Sunshine Act
- 209 Mandates by ACOs Regarding Specific EMR Use
- 210 Air Ambulances
- 211 Use of FAIR Health
- 212 Pharmacy Benefit Managers
- 213 Financial Penalties and Clinical Decision-Making
- 214 The Term Physician
- 215 Reimbursement for Health Information Technology
- 216 Eliminate the Word Provider from Healthcare Contracts
- 217 Medicare Vaccine Billing
- 218 Payment for Medications Used Off Label for Treatment of Pain
- 219 Medical Marijuana License Safety
- 220 Study of Confidentiality and Privacy Protection in the Treatment of Substance Disorders
- 221 Extending Medicaid Coverage to 12-Months Postpartum
- 222 Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads
- 223 Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record
- 224 Extending Pregnancy Medicaid to One Year Postpartum
- 225 DACA in GME
- 226 Physician Access to Their Medical and Billing Records
- 227 Controlled Substance Management
- 228 Truth in Advertising
- 229 Clarification of CDC Opioid Prescribing Guidelines

# Contained in the Handbook Addendum

\* Contained in the Sunday Tote



## Reference Committee B

### Resolution(s)

- 230# State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes
- 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
- 232# COPD National Action Plan
- 233# GME Cap Flexibility
- 234# Improved Access to Non-Opioid Therapies
- 235# Prescription Coverage of the Lidocaine Transdermal Patch
- 236# Support for Universal Basic Income Pilot Studies
- 237# Opportunities in Blockchain for Healthcare
- 238# Coverage Limitations and Non-Coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis
- 239# Improving Access to Medical Care Through Tax Treatment of Physicians
- 240# Formation of Collective Bargaining Workgroup
- 241# Facilitation of Research with Medicare Claims Data
- 242\* Improving Health Information Technology Products to Properly Care for LGBTQ Patients
- 243\* Improving the Quality Payment Program and Preserving Patient Access
- 244\* EHR-Integrated Prescription Drug Monitoring Program Rapid Access
- 245\* Sensible Appropriate Use Criteria in Medicare
- 246\* Call for Transparency Regarding the Announcement of 17,000 Cuts to Military Health Providers

## **Reference Committee C**

### **BOT Report(s)**

- 25 All Payer Graduate Medical Education Funding

### **CME Report(s)**

- 01 Council on Medical Education Sunset Review of 2009 House Policies
- 02 Update on Maintenance of Certification and Osteopathic Continuous Certification
- 03 Standardizing the Residency Match System and Timeline
- 04 Augmented Intelligence in Medical Education
- 06 Study of Medical Student, Resident, and Physician Suicide

### **Joint Report(s)**

- 01 CME/CSAPH Joint Report - Protecting Medical Trainees from Hazardous Exposure

### **Resolution(s)**

- 301 American Board of Medical Specialties Advertising
- 302 The Climate Change Lecture for US Medical Schools
- 303 Graduate Medical Education and the Corporate Practice of Medicine
- 304 Tracking Outcomes and Supporting Best Practices of Health Care Career Pipeline Programs
- 305 Lack of Support for Maintenance of Certification
- 306 Interest Rates and Medical Education
- 307 Mental Health Services for Medical Students
- 308 MOC Moratorium
- 309 Promoting Addiction Medicine During a Time of Crisis
- 310 Mental Health Care for Medical Students
- 311 Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure
- 312 Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians
- 313 Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows
- 314 Evaluation of Changes to Residency and Fellowship Application and Matching Processes
- 315 Scholarly Activity by Resident and Fellow Physicians
- 316 Medical Student Debt
- 317 A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities
- 318 Rural Health Physician Workforce Disparities
- 319# Adding Pipeline Program Participation Questions to Medical School Applications
- 320# Opioid Education in Medical Schools
- 321# Physician Health Program Accountability, Consistency, and Excellence in Provision of Service to the Medical Profession
- 322# Support for the Study of the Timing and Causes for Leave of Absence and Withdrawal from United States Medical Schools
- 323\* Improving Access to Care in Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model
- 324\* Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary Reimbursement

# Contained in the Handbook Addendum

\* Contained in the Sunday Tote

## Reference Committee D

### **BOT Report(s)**

- 11 Policy and Economic Support for Early Child Care
- 16 Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients
- 28 Opposition to Measures that Criminalize Homelessness
- 29 Improving Safety and Health Code Compliance in School Facilities

### **CSAPH Report(s)**

- 03 Low Nicotine Product Standard
- 04 Vector-Borne Diseases

### **Resolution(s)**

- 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
- 402 Bullying in the Practice of Medicine
- 403 White House Initiative on Asian Americans and Pacific Islanders
- 404 Shade Structures in Public and Private Planning and Zoning Matters
- 405 Gun Violence Prevention: Safety Features
- 406 Reduction in Consumption of Processed Meats
- 407 Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents
- 408 Banning Edible Cannabis Products
- 409 Addressing the Vaping Crisis
- 410 Reducing Health Disparities Through Education
- 411 AMA to Analyze Benefits / Harms of Legalization of Marijuana
- 412 Regulating Liquid Nicotine and E-Cigarettes
- 413 End the Epidemic of HIV Nationally
- 414 Patient Medical Marijuana Use in Hospitals
- 415 Distracted Driving Legislation
- 416 Non-Medical Exemptions from Immunizations
- 417 Improved Health in the United States Prison System Through Hygiene and Health Educational Programming for Inmates and Prison Staff
- 418 Eliminating the Death Toll from Combustible Cigarettes
- 419 Universal Access for Essential Public Health Services
- 420 Coordinating Correctional and Community Healthcare
- 421 Contraception for Incarcerated Women
- 422 Promoting Nutrition Education Among Healthcare Providers
- 423# Mandatory Immunizations for Asylum Seekers
- 424# Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Injury
- 425# Distracted Driver Education and Advocacy
- 426# Health Care Accreditation of Correctional, Detention and Juvenile Facilities
- 427# Utility of Autonomous Vehicles for Individuals Who are Visually Impaired or Developmentally Disabled
- 428# Dangers of Vaping
- 429# Support for Children of Incarcerated Parents (MOVED TO REF COMM E - now Resolution 531)
- 430# Compassionate Release for Incarcerated Patients

# Contained in the Handbook Addendum

\* Contained in the Sunday Tote

## **Reference Committee D**

### **Resolution(s)**

- 431# Eliminating Recommendations to Restrict Dietary Cholesterol and Fat
- 432# Decriminalization of Human Immunodeficiency Virus (HIV) Status Non-Disclosure in Virally Suppressed Individuals
- 433# Transformation of Rural Community Public Health Systems
- 434# Change in Marijuana Classification to Allow Research

## Reference Committee E

### CSAPH Report(s)

01 CSAPH Sunset Review of 2009 House of Delegates Policies

### Resolution(s)

- 501 USP 800
- 502 Destigmatizing the Language of Addiction
- 503 Addressing Healthcare Needs of Children of Incarcerated Parents
- 504 Screening, Intervention, and Treatment for Adverse Childhood Experiences
- 505 Glyphosate Studies
- 506 Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements
- 507 Removing Ethylene Oxide as a Medical Sterilant from Healthcare
- 508 Benzodiazepine and Opioid Warning
- 509 Addressing Depression to Prevent Suicide Epidemic
- 510 The Intracranial Hemorrhage Anticoagulation Reversal Initiative
- 511 Mandating Critical Congenital Heart Defect Screening in Newborns
- 512 Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients
- 513 Determining Why Infertility Rates Differ Between Military and Civilian Women
- 514 Opioid Addiction
- 515 Reversing Opioid Epidemic
- 516 Alcohol Consumption and Health
- 517# Compounding
- 518# Chemical Variability in Pharmaceutical Products
- 519# Childcare Availability for Persons Receiving Substance Use Disorder Treatment
- 520# Substance Use During Pregnancy
- 521# Put Over-the-Counter Inhaled Epinephrine Behind Pharmacy Counter
- 522# Improved Deferral Periods for Blood Donors
- 523# Availability and Use of Low Starting Opioid Doses
- 524# Availability of Naloxone Boxes
- 525# Support for Rooming-in of Neonatal Abstinence Syndrome Patients with Their Parents
- 526# Trauma-Informed Care Resources and Settings
- 527# Increasing the Availability of Bleeding Control Supplies
- 528# Developing Diagnostic Criteria and Evidence-Based Treatment Options for Problematic Pornography Viewing
- 529# Adverse Impacts of Delaying the Implementation of Public Health Regulations
- 530# Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program
- 531\* Support for Children of Incarcerated Parents
- 532\* Dispelling Myths of Bystander Opioid Overdoes

# Contained in the Handbook Addendum

\* Contained in the Sunday Tote

## **Reference Committee F**

### **BOT Report(s)**

- 01 Annual Report
- 04 AMA 2020 Dues
- 10 Conduct at AMA Meetings and Events
- 12 Data Used to Apportion Delegates
- 24 Discounted/Waived CPT Fees as an AMA Member Benefit and for Membership Promotion
- 27 Advancing Gender Equity in Medicine

### **HOD Comm on Compensation of the Officers**

- 01# Report of the House of Delegates Committee on Compensation of the Officers

### **Resolution(s)**

- 601 AMA Policy Statement with Editorials
- 602 Expectations for Behavior at House of Delegates Meetings
- 603 Creation of an AMA Election Reform Committee
- 604 Engage and Collaborate with The Joint Commission
- 605 State Societies and the AMA Litigation Center
- 606 Investigation into Residents, Fellows and Physician Unions
- 607 Re-establishment of National Guideline Clearinghouse
- 608 Financial Protections for Doctors in Training
- 609 Update to AMA Policy H-525.998, "Women in Organized Medicine"
- 610 Mitigating Gender Bias in Medical Research
- 611# Election Reform
- 612# Request to AMA for Training in Health Policy and Health Law
- 613# Language Proficiency Data of Physicians in the AMA Masterfile
- 614# Racial and Ethnic Identity Demographic Collection by the AMA
- 615# Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership
- 616# TIME'S UP Healthcare
- 617# Disabled Physician Advocacy
- 618\* Stakeholder Input to Reports of the House of Delegates

## **Reference Committee G**

### **BOT Report(s)**

- 13 Employed Physician Bill of Rights and Basic Practice Professional Standards
- 15 Physician Burnout and Wellness Challenges; Physician and Physician Assistant Safety Net; Identification and Reduction of Physician Demoralization
- 31 Non-Payment and Audit Takebacks by CMS
- 32 Impact of High Capital Costs of Hospital EHRs on the Medical Staff

### **CMS Report(s)**

- 01 Council on Medical Service Sunset Review of 2009 AMA House Policies
- 07 Hospital Consolidation
- 08 Group Purchasing Organizations and Pharmacy Benefit Manager Safe Harbor
- 09 Health Plan Payment of Patient Cost-Sharing
- 10 Alternative Payment Models and Vulnerable Populations
- 11 Corporate Investors

### **Resolution(s)**

- 701 Coding for Prior Authorization Obstacles
- 702 Peer Support Groups for Second Victims
- 703 Preservation of the Patient-Physician Relationship
- 704 Prior Authorization Reform
- 705 Physician Requirements for Comprehensive Stroke Center Designation
- 706 Hospital Falls and "Never Events" - A Need for More in Depth Study
- 707 Cost of Unpaid Patient Deductibles on Physician Staff Time
- 708# Access to Psychiatric Treatment in Long Term Care
- 709# Promoting Accountability in Prior Authorization
- 710# Council for Affordable Quality Healthcare Attestation
- 711# Impact on the Medical Staff of the Success or Failure in Generating Savings of Hospital Integrated System ACOs
- 712# Promotion of Early Recognition and Treatment of Sepsis by Out-of-Hospital Healthcare Providers to Save Lives
- 713\* Selective Application of Prior Authorization
- 714\* Medicare Advantage Step Therapy
- 715\* Managing Patient-Physician Relations Within Medicare Advantage Plans
- 716\* Health Plan Claim Auditing Programs
- 717\* Military Physician Reintegration into Civilian Practice
- 718\* Economic Discrimination in the Hospital Practice Setting
- 719\* Interference with Practice of Medicine by the Nuclear Regulatory Commission

## **Informational Reports**

### **BOT Report(s)**

- 03 2018 Grants and Donations
- 05 Update on Corporate Relationships
- 06 Redefining AMA's Position on ACA and Healthcare Reform
- 07 AMA Performance, Activities and Status in 2018
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2018 Through February 2019

### **CC&B Report(s)**

- 02 Section Internal Operating Procedures and Council Rules: Roles of the House of Delegates, Board of Trustees and the Council on Constitution and Bylaws

### **CEJA Opinion(s)**

- 01 Amendment to E-2.2.1, "Pediatric Decision Making"

### **CEJA Report(s)**

- 04 Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report
- 05 Discrimination Against Physicians by Patients

### **CLRPD Report(s)**

- 01 Demographic Characteristics of the House of Delegates and AMA Leadership

### **CME Report(s)**

- 05 Accelerating Change in Medical Education Consortium Outcomes
- 07 For-Profit Medical Schools or Colleges

### **CSAPH Report(s)**

- 02 Drug Shortages: 2019 Update

### **Report of the Speakers**

- 01 Recommendations for Policy Reconciliation



## REPORT OF THE BOARD OF TRUSTEES

B of T Report 33-A-19

Subject: Specialty Society Representation in the House of Delegates -  
Five-Year Review

Presented by: Jack Resneck, Jr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(William Reha, MD, Chair)

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1 The Board of Trustees (BOT) has completed its review of the specialty organizations seated in  
2 the House of Delegates (HOD) scheduled to submit information and materials for the 2019  
3 American Medical Association (AMA) Annual Meeting in compliance with the five-year  
4 review process established by the House of Delegates in Policy G-600.020, "Summary of  
5 Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw  
6 8.5, "Periodic Review Process."

7  
8 Organizations are required to demonstrate continuing compliance with the guidelines  
9 established for representation in the HOD. Compliance with the five responsibilities of  
10 professional interest medical associations and national medical specialty organizations is also  
11 required as set out in AMA Bylaw 8.2, "Responsibilities of National Medical Specialty  
12 Societies and Professional Interest Medical Associations."

13  
14 The following organizations were reviewed for the 2019 Annual Meeting:

15  
16 American Association of Gynecologic Laparoscopists  
17 American Academy of Cosmetic Surgery  
18 American Association for Thoracic Surgery  
19 American Association of Plastic Surgeons  
20 American Association of Public Health Physicians  
21 American College of Allergy, Asthma and Immunology  
22 American Society for Aesthetic Plastic Surgery  
23 American Society for Metabolic and Bariatric Surgery  
24 American Society of Interventional Pain Physicians  
25 Association of University Radiologists  
26 Infectious Diseases Society of America  
27 International Society for the Advancement of Spine Surgery  
28 Society of Laparoendoscopic Surgeons  
29

30 Each organization was required to submit materials demonstrating compliance with the  
31 guidelines and requirements along with appropriate membership information. A summary of  
32 each group's membership data is attached to this report (Exhibit A). A summary of the  
33 guidelines for specialty society representation in the AMA HOD (Exhibit B), the five  
34 responsibilities of national medical specialty organizations and professional medical interest  
35 associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-  
36 year review process (Exhibit D) are also attached.

1 The materials submitted indicate that: American Association of Gynecologic Laparoscopists,  
2 American Academy of Cosmetic Surgery, American Association for Thoracic Surgery,  
3 American Association of Plastic Surgeons, American Association of Public Health Physicians,  
4 American College of Allergy, Asthma and Immunology, American Society for Metabolic and  
5 Bariatric Surgery, and the Society of Laparoendoscopic Surgeons meet all guidelines and are in  
6 compliance with the five-year review requirements of specialty organizations represented in the  
7 HOD.

8  
9 The materials submitted also indicated that: American Society for Aesthetic Plastic Surgery,  
10 American Society of Interventional Pain Physicians, Association of University Radiologists,  
11 Infectious Diseases Society of America and the International Society for the Advancement of  
12 Spine Surgery did not meet all guidelines and are not in compliance with the five-year review  
13 requirements of specialty organizations represented in the HOD.

#### 14 15 RECOMMENDATIONS

16  
17 The Board of Trustees recommends that the following be adopted and the remainder of this  
18 report be filed:

- 19  
20 1. That American Association of Gynecologic Laparoscopists, American Academy of  
21 Cosmetic Surgery, American Association for Thoracic Surgery, American Association  
22 of Plastic Surgeons, American Association of Public Health Physicians, American  
23 College of Allergy, Asthma and Immunology, American Society for Metabolic and  
24 Bariatric Surgery, and the Society of Laparoendoscopic Surgeons retain representation  
25 in the American Medical Association House of Delegates. (Directive to Take Action)  
26
- 27 2. Having failed to meet the requirements for continued representation in the AMA House  
28 of Delegates as set forth in AMA Bylaw B-8.50, American Society for Aesthetic Plastic  
29 Surgery, American Society of Interventional Pain Physicians, Association of University  
30 Radiologists, Infectious Diseases Society of America and the International Society for  
31 the Advancement of Spine Surgery be placed on probation and be given one year to  
32 work with AMA membership staff to increase their AMA membership. (Directive to  
33 Take Action)

Fiscal Note: Less than \$500 to implement.

## APPENDIX

### *Exhibit A - Summary Membership Information*

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
American Association of Gynecologic Laparoscopists	1,571 of 4,046 (39%)
American Academy of Cosmetic Surgery	319 of 901 (35%)
American Association for Thoracic Surgery	226 of 959 (24%)
American Association of Plastic Surgeons	193 of 801 (24%)
American Association of Public Health Physicians	48 of 81 (59%)
American College of Allergy, Asthma and Immunology	544 of 2068 (26%)
American Society for Aesthetic Plastic Surgery	341 of 1,894 (18%)
American Society for Metabolic and Bariatric Surgery	271 of 1,390 (20%)
American Society of Interventional Pain Physicians	701 of 3,616 (19%)
Association of University Radiologists	147 of 836 (18%)
Infectious Diseases Society of America	537 of 3,950 (14%)
International Society for the Advancement of Spine Surgery	55 of 235 (23%)
Society of Laparoendoscopic Surgeons	985 of 2,548 (39%)

***Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)***

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
  - (a) represent a field of medicine that has recognized scientific validity;
  - (b) not have board certification as its primary focus; and
  - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
  - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
  - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
  - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

***Exhibit C***

**8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations.** Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

***Exhibit D – AMA Bylaws on Specialty Society Periodic Review***

**8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates**

**8.5 Periodic Review Process.** Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

**8.5.1** If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.

**8.5.2** If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

**8.5.3** Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

**8.5.3.1** If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

**8.5.3.2** If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

**8.5.3.2.1** The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

**8.5.3.2.2** The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of

Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

**AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-19)**  
**INFORMATION STATEMENT \***  
**PROVIDED BY THE AMERICAN ASSOCIATION OF CLINICAL UROLOGISTS AND**  
**AMERICAN UROLOGICAL ASSOCIATION**

*A New Podcast Series*

## **The Original Guide To Men's Health**

During the month of June, Men's Health Month is celebrated across the country with screenings, health fairs, media appearances, and other education and outreach activities.

According to the Men's Health Network, the purpose of Men's Health Month is to heighten the awareness of preventable health problems and encourage early detection and treatment of disease among men and boys.

This month gives health care providers, public policy makers, the media, and individuals an opportunity to encourage men and boys to seek regular medical advice and early treatment for disease and injury.



Special attention to these issues is necessary because men consistently demonstrate a higher risk of death at all ages than women. Many men tend to neglect preventive care and present late in the course of a disease state that might otherwise be highly manageable at an early stage. Men tend to shun preventive care for several reasons, including societal pressure, embarrassment, economic insecurity, inadequate awareness, and lack of time.

In 2017, the House of Delegates reaffirmed American Medical Association policy to encourage the establishment of an Office of Men's Health at the U.S. Department of Health and Human Services to coordinate awareness, outreach, and outcomes on men's health (D-160.985). This policy dates back to the 2007 Annual Meeting and the goal has yet to be achieved.

As physicians who treat many of the conditions affecting men that are made worse because of a lack of awareness, the urology delegation directs delegates' attention to a new podcast series, **The Original Guide To Men's Health**, featuring casual, in-depth, and frank interviews, with leading experts in men's health and a broad range of other specialty areas, that provide tips on how to access and optimize health, with the latest knowledge, technology, and treatment. To listen/subscribe to podcasts, search for "**The Original Guide To Men's Health**" podcast on iTunes, Apple podcast, Google Play, or your favorite podcast app, and then tap the Washington State Urology Society logo, tap subscribe, and choose an episode.

The AUA and AACU delegations also direct attention to well-established resources for men's health and urologic conditions:

Men's Health Month  
[www.menshealthmonth.org](http://www.menshealthmonth.org)

Urology Care Foundation  
[www.urologyhealth.org](http://www.urologyhealth.org)

AUA treatment guidelines  
[www.auanet.org](http://www.auanet.org)

The Partnership for Male Youth  
[www.ayamalehealth.org](http://www.ayamalehealth.org)

*\*This item is an "information statement." An information statement may be submitted to bring an issue to the attention of the HOD. The item will be included as an informational item but will not go to a reference committee or be acted upon in any way by the House, unless extracted.*



# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

**Robert William Davis, Jr.**

**Introduced by Susan R. Bailey, MD, Delegate  
Bruce A. Scott, MD, Delegate**

Whereas, Robert William Davis, Jr., was the Senior Vice President for Human Resources and Corporate Services at our AMA for many years before retiring on May 17; and

Whereas, Robert William Davis Jr. was better known to all who knew him as Bob Davis; and

Whereas, Bob worked closely with multiple members of the House of Delegates who served on the Selection Committee for the Public Member of the Board of Trustees; and

Whereas, Bob worked with the House of Delegates Committee on Compensation of the Officers for many years as well; and

Whereas, Bob's work on behalf of and for the House of Delegates extended to many areas that are largely behind the scenes, including contracting for Annual and Interim Meetings, arrangements for child care, security in the House, and the development of our code of conduct; and

Whereas, Bob made innumerable contributions to our Board of Trustees as they conducted the business of our AMA and executed the policies adopted by the House of Delegates; and

Whereas, Bob brought an appreciation of the humanity of each individual to all his work, but especially to his efforts in human resources; and

Whereas, Bob was a loyal alumnus and fan of Michigan State University and an avid golfer in his free time; and

Whereas, Bob passed away on May 30 at the age of 65; and

Whereas, Bob leaves behind his loving wife Chong Sun (nee Ahn) Davis, his cherished brother George Davis and sister Lisa Shankle as well as nieces, nephews and cousins; and

Whereas, His colleagues at our American Medical Association shall miss his quick humor, balanced perspective, and leadership; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions made by Robert William Davis, Jr., to our Association and through it to the larger profession; and be it further

RESOLVED, That our American Medical Association House of Delegates express its sympathy for the death of Robert William Davis Jr. to his family and present them with a copy of this resolution.

# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

**John A. Knoté, MD**

### **Introduced by Indiana and the AMA Senior Physicians Section**

Whereas, Dr. John A. Knoté, MD, a radiologist who practiced in Lafayette and Indianapolis, Indiana, passed away on April 22, 2019; and

Whereas, Dr. Knoté graduated from Purdue University with a degree in Physical Education for Men and was the third person ever to represent the university as “Purdue Pete”; and

Whereas, Dr. Knoté graduated from Indiana University School of Medicine, and continued his post-graduate education through an Internship at Baptist Memorial Hospital in Memphis, and Radiology Residency at Indiana University; and

Whereas, Dr. Knoté promoted improving the practice of medicine in many ways including service to the Indiana State Medical Association, culminating as ISMA President in 1983-84, and numerous positions in the American College of Radiology (from whom he received the Gold Medal), the American Roentgen Ray Society, the Radiologic Society of North America and the American College of Nuclear Medicine; and

Whereas, Dr. Knoté continued his service to the medical profession through the American Medical Association (where his exploits are legendary), ultimately serving as Speaker of the House of Delegates from 2000-2003; and

Whereas, Dr. Knoté continued his contributions to the AMA through the Senior Physicians Section, serving as Chair of the Senior Physicians Section Governing Council in 2009-2010; and

Whereas, Dr. Knoté continued throughout his life to be a valued mentor to all who sought his counsel with honest, respectful, and often humorous advice that will be sorely missed by all who knew him; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize Dr. John A. Knoté’s outstanding service to the profession; and be it further

RESOLVED, That a copy of this resolution be recorded in the proceedings of this House and be forwarded to his family with an expression of the House’s deepest sympathy.

# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

**Marvin Horton Rorick, III, MD**

**Introduced by Ohio**

Whereas, Marvin H. Rorick III, MD, an esteemed member of the Academy of Medicine of Cincinnati, Ohio State Medical Association, and American Medical Association, passed away suddenly on August 2, 2018; and

Whereas, Dr. Rorick received his MD degree in 1984 from University of Cincinnati College of Medicine, served his internship at Good Samaritan Hospital, and his residency at University of Cincinnati Medical Center; and

Whereas, Dr. Rorick was president of the Academy of Medicine of Cincinnati in 1998 and was an active member of numerous committees and boards, including Legislative Affairs, Communications, Program, Membership, Academy Council, and The Medical Foundation; and

Whereas, Dr. Rorick was actively involved for many years with the OSMA, serving as a long-time member of the First District Delegation to the OSMA House of Delegates, First District Councilor from 2004-2010, and chair of the Organized Medical Staff Section from 2014-2018; and

Whereas, Dr. Rorick was the District 1 Chair of the OSMA Political Action Committee; and

Whereas, Dr. Rorick was active in many community activities and organizations including Hospice of Cincinnati, Ohio Valley Life Center, Cincinnati Council for Epilepsy, and Greater Cincinnati Foundation, and was chosen to participate in Leadership Cincinnati Class XXI; and

Whereas, Dr. Rorick worked throughout his more than 30-year medical career to bring the best possible medical care to his patients in the Greater Cincinnati area and was well respected in the local medical community by both his colleagues and his patients; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize the many contributions made by Dr. Rorick to the medical profession, as well as the Greater Cincinnati community; and be it further

RESOLVED, That our American Medical Association House of Delegates express its sympathy for the death of Dr. Rorick to his family and present them with a copy of this resolution.

# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

**Ralph E. Schlossman, MD**

**Introduced by New York**

Whereas, It is with the deepest regret that we mourn the passing of our esteemed colleague and friend, Ralph E. Schlossman, MD on January 17, 2019; and

Whereas, Dr. Schlossman was born in Brooklyn, NY; graduated from the Polytechnic Preparatory School and Syracuse University; received his medical degree in 1955 from the New York University Bellevue College of Medicine; and completed his internship at the Kings County Hospital Center in Brooklyn in 1956; and

Whereas, Dr. Schlossman served his Country in the United States Air Force from 1956 to 1958; serving as Chief Flight Surgeon of the 31<sup>st</sup> Tactical Fighter Wing and Commander of the 31<sup>st</sup> Tactical Hospital; and was one of the first physicians to fly faster than the speed of sound; and

Whereas, Dr. Schlossman was a Diplomate of the American Board of Family Medicine and held teaching positions at the State University of New York Downstate Medical Center, the New York Hospital Weill College of Medicine of Cornell University, and the Touro College of Osteopathic Medicine; and was an attending physician at State University Hospital in Brooklyn and New York Hospital Queens; and

Whereas, Dr. Schlossman joined both the Medical Society of the County of Queens (MSCQ) and the Medical Society of the State of New York (MSSNY) in December 1958; and served faithfully on numerous committees and in multiple officer positions; and

Whereas, Dr. Schlossman served as President of the Medical Society of the County of Queens in 1970-1971; served on the MSCQ Board of Trustees from 1972-1984 and subsequently as its Chair for over twenty years and was serving as Trustee Emeritus until his passing; and

Whereas, Dr. Schlossman was the recipient of the Medical Society of the County of Queens highest honor, the MSCQ Lifetime Achievement Award; and

Whereas, Dr. Schlossman served as President of the Medical Society of the State of New York in 1998-1999; and served on the MSSNY Board of Trustees from 2000-2005 and as its Chair in 2004-2005; and

Whereas, Dr. Schlossman was the recipient of the Medical Society of the State of New York highest honor, the Henry I. Feinberg Award for Leadership; and

Whereas, Dr. Schlossman was a longtime delegate from the MSCQ to the MSSNY and from the MSSNY to the American Medical Association; and

Whereas, Dr. Schlossman practiced Family Medicine in Queens for over 50 years; was a regular health news contributor to Queens Public Access Cable TV; and mentored many medical students and physicians, including two individuals who also became Presidents of the Medical Society of the State of New York; and

Whereas, Dr. Schlossman possessed a warm sense of humor and delighted in turning frowns into smiles and laughter; and

Whereas, Dr. Schlossman leaves a legacy of service and leadership to his Country and to the profession of medicine and will be dearly remembered by the numerous patients for whom he cared; and by his numerous friends and colleagues; and

Whereas, Dr. Schlossman enjoyed a long and loving marriage to his wife, Ruth, who passed away on March 9, 2019; and

Whereas, Dr. Schlossman leaves a legacy of quiet dignity, leadership, honor, integrity, and boundless love for his children, Marcie, Andrew, and Wendy; and his grandchildren; therefore be it

RESOLVED, That this House of Delegates of the American Medical Association express its sorrow at the passing of our dear friend and colleague, Ralph E. Schlossman, MD, and that this resolution be made part of the proceedings of the 2019 Annual Meeting of the House of Delegates.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 023  
(A-19)

Introduced by: Texas

Subject: Distribution and Display of Human Trafficking Aid Information in Public Places

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(William Reha, MD, MBA, Chair)

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1 Whereas, Human trafficking is slavery, including both labor and sex trafficking, and involves  
2 people of every age, gender, race/ethnicity, nationality, immigration status, and sexual  
3 orientation; and  
4

5 Whereas, Human trafficking represents one of the most insidious and seemingly invisible public  
6 health challenges; and  
7

8 Whereas, The National Human Trafficking Hotline has reported cases of human trafficking in  
9 every state, and since 2007 has reported nearly 19,000 cases in California, Texas, Florida,  
10 New York, and Ohio alone; and  
11

12 Whereas, The National Human Trafficking Hotline recently reported more than 5,000 cases  
13 nationwide in the first half of 2018; and  
14

15 Whereas, Reports presented by the National Human Trafficking Hotline are not comprehensive  
16 reports on the scale or scope of human trafficking within the United States, and the actual  
17 number of victims is likely much higher; and  
18

19 Whereas, Reports from the National Human Trafficking Hotline indicate a persistent need for  
20 community response in order to serve victims and survivors, respond to human trafficking  
21 cases, and share information and resources; and  
22

23 Whereas, Physicians have a unique and critical role to play in preventing human trafficking, and  
24 identifying and treating its victims; and  
25

26 Whereas, Victims and survivors of human trafficking may be seen at local clinics, emergency  
27 departments, or other medical settings, and the health care team's actions at that moment can  
28 make a lifesaving difference; therefore be it  
29

30 RESOLVED, That our American Medical Association adopt as policy that readily visible signs,  
31 notices, posters, placards, and other readily available educational materials providing  
32 information about reporting human trafficking activities or providing assistance to victims and  
33 survivors be permitted in local clinics, emergency departments, or other medical settings (New  
34 HOD Policy); and be it further

1 RESOLVED, That our AMA, through its website or internet presence, provide downloadable  
 2 materials displaying the National Human Trafficking Hotline number to aid in displaying such  
 3 information in local clinics, emergency departments, or other medical settings and advocate that  
 4 other recognized medical professional organizations do the same (Directive to Take Action);  
 5 and be it further  
 6

7 RESOLVED, That our AMA urge the federal government to make changes in laws to advocate  
 8 for the broad posting of the National Human Trafficking Hotline number in areas such as local  
 9 clinics, emergency departments, and other medical settings. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/24/19

## RELEVANT AMA POLICY

### Physicians Response to Victims of Human Trafficking H-65.966

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -

In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:

- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
  - a. An assessment tool for health care professionals
  - b. Online training in recognizing and responding to human trafficking in a health care context
  - c. Speakers and materials for in-person training
  - d. Links to local resources across the country

The Rescue & Restore Campaign -

The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

Citation: (BOT Rep. 20, A-13; Appended: Res. 313, A-15)

### Human Trafficking / Slavery Awareness D-170.992

Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.

Citation: Res. 015, A-18

### Commercial Exploitation and Human Trafficking of Minors H-60.912

Our AMA supports the development of laws and policies that utilize a public health framework to address the commercial sexual exploitation and sex trafficking of minors by promoting care and services for victims instead of arrest and prosecution.

Citation: Res. 009, A-17

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 024  
(A-19)

Introduced by: Texas

Subject: Eliminating Use of the Term “Mental Retardation” by Physicians in Clinical Settings

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(William Reha, MD, MBA, Chair)

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1 Whereas, The term “mental retardation” promotes the stigma and negative treatment of people  
2 with intellectual disabilities, which also is associated with diminished access to health care and  
3 poorer health, employment, and quality of life outcomes; and  
4

5 Whereas, A movement to change the terminology from “mental retardation” to “intellectual  
6 disability” began as a grassroots effort by self-advocates who were offended by the term.  
7 National groups such as The Arc, Inclusion International, and Special Olympics embraced the  
8 movement, resulting in sweeping changes in federal law and a societal shift in use of the  
9 preferred terminology; and  
10

11 Whereas, In 2017, Public Law 111–256, also known as Rosa’s Law, amended sections of the  
12 Rehabilitation Act of 1973 to replace the use of the term “mental retardation” in federal law with  
13 “intellectual disability” without changing the definition, coverage, eligibility, rights, and  
14 responsibilities of the affected individuals; and  
15

16 Whereas, The World Health Organization in 2016 updated its International Classification of  
17 Diseases to expand the term “intellectual disability” to include a variety of disorders that are on  
18 the same developmental spectrum as “mental retardation,” thereby removing a core  
19 classification and implementing a more effective, parent category for developmental disorders;  
20 and  
21

22 Whereas, The American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental*  
23 *Disorders*, Fifth Edition (DSM-5) replaced the diagnosis of “mental retardation” in 2013 with  
24 “intellectual disability” for childhood-onset neurodevelopmental disorders; as was done in the  
25 11th edition of Diagnostic Manual of the American Association on Intellectual and  
26 Developmental Disabilities; and  
27

28 Whereas, The updated DSM-5 terminology more specifically reflects an affected individual’s  
29 condition, its impact on his or her intellectual and adaptive functioning, and encourages a more  
30 in-depth comprehension of a patient’s diagnosis; and  
31

32 Whereas, The U.S. Supreme Court began using the term “intellectual disability” instead of  
33 “mental retardation” in court cases beginning in 2014; and  
34

35 Whereas, The campaign *Spread the Word to End the Word* is led by Special Olympics and  
36 other organizations that seek to eliminate the pejorative and dehumanizing word “retarded” from  
37 public vernacular to promote the shift in focus from the disability to the individual and his or her  
38 accomplishments; therefore be it



- 1 RESOLVED, That our American Medical Association recommend that physicians adopt the term
- 2 “intellectual disability” instead of “mental retardation” in clinical settings. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/24/19

## RELEVANT AMA POLICY

### Medical Care of Persons with Developmental Disabilities H-90.968

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 co-morbid 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.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18

### **Support for Persons with Intellectual Disabilities H-90.967**

Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

Citation: Res. 01, A-16

### **Early Intervention for Individuals with Developmental Delay H-90.969**

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17

#### **Sources:**

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## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 025  
(A-19)

Introduced by: Organized Medical Staff Section

Subject: Gender Equity in Hospital Medical Staff Bylaws

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(William Reha, MD, MBA, Chair)

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1 Whereas, Documented gaps exist in compensation and career advancement between male  
2 physicians and their female counterparts, even after accounting for other factors and  
3 characteristics; and  
4

5 Whereas, Current and ongoing American Medical Association (AMA) advocacy efforts seek to  
6 reduce gender bias, promote objective criteria for equal base pay, create guidance for  
7 instructional transparency of compensations, and establish educational initiatives on institutional  
8 and structural bias within medicine; and  
9

10 Whereas, Despite these efforts, there is no evidence of gender equity being addressed in  
11 hospital bylaws; therefore be it  
12

13 RESOLVED, That our American Medical Association affirm that hospital medical staff bylaws  
14 should promote, and not impede, gender equity in their implementation (New HOD Policy); and  
15 be it further  
16

17 RESOLVED, That our AMA study existing hospital medical staff bylaws as to how they impact  
18 on issues of gender equity, directly or indirectly, and suggest any addition(s) to its model  
19 bylaws to assure this issue is properly addressed, and gender equity affirmed. (Directive to  
20 Take Action)

Fiscal Note: Modest – between \$1,000 and \$5,000

Received: 06/07/19

### RELEVANT AMA POLICY

#### **D-65.989 Advancing Gender Equity in Medicine**

1. Our AMA will 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, to be submitted to the House for consideration at the 2019 Annual Meeting.

2. Our AMA will: (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.

3. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

4. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

5. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

Citation: Res. 010, A-18

#### **D-200.981 Gender Disparities in Physician Income and Advancement**

Our AMA:

(1) encourages medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;

(2) supports physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;

(3) urges medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;

(4) will collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and

(5) will provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

Citation: (BOT Rep. 19, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13

#### **H-310.976 Gender-Based Questioning in Residency Interviews**

The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.

Citation: (Res. 125, I-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13

#### **H-65.968 Equal Opportunity**

Our AMA: (1) declares it is opposed to any exploitation and discrimination in the workplace based on gender; (2) affirms the concept that 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) affirms the concept of equal rights for men and women; and (4) endorses the principle of equal opportunity of employment and practice in the medical field.

Citation: CCB/CLRPD Rep. 4, A-13

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 026  
(A-19)

Introduced by: Organized Medical Staff Section

Subject: Restrictive Covenants of Large Health Care Systems

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(William Reha, MD, MBA, Chair)

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1 Whereas, Historically, the American Medical Association (AMA) was the only prominent society  
2 to opine on restrictive covenants; and  
3

4 Whereas, In 1933, the AMA published an opinion which stated its position that restrictive  
5 covenants were unethical because they interfered with reasonable competition and prevented  
6 the patient's free choice of physicians; and  
7

8 Whereas, However, in 1960, this position changed when the AMA stated that "[t]here is no  
9 ethical proscription against suggesting or entering into a reasonable agreement not to practice  
10 within a certain area for a certain time, if it is knowingly made, understood and consistent with  
11 local law. Ethically, such agreements are not forbidden;" and  
12

13 Whereas, In 1969, The American Bar Association adopted a code of professional conduct that  
14 included a disciplinary rule prohibiting restrictive covenants between attorneys, using the logic  
15 that they interfere with the client's freedom to choose a lawyer; and  
16

17 Whereas, In the past, the majority of restrictive covenants were written to protect small  
18 physician practices and were of a reasonable geographic restriction; and  
19

20 Whereas, However, the recent trend of physicians becoming contract employees and entering  
21 into written agreements with their employers has created contractual disputes for an increasing  
22 number of physicians; and  
23

24 Whereas, With hospital mergers on the rise, the adverse impact that restrictive covenants may  
25 have on patients and physicians is likely to increase; therefore be it  
26

27 RESOLVED, That our American Medical Association, through its Organized Medical Staff  
28 Section, educate medical students, physicians-in-training, and physicians entering into  
29 employment contracts with large health care system employers on the dangers of aggressive  
30 restrictive covenants, including but not limited to the impact on patient choice and access to  
31 care (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA study the impact that restrictive covenants have across all practice
- 2 settings, including but not limited to the effect on patient access to health care, the patient-
- 3 physician relationship, and physician autonomy, with report back at the 2019 Interim Meeting.
- 4 (Directive to Take Action)

Fiscal Note: Moderate – Between \$5,000 and \$10,000

Received: 06/07/19

## **RELEVANT AMA POLICY**

### **H-225.950 AMA Principles for Physician Employment**

...(3)(g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment...

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17

### **Restrictive Covenants in Physician Contracts H-383.987**

Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.

Citation: BOT Rep. 13, A-16

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 027  
(A-19)

Introduced by: Young Physicians Section

Subject: Model Legislation for "Mature Minor" Consent to Vaccinations

Referred to: Reference Committee on Amendments to Constitution and Bylaws  
(William Reha, MD, MBA, Chair)

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Whereas, According to the World Health Organization (WHO), vaccination is one of the most cost-effective ways of avoiding disease and currently prevents 2 to 3 million deaths yearly, and an additional 1.5 million deaths could be avoided if global vaccination coverage is improved; and

Whereas, The WHO named vaccine hesitancy, defined as the delay in acceptance or refusal of vaccines, as one of the biggest global health threats of 2019;<sup>i, ii</sup> and

Whereas, Vaccine hesitancy has been attributed to a thirty percent increase in measles cases globally;<sup>1, 2</sup> and

Whereas, In 2018, the United States saw the second-highest rate of measles cases since the disease was eliminated in 2000;<sup>iii</sup> and

Whereas, Vaccination laws, exemptions and enforcement vary by state, as well as clusters of unvaccinated populations, creating pockets of concentrated risk for serious communicable disease;<sup>iv</sup> and

Whereas, There are 18 states (Alabama, Alaska, Arkansas, Delaware, Idaho, Illinois, Kansas, Louisiana, Maine, Massachusetts, Montana, Nevada, Oregon, Pennsylvania, South Carolina, Tennessee, Washington and West Virginia) that have made allowances for "mature minors" (someone who is old enough to understand and appreciate the consequences of a medical procedure, as determined by their physician) as young as 12 years old to independently consent to vaccinations without parental approval;<sup>v,vi,vii</sup> and

Whereas, A majority of adolescent health professionals surveyed reported that they would support minors having the ability to consent for their own vaccines;<sup>viii</sup> therefore be it

RESOLVED, That our American Medical Association 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 (Directive to Take Action); and be it further

RESOLVED, That our AMA 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. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 06/08/19

## **RELEVANT AMA POLICY**

### **2.2.1 Pediatric Decision Making:**

Unlike health care decisions for most adult patients, decisions for pediatric patients usually involve a three-way relationship among the minor patient, the patient's parents (or guardian), and the physician. Although children who are emancipated may consent to care on their own behalf, in general, children below the age of majority are not considered to have the capacity to make health care decisions on their own. Rather, parents or guardians are expected, and authorized, to provide or decline permission for treatment for minor patients. Nonetheless, respect and shared decision making remain important in the context of decisions for minors, and physicians have a responsibility to engage minor patients in making decisions about their own care to the greatest extent possible, including decisions about life-sustaining treatment. Decisions for pediatric patients should be based on the child's best interest, which is determined by weighing many factors, including effectiveness of appropriate medical therapies and the needs and interests of the patient and the family as the source of support and care for the patient. When there is legitimate inability to reach consensus about what is in the best interest of the child, the wishes of the parents/guardian should generally receive preference. For health care decisions involving minor patients, physicians should: (a) Involve all patients in decision making at a developmentally appropriate level. (b) Base recommendations for treatment on the likely benefit to the patient, taking into the effectiveness of treatment, risks of additional suffering with and without treatment, available alternatives, and overall prognosis. (c) For patients capable of assent, truthfully explain the medical condition, its clinical implications, and the treatment plan in a manner that takes into account the child's cognitive and emotional maturity and social circumstances for patients capable of assent. (d) Provide a supportive environment and encourage parents to discuss their child's health status with the patient. Offer to facilitate the parent-child conversation for reluctant parents. (e) Recognize that for certain medical conditions, such as those involving HIV/AIDS or inherited conditions, disclosing the child's health status may also reveal health information about biological relatives or disrupt existing presumptions about the child's relationships within the family. (f) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents in ways to avoid behaviors that put the child or others at risk. (g) Ensure that when decisions involve life-sustaining interventions, patients have opportunity to be involved in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardian understand the patient's diagnosis, both with and without treatment. Physicians should discuss with the patient and parents/guardian of initiating an intervention with the intention of evaluating its clinical effectiveness after a specified amount of time to determine if it has led to improvement. Confirm that if the intervention has not achieved agreed-on goals it may be withdrawn. (h) Respect the decisions of the patient and parents/guardian when it is not clear whether a specific intervention promotes the patient's best interests. (i) Seek consultation with an ethics committee or other institutional resource when: (i) there is a reversible life-threatening condition and the patient (if capable) or parents/guardian refuse treatment the physician believes is clearly in the patient's best interest; or (ii) there is disagreement about what the patient's best interests are. Physicians should turn to the courts to resolve disagreements only as a last resort. (j) Provide compassionate and humane care to all pediatric patients, including patients who forgo or discontinue life-sustaining interventions.

### **Distribution and Administration of Vaccines H-440.877**

1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record.

2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP recommendations must be ensured timely access to adequate vaccine supply.



3. Physicians and other qualified health care providers should: (a) incorporate immunization needs into clinical encounters, as appropriate; (b) strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines; (c) either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws; (d) ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists; and (e) maintain professional competencies in immunization practices, as appropriate.
  4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law.
  5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician.
  6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers.
  7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community.
  8. Our AMA encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.
- Citation: Sub. Res. 512, A-06; Reaffirmed: BOT Rep. 26, A-07; BOT Action in response to referred for decision Res. 902, I-08; Modified: CSAPH Rep. 4, I-14; Appended: Res. 404, A-16; Reaffirmed: CMS Rep. 07, A-17

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i. Ten threats to global health in 2019. Available at <https://www.who.int/emergencies/ten-threats-to-global-health-in-2019>. Accessed April 2019.

ii. Anti-Vax Movement Listed by World Health Organization as One of the Top 10 Health Threats for 2019. Available at <https://www.newsweek.com/world-health-organization-who-un-global-health-air-pollution-anti-vaxxers-1292493>. Accessed April 2019.

iii. Measles Cases and Outbreaks. Available at <https://www.cdc.gov/measles/cases-outbreaks.html>. Accessed April 2019.

iv. State Vaccination Requirements. Available at <https://www.cdc.gov/vaccines/imz-managers/laws/state-reqs.html>. Accessed April 2019.

v. Can teenagers get vaccinated without their parents' permission? Available at <https://www.newscientist.com/article/2193937-can-teenagers-get-vaccinated-without-their-parents-permission/>. Accessed April 2019.

vi. Can Minors Get Vaccinated Without Parental Consent? Available at <https://www.ibtimes.com/can-minors-get-vaccinated-without-parental-consent-2763119>. Accessed April 2019.

vii. Measles Outbreak: Children of Anti-Vaxxers Are Asking How to Get Vaccinated Without Their Parents Knowing. Available at <https://www.newsweek.com/measles-outbreak-children-anti-vaxxers-asking-how-get-vaccinated-without-1314428>. Accessed April 2019.

8. Minor Consent and Delivery of Adolescent Vaccines. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4916962/>. Accessed April 2019.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 128  
(A-19)

Introduced by: New Jersey

Subject: Elimination of CMS Hospital Readmission Penalties

Referred to: Reference Committee A  
(John Montgomery, MD, Chair)

Whereas, Readmission of patients for “any cause,” regardless of the discharge diagnosis, within 30 days, anywhere in the US, results in a penalty by CMS (e.g. A patient with pneumonia is discharged home, trips and falls sustaining a hip fracture and is re-admitted within 30 days); and

Whereas, Our AMA has policy against denial of payment due to readmissions (H-340.989) and believes this is a discriminatory practice by CMS; and

Whereas, This penalty has created barriers to care and potentially life threatening situations for a particularly fragile patient population and such readmissions may be due to factors outside of the control of physicians; and

Whereas, Such penalty results in financial implication to the physician and to hospitals; and

Whereas, This penalty can also negatively impact individual, group or hospital ratings; therefore be it

RESOLVED, That our American Medical Association immediately write a letter to the Centers for Medicare and Medicaid Services and Congress with the goal of working together to remove the financial penalty for any cause readmissions to a hospital (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm policy H-340.989, “PRO Readmission Review.” (Reaffirm HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/09/19

### RELEVANT AMA POLICY

#### PRO Readmission Review H-340.989

1. The AMA urges CMS to allow payment for second or subsequent admissions which reflect accepted standards of medical practice and which will benefit the quality of patient care.

2. Our AMA will publicly protest any payer system, that will deny payment to hospitals and physicians based primarily on readmission within a certain period of time.

3. Our AMA, in its commitment to serve our most fragile patients, will never tolerate any denial of payment from Medicare which discriminates against the most vulnerable of our patients and will partner with the American Hospital Association and other appropriate organizations to establish legislative action with Congress to reverse Medicare's nonpayment because of readmission within 30 days.

Citation: (Res. 141, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Appended: Res. 131, A-10)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 129  
(A-19)

Introduced by: Texas

Subject: The Benefits of Importation of International Pharmaceutical Medications

Referred to: Reference Committee A  
(John Montgomery, MD, Chair)

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1 Whereas, The cost of basic prescription drugs in the United States is among the highest in the  
2 world due to market exclusivity and a lack of payer negotiating power; and  
3

4 Whereas, These prescription drug prices impose a substantial financial burden on consumers  
5 and represent a significant cause of nonadherence, resulting in worsened health outcomes; and  
6

7 Whereas, There is bipartisan support for prescription drug importation programs; and  
8

9 Whereas, Several states are considering passing legislation or already have legislation that  
10 allows for wholesale importation or purchasing of prescription drugs; and  
11

12 Whereas, State legislation allowing for wholesale importation of prescription drugs could save  
13 money for both private sector and state-funded insurance programs; and  
14

15 Whereas, Patients from Arizona, New Mexico, California, Texas, and other states already are  
16 obtaining their prescription drugs from pharmacies in Mexico and other countries; and  
17

18 Whereas, A 2015 study by the United States International Trade Commission estimates that  
19 close to 1 million people in California alone cross to Mexico annually for health care, including to  
20 buy prescription drugs;<sup>i</sup> and  
21

22 Whereas, In 1995 the U.S. Food and Drug Administration, the Subsecretaría de Regulación y  
23 Fomento Sanitario of the Secretaría de Salud of the United Mexican States, and the Health  
24 Protection Branch of Health Canada signed a memorandum of cooperation that includes  
25 working to strengthen existing mutual cooperation in the scientific and regulatory areas of  
26 regulated products including drugs and biologics;<sup>ii</sup> and  
27

28 Whereas, The increasing illegal importation of drugs from Mexico could be controlled by a legal  
29 process that would protect the health and well-being of patients; and  
30

31 Whereas, Our American Medical Association's existing drug importation policy D-100.983  
32 focuses solely on importation of prescription drugs from Canada; therefore be it  
33

34 RESOLVED, That our American Medical Association study the implications of prescription drug  
35 importation for personal use and wholesale prescription drug purchase across our southern and  
36 northern borders. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.  
Received: 05/24/19

## RELEVANT AMA POLICY

### **Prescription Drug Importation and Patient Safety D-100.983**

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.

Citation: BOT Rep. 3, I-04; Reaffirmation A-09; Reaffirmed in lieu of: Res. 817, I-16; Appended: CMS Rep. 01, I-18

### **Pharmaceutical Quality Control for Foreign Medications D-100.977**

Our AMA will call upon Congress to provide the US Food and Drug Administration with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients.

Citation: Res. 508, A-08;A-16;A-16

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<sup>i</sup> USITC. Trends In U.S. Health Travel Services Trade. August 2015.

[www.usitc.gov/publications/332/executive\\_briefings/chambers\\_health-related\\_travel\\_final.pdf](http://www.usitc.gov/publications/332/executive_briefings/chambers_health-related_travel_final.pdf)

<sup>ii</sup> FDA. Mexico and Canada, cooperation in the Scientific and Regulatory Fields of Health. Oct. 30, 1995. [www.fda.gov/international-programs/cooperative-arrangements/fda-mexico-and-canada-cooperation-scientific-and-regulatory-fields-health](http://www.fda.gov/international-programs/cooperative-arrangements/fda-mexico-and-canada-cooperation-scientific-and-regulatory-fields-health)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 130  
(A-19)

Introduced by: Texas

Subject: Notification of Generic Drug Manufacturing Changes

Referred to: Reference Committee A  
(John Montgomery, MD, Chair)

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1 Whereas, Generic drug use is prevalent across the medical spectrum, with multiple  
2 manufacturers producing the same base drug; and  
3

4 Whereas, Pharmacies and pharmacy benefit managers may change a drug prescription from  
5 one generic drug manufacturer to another; and  
6

7 Whereas, Generic drugs are not required to replicate the extensive clinical trials used in the  
8 development of brand drugs; and  
9

10 Whereas, Bioequivalence only needs 24 to 36 healthy, normal volunteers to demonstrate the  
11 time it takes a generic to reach the bloodstream and its concentration in the bloodstream; and  
12

13 Whereas, Two versions of a drug are said to be bioequivalent if the 90% confidence intervals for  
14 the ratios of the geometric means of the area under the curve and chemical makeup fall within  
15 80% and 125%; and  
16

17 Whereas, Generic drugs are not required to contain the same nonmedicinal ingredients as the  
18 brand name drug or another manufacturer's generic drug; and  
19

20 Whereas, Most patients are unaware of a change from one manufacturer to another of their  
21 generic drug prescription; and  
22

23 Whereas, The unknown change in generic manufacturers has caused harm to patients;  
24 therefore be it  
25

26 RESOLVED, That our American Medical Association lobby Congress to pass legislation that  
27 ensures that each patient is expressly notified at the time of dispensing by the pharmacy or  
28 pharmacy benefit manager of a change in the manufacturer of his or her generic medication.  
29 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/24/19

**RELEVANT AMA POLICY****Prescription Labeling H-115.974**

Our AMA recommends (1) That when a physician desires to prescribe a brand name drug product, he or she do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, he or she do so by designating the USAN-assigned generic name of the drug on the prescription.

(2) That, except where the prescribing physician has indicated otherwise, the pharmacist should include the following information on the label affixed to the container in which a prescription drug is dispensed: in the absence of product substitution, (a) the brand and generic name of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; and (d) the name of the manufacturer or distributor.

(3) When generic substitution occurs: (a) the generic name (or, when applicable, the brand name of the generic substitute ["branded" generic name]) of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; (d) the manufacturer or distributor; and (e) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]".

(4) When a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: (a) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; (b) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug container with the name of the new generic drug manufacturer or distributor and, show this to the patient; (c) affix to the primary label an auxiliary (sticker) label that states, "This is the same medication you have been getting. Color, size, or shape may appear different;" and (d) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed.

Citation: BOT Rep. 1, A-95; Amended: CSA Rep. 2, I-99; Modified Res. 512, I-00; Reaffirmed: CSA Rep. 6, A-02; Reaffirmed: CSAPH Rep. 2, A-07; Reaffirmed: Sub. Res. 509, A-07; Reaffirmed: CSAPH Rep. 01, A-17

**Pharmaceutical Benefits Management Companies H-125.986**

Our AMA:

(1) encourages physicians to report to the Food and Drug Administrations (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;

(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;

(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;

(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;

(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care;

(6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and

(7) encourages the FTC and FDA to monitor PBMs policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest.

Citation: BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533; A-03; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: Alt. Res. 806, I-17; Modified: Res. 242, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 131  
(A-19)

Introduced by: Texas

Subject: Update Practice Expense Component of Relative Value Units

Referred to: Reference Committee A  
(John Montgomery, MD, Chair)

Whereas, In 1992, Medicare established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS), where payments for services are determined by the resource costs needed to provide them; and

Whereas, Our AMA created the RVS Update Committee (RUC) to recommend payment schedules to the Centers for Medicare & Medicaid Services; and

Whereas, RBRVS costs have three components: physician work, practice expense, and professional liability insurance; and

Whereas, The AMA Practice Expense Advisory Committee, a subcommittee of the RUC, was charged with reviewing direct practice expenses to calculate practice expense relative values and to make code-specific recommendations to the RUC; and

Whereas, Physician practice expenses have not been comprehensively reviewed since 2004, nor updated since 2007, while actual practice costs have increased dramatically since the last reviews in 2004 and 2007, including new practice costs related to electronic health records; quality documentation and reporting; population health registries; prior authorizations; pharmacy benefit manager reviews; prescription drug monitoring programs; interval increases in other federal, state, and local documentation requirements; and additional staff required to comply with these new reporting requirements; as well as rent, equipment, supplies, salaries, and inflation; and

Whereas, Physicians require the resources to practice 21st-century medicine and implement the value-based payment requirements established by the 2015 Medicare Access and CHIP Reauthorization Act; and

Whereas, The 2018 Rand Practice Expense Analysis concluded, “[T]he PPIS [Physician Practice Information Survey] survey inputs that are used for indirect cost allocation are outdated and likely to become increasingly inaccurate over time. ... We recommend establishing a new PE survey that can be repeated on an ongoing basis”; therefore be it

RESOLVED, That our American Medical Association 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.  
(Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$5M.  
Received: 05/24/19

## **RELEVANT AMA POLICY**

### **The RUC: Recent Activities to Improve the Valuation of Primary Care Services D-400.986**

Our AMA continues to advocate for the adoption of AMA/Specialty Society RVS Update Committee (RUC) recommendations, and separate payment for physician services that do not necessarily require face-to-face interaction with a patient.

Citation: BOT Rep. 14, A-08; Reaffirmed: CMS Rep. 01, A-18

### **PLI-RVU Component of RBRVS Medicare Fee Schedule D-400.988**

Our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of professional liability insurance and its funding; and (3) support federal legislation to provide additional funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion.

Citation: (Res. 707, I-03; Reaffirmed: BOT Rep. 18, A-05; Modified: CCB/CLRPD Rep. 2, A-14



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242  
(A-19)

Introduced by: Texas

Subject: Improving Health Information Technology Products to Properly Care for  
LGBTQ Patients

Referred to: Reference Committee B  
(Charles Rothberg, MD, Chair)

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1 Whereas, Electronic health records (EHRs) and other health information technology (HIT)  
2 products have historically ignored the needs of patients identifying as LGBTQ; and  
3

4 Whereas, The Office of the National Coordinator required EHR vendors, as part of the 2015  
5 certified EHR technology (CEHRT) certification, to provide the functionality to capture sexual  
6 orientation and gender identity data; and  
7

8 Whereas, Such 2015-certified EHRs generally do not change the underlying EHR logic of (1)  
9 clinical decision support related to sex and gender issues and (2) patient demographics, the  
10 EHR may create erroneous alerts/recommendations and inappropriate displays/reports; and  
11

12 Whereas, The 2015 CEHRT requirements do not include other HIT products, such as health  
13 information exchange products or third-party apps; and  
14

15 Whereas, Without appropriate EHRs and HIT functionality, care for patients identifying as  
16 LGBTQ is more likely to be both unequal and burdensome for both patients and physicians; and  
17

18 Whereas, Web services, cloud-based algorithms, and personal health records can reduce the  
19 impact of having to program each EHR with custom logic for providing appropriate care for  
20 patients identifying as LGBTQ; and  
21

22 Whereas, Collection of discrete medical, surgical, and social data that is inclusive of nonbinary  
23 gender will become increasingly important for relevant medical research; therefore be it  
24

25 RESOLVED, That our American Medical Association research the problems related to the  
26 handling of sex and gender within health information technology (HIT) products and how to best  
27 work with vendors so their HIT products treat patients equally and appropriately, regardless of  
28 sexual or gender identity (Directive to Take Action); and be it further  
29

30 RESOLVED, That our AMA investigate the use of personal health records to reduce physician  
31 burden in maintaining accurate patient information instead of having to query each patient  
32 regarding sexual orientation and gender identity at each encounter (Directive to Take Action);  
33 and be it further

- 1 RESOLVED, That our AMA advocate for the incorporation of recommended best practices into
- 2 electronic health records and other HIT products at no additional cost to physicians. (Directive to
- 3 Take Action)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/24/19

## RELEVANT AMA POLICY

### Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

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

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

### Medical Spectrum of Gender D-295.312

Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

Citation: Res. 003, A-17; Modified: Res. 005, I-18

### Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974

Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, to our membership.

Citation: Res. 014, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243  
(A-19)

Introduced by: Texas

Subject: Improving the Quality Payment Program and Preserving Patient Access

Referred to: Reference Committee B  
(Charles Rothberg, MD, Chair)

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1 Whereas, The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires that  
2 the Merit-Based Incentive Payment System (MIPS) under the Quality Payment Program (QPP)  
3 be a budget-neutral program where incentive payments are funded from physician practices that  
4 receive payment penalties, creating winners and losers among physicians and other clinicians in  
5 Medicare; and  
6

7 Whereas, Many of the MIPS clinical quality and cost metrics that physicians are scored on are  
8 not in physician control nor are they often evenly distributed in the population, resulting in  
9 physicians being penalized if they serve disproportionate numbers of disadvantaged or high-risk  
10 patient populations; and  
11

12 Whereas, The MIPS program's one-size-fits-all approach adversely affects small and rural  
13 practices, a concern the Centers for Medicare & Medicaid Services (CMS) has acknowledged in  
14 its past proposed rules stating that "physicians in these practices tend to have patient  
15 populations with a higher proportion of older adults, as well as higher rates of poor health  
16 outcomes, co-morbidities, chronic conditions, and other social risk factors, which can result in  
17 the costs of providing care and services being significantly higher, compared to physicians in  
18 other areas"; and  
19

20 Whereas, CMS further acknowledged concerns that physicians in small and rural practices "may  
21 be disproportionately more susceptible to lower performance scores across all performance  
22 categories and negative MIPS payments adjustments, and as a result, such outcomes may  
23 further strain already limited resources and workforce shortages, and negatively impact access  
24 to care (reduction and/or elimination of available services)"; and  
25

26 Whereas, MACRA requires that CMS, based on individuals' health status and other risk factors,  
27 assess and implement appropriate adjustments, but after three years of program  
28 implementation, while few bonus points are provided to small practices and those who care for  
29 complex patients, the agency has not yet proposed any methodology for properly risk adjusting  
30 MIPS cost and quality measures. This lack of compliance with congressional intent results in  
31 flawed performance measurement methodologies, inadequate and/or unfair scoring policies,  
32 lower performance scores for many physicians, and tarnished physician reputations via data  
33 publicly reported on Medicare's Physician Compare website, and these problems may have the  
34 unintended consequence of physicians deciding not to treat certain patients; and  
35

36 Whereas, On March 21, 2019, CMS published the 2017 QPP Experience Report with an  
37 accompanying appendix that failed to provide a full account of physicians' experience for the  
38 first year of the QPP or to successfully illustrate the successes and challenges experienced by  
39 ALL physicians; and

1 Whereas, Limited state and national data; questionable, misleading, and incomplete data;  
2 selection bias; lack of meaningful clinical data; poor electronic health record participation;  
3 limited-to-no return on investment; no data insights on vendors; and an inaccurate definition of  
4 physician are among the numerous flaws and/or troubling results found in the 2017 QPP  
5 Experience Report; and  
6

7 Whereas, The 2017 QPP Experience Report showed that mean and median final scores for  
8 physicians and other clinicians who submitted data at the individual level, including physicians in  
9 solo practice, were lower than for group practices, and scores for small and rural practices were  
10 significantly lower than for large practices and MIPS APM participants. Most notably, among all  
11 practices, small practices fared the worst, resulting in lower incentive payments or payment  
12 penalties for many physicians in small practices nationwide; and  
13

14 Whereas, The 2017 QPP Experience Report showed that of the 51,505 clinicians who currently  
15 are receiving the 4% payment penalty nationally and funding the MIPS incentive payment for  
16 the rest of the country, 83% (42,678) are clinicians from small practices and 18% (9,289) are  
17 clinicians from rural practices; and  
18

19 Whereas, Budget neutrality in the first year of MACRA implementation has proven to be harmful  
20 to small and rural practices, creating financial incentives for a massive restructuring of  
21 ambulatory care delivery systems, potentially eliminating small and rural physician practices  
22 nationally, and significantly harming access to care; and  
23

24 Whereas, Physicians in small and rural practices likely will continue to be the most adversely  
25 affected by CMS' flawed MIPS policies and MACRA's budget neutrality requirement; and  
26

27 Whereas, While the low-volume threshold policy decreases the number of physicians in small  
28 practices required to participate in MIPS, the policy does not exclude ALL physicians in small  
29 practices who continue to experience financial, technological, and administrative challenges to  
30 program participation; and  
31

32 Whereas, While our American Medical Association advocates for keeping the low-volume  
33 threshold policy and calls for other improvements, it has not explicitly advocated for an  
34 exemption from MIPS for ALL small practices (on a voluntary basis) as per AMA policies MIPS  
35 and MACRA Exemption H-390.838 and Preserving Patient Access to Small Practices Under  
36 MACRA D-390.949; and  
37

38 Whereas, CMS has not published any data to date that show whether the QPP is meeting its  
39 aims as envisioned by MACRA and Congress, such as improving the care and population  
40 health of Medicare beneficiaries, lowering Medicare costs, and minimizing burden on practicing  
41 physicians; and  
42

43 Whereas, As MIPS penalties increase to 9% and as the program becomes more complex with a  
44 higher overall MIPS performance threshold along with flawed performance measurement  
45 methodologies, thousands of physician practices, particularly those in small and rural practices,  
46 likely will continue to receive a payment penalty every year. This threatens practice viability,  
47 continued physician participation in Medicare, and access to care; therefore be it  
48

49 RESOLVED, That our American Medical Association strongly advocate for Congress to make  
50 participation in the Merit-Based Incentive Payment System and alternative payment models  
51 under the Quality Payment Program completely voluntary (Directive to Take Action); and be it  
52 further

1 RESOLVED, That our AMA strongly advocate for Congress to eliminate budget neutrality in the  
 2 Merit-Based Incentive Payment System and to finance incentive payments with supplemental  
 3 funds that do not come from Medicare Part B payment cuts to physicians and other clinicians  
 4 (Directive to Take Action); and be it further  
 5

6 RESOLVED, That our AMA call on the Centers for Medicare & Medicaid Services (CMS) to  
 7 provide a transparent, accurate, and complete Quality Payment Program Experience Report on  
 8 an annual basis so physicians and medical societies can analyze the data to advocate for  
 9 additional exemptions; flexibilities; and reductions in reporting burdens, administrative hassles,  
 10 and costs (Directive to Take Action); and be it further  
 11

12 RESOLVED, That our AMA advocate that CMS increase the low-volume threshold for the 2020  
 13 Quality Payment Program and future years of the program for all physicians and continue to  
 14 offer them the opportunity to opt in or voluntarily report (Directive to Take Action); and be it  
 15 further  
 16

17 RESOLVED, That our AMA reaffirm Policy H-390.838, "MIPS and MACRA Exemption," and  
 18 advocate to preserve patient access by exempting small practices (one to 15 clinicians) from  
 19 required participation in the Merit-Based Incentive Payment System and continue to offer them  
 20 the opportunity to opt in or voluntarily report. (Reaffirm HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/24/19

## RELEVANT AMA POLICY

### **MIPS and MACRA Exemption H-390.838**

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Citation: Res. 208, I-16; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18

### **Preserving Patient Access to Small Practices Under MACRA D-390.949**

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.

2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.

3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Citation: Res. 243, A-16; Reaffirmation: I-17; Reaffirmation: A-18

### **MACRA and the Independent Practice of Medicine H-390.837**

1. Our AMA, in the interest of patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to revise the Merit-Based Incentive Payment System to a simplified quality and payment system with significant input from practicing physicians, that focuses on easing regulatory burden on physicians, allowing physicians to focus on quality patient care.

2. Our AMA will advocate for appropriate scoring adjustments for physicians treating high-risk beneficiaries in the MACRA program.

3. Our AMA will urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to sicker Medicare patients.

Citation: Alt. Res. 206, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

### **Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) D-390.950**

1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

Citation: Res. 242, A-16

### **Reducing MIPS Reporting Burden D-395.999**

Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physicians choosing) within the calendar year.

Citation: Res. 236, A-18

### **Physician Payment Reform H-390.849**

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
  - a) promote improved patient access to high-quality, cost-effective care;
  - b) be designed with input from the physician community;
  - c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
  - d) not require budget neutrality within Medicare Part B;
  - e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
  - f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
  - g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
  - h) use adequate risk adjustment methodologies;
  - i) incorporate incentives large enough to merit additional investments by physicians;
  - j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
  - k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
  - l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
  - m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Citation: CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-

12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

### **Pay-for-Performance Principles and Guidelines H-450.947**

1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

#### **PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS**

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

- 1. Ensure quality of care** - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
- 2. Foster the patient/physician relationship** - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
- 3. Offer voluntary physician participation** - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
- 4. Use accurate data and fair reporting** - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
- 5. Provide fair and equitable program incentives** - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

#### **GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS**

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

##### **Quality of Care**

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
  - Evidence-based quality of care measures must be the primary measures used in any program.
1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
  2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
  3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
  4. Performance measures should be scored against both absolute values and relative improvement in those values.
  5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
  6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
  7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

#### Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
- 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
- 2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

#### Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
- 1. Programs should provide physicians with tools to facilitate participation.
- 2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

#### Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
- 1. Programs should use accurate administrative data and data abstracted from medical records.



2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.

3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.

1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.

2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

#### Program Rewards

- Programs must be based on rewards and not on penalties.

- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.

- Programs must not reward physicians based on ranking compared with other physicians in the program.

- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

- Programs must not financially penalize physicians based on factors outside of the physician's control.

- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

Citation: BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13; Appended: BOT Rep. 1, I-14; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of Res. 216, I-15; Reaffirmation I-15; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmation: A-18

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 244  
(A-19)

Introduced by: Organized Medical Staff Section

Subject: EHR-Integrated Prescription Drug Monitoring Program Rapid Access

Referred to: Reference Committee B  
(Charles Rothberg, MD, Chair)

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1 Whereas, The American Medical Association (AMA) Opioid Task Force recently published its  
2 2019 Progress Report, which found that physicians and other health care professionals are  
3 taking significant actions in the face of the opioid epidemic, including registering for and using  
4 state Prescription Drug Monitoring Programs (PDMPs); and  
5

6 Whereas, PDMPs are highly effective tools that reduce prescription drug abuse and diversion by  
7 identifying potentially inappropriate prescribing, dispensing, and consuming behaviors, referring  
8 them for investigation, and where such behaviors prove to be actually inappropriate, referring  
9 those involved for ameliorative and corrective remedies; and  
10

11 Whereas, The AMA remains vigorous in its efforts to support the refinement of state-based  
12 PDMPs, as well as the development and implementation of appropriate technology to allow for  
13 Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on  
14 prescriptions for controlled substances among states; and  
15

16 Whereas, Despite these ongoing efforts—and in the absence of a federal, standards-based  
17 approach—there remains wide variation across states with respect to who is able to access  
18 PDMP information and how retention of that prescribing data might be limited within an  
19 Electronic Health Record (EHR); and  
20

21 Whereas, This has created complex environments that are misaligned, confusing, costly, and  
22 continue to leave physicians with little to no access or visibility of opioid data in Electronic  
23 Health Records (EHRs); therefore be it  
24

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

Fiscal Note: Modest – between \$1,000 and \$5,000

Received: 06/07/19

## **RELEVANT AMA POLICY**

### **H-95.920 Advocacy for Seamless Interface Between Physicians Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs**

Our AMA: (1) will advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying whether PDMPs can distinguish team-based care from uncoordinated care, misuse, or “doctor shopping,” as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care; (2) urges EHR vendors and Health Information Exchanges (HIEs) to increase transparency of custom connections and costs for physicians to integrate their products in their practices; (3) supports state-based pilot studies of best practices to integrate EHRs, HIEs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring; and (4) supports initiatives to improve the functionality of state PDMPs, including: (a) lessening the time delay between when a prescription is dispensed and when the prescription would be available to physicians through a PDMP; and (b) directing state-based PDMP’s to support improved integrated EHR interfaces.

Citation: BOT Rep. 07, I-18

### **H-95.947 Prescription Drug Monitoring to Prevent Abuse of Controlled Substances**

Our AMA:

- (1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
- (2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
- (3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
- (4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
- (5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
- (6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
- (7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
- (8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
- (9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

Citation: BOT Rep. 3, A-08; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16; Appended: BOT Rep. 13, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245  
(A-19)

Introduced by: Organized Medical Staff Section

Subject: Sensible Appropriate Use Criteria In Medicare

Referred to: Reference Committee B  
(Charles Rothberg, MD, Chair)

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1 Whereas, The Protecting Access to Medicare Act (PAMA) of 2014 (P.L. 113-93) established a  
2 program promoting the use of Appropriate Use Criteria (AUC) for advanced imaging services;  
3 and  
4

5 Whereas, The number of clinicians affected by the program is vast, crossing almost every  
6 medical specialty, including primary care, and for which the Centers for Medicare & Medicaid  
7 Services (CMS) estimates 579,687 ordering professionals will be subject to this program; and  
8

9 Whereas, While clinicians have embraced AUC, the law sets up an unnecessarily rigid system  
10 for consulting AUC, a complex exchange of information between the health care professional  
11 who orders an advanced imaging test and the health care professional who furnishes the test,  
12 and onerous documentation requirements; and  
13

14 Whereas, All health care professionals who order advanced diagnostic imaging tests will be  
15 required to acquire and consult a qualified Clinical Decision Support Mechanism (CDSM) for  
16 every advanced diagnostic test unless an exception applies; and  
17

18 Whereas, Health care professionals who furnish advanced diagnostic imaging tests will be  
19 required to include detailed information received from the ordering professional on the claim  
20 form to receive payment for the test; and  
21

22 Whereas, Clinicians are required only to use CDSMs that are qualified by CMS, which, in many  
23 cases, will force clinicians to abandon long-standing methods of AUC consultation, as well as  
24 the consultation of specialty-specific AUC; and  
25

26 Whereas, Various CMS-approved AUC guidelines are in conflict and not aligned; and  
27

28 Whereas, The AUC Program, designed to curtail inappropriate imaging, is outdated and  
29 unnecessary in the environment of evolving payment and delivery models in which providers are  
30 at financial risk; and  
31

32 Whereas, The AUC Program also diverts provider resources away from quality improvement as  
33 providers are struggling to assign adequate resources for IT infrastructure and Quality Payment  
34 Program participation; and  
35

36 Whereas, The Merit-based Incentive Payment System and Alternative Payment Models already  
37 incentivize appropriate use of health care resources, including advanced diagnostic imaging;  
38 and

1 Whereas, While the regulations surrounding the Medicare AUC Program have been finalized,  
2 the first year of implementation, beginning January 1, 2020, will be an education and operations  
3 testing period during which time claims will not be denied for failure to include proper AUC  
4 consultation information, and denial of claims will not occur before 2021; and

5  
6 Whereas, Given this timeline, the AMA is well-positioned to advocate for regulatory change that  
7 may effectively minimize the barriers to modifying or aligning the AUC Program and the QPP;  
8 therefore be it

9  
10 RESOLVED, That our American Medical Association Policy H-320.940, "Medicare's Appropriate  
11 Use Criteria Program," be amended by addition as follows:

12  
13 Our AMA will continue to advocate to delay the effective date of the Medicare AUC  
14 Program until the Centers for Medicare & Medicaid Services can adequately address  
15 technical and workflow challenges with its implementation and any interaction between  
16 the Quality Payment Program (QPP) and the use of advanced diagnostic imaging  
17 appropriate use criteria, and support regulatory change that resolves technical and  
18 workflow challenges and/or removes barriers to modifying or aligning the AUC Program  
19 and the QPP. (Modify HOD Policy)

Fiscal Note: Modest – between \$1,000 and \$5,000

Received: 06/07/19

## RELEVANT AMA POLICY

### H-320.940 Medicare's Appropriate Use Criteria Program

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 and the use of advanced diagnostic imaging appropriate use criteria.

Citation: Res. 229, A-17

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 246  
(A-19)

Introduced by: Medical Student Section

Subject: Call for Transparency Regarding the Announcement of 17,000 Cuts to  
Military Health Providers

Referred to: Reference Committee B  
(Charles Rothberg, MD, Chair)

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Whereas, The Department of Defense (DoD) is finalizing plans to cut 17,000 medical billets, including doctors, nurses, technicians, dentists, medics, and support personnel as part of a larger reorganization of services under the Defense Health Agency (DHA);<sup>1</sup> and

Whereas, Details regarding the depth, span, and impact of the proposed billet cuts to military medical care teams, to include uniformed physicians, nurse practitioners, physician's assistants, and other medical-branched service members has not been released;<sup>2</sup> and

Whereas, Military physicians who have served in an active combat zone or deployed environment are often highly skilled in providing critical, complex, life-saving care to victims of complex trauma;<sup>3</sup> and

Whereas, The civilian healthcare system benefits from military-trained physicians with experience treating complex injuries under wartime conditions and with limited resources who contribute greatly to the body of knowledge surrounding trauma care;<sup>4</sup> and

Whereas, Medical Readiness is a top priority for successful support of the United States Military's mission and protection of the American people;<sup>5</sup> and

Whereas, Military physicians share a unique positive connection with military patients and are better able to understand the career ramifications, lifestyle, and culture regarding diagnosis and treatment;<sup>6,7</sup> and

Whereas, Military physicians when not deployed remain on active duty in peacetime, maintaining a continual state of military medical readiness in support of the military mission, and treat a population often requiring special considerations;<sup>7-9</sup> and

Whereas, It may take years to acculturate a physician to his or her military environment, and service on active duty within the warfighter context is a critical means of attaining military cultural competency, and scaling down the number of active duty providers will reduce the military health system's ability to serve the unique needs of the American warfighter, their families, and those who have already dedicated twenty or more years to the service of our nation;<sup>10</sup> and

Whereas, "The Department of Defense recognizes that global health and security are linked, and our global health engagement efforts address the intersection of these concerns"<sup>11</sup> and military physicians are essential for implementing and maintaining these vital efforts including "enhancing interoperability by helping partner nations build health capacity, combating global

1 health threats like emerging infectious diseases and antibiotic-resistant bacteria, and supporting  
2 humanitarian assistance and disaster relief initiatives;<sup>11,12</sup> and  
3

4 Whereas, Announced cuts by the Department of Defense to more than 17,000 military  
5 healthcare provider billets could threaten the success and impact of healthcare services for over  
6 9.5 million defense service servicemembers and beneficiaries, global health engagement efforts  
7 which are intimately linked to stability and national security, force health protection, and military  
8 medical surge capacity as discussed above;<sup>1</sup> and  
9

10 Whereas, A decrease in associated military graduate medical education positions will  
11 likely displace available GME positions in civilian programs significantly and further exacerbate  
12 physician shortages “if the military cut the slots it now has to train doctors because there  
13 wouldn’t be new civilian residencies created to compensate;”<sup>13</sup> and  
14

15 Whereas, The Government Accountability Office has warned in a 2018 report that “All of the  
16 [military services] experienced gaps in a number of specialties; several of these were below 80  
17 percent of authorized levels and are in what are considered critically short wartime specialties  
18 [and] until the services develop and implement strategies to alleviate these gaps, they could be  
19 at risk of not being able to provide medical care to service members during wartime;”<sup>14</sup> and  
20

21 Whereas, The quality and availability of Graduate Medical Education (GME) opportunities could  
22 have a profound impact on the quality and quantity of physicians the DoD can recruit, retain,  
23 and train to support the operational mission of the military Services;<sup>15</sup> therefore, be it  
24

25 RESOLVED, That our American Medical Association urge the Department of Defense to  
26 immediately and publicly release the required assessments that the Military Departments, the  
27 Joint Staff, and organizations within the Office of the Secretary of Defense reportedly conducted  
28 as submitted in writing by the US Army Surgeon General in Congressional testimony to Senate  
29 Appropriations Committee regarding the operational medical requirements needed to support  
30 the National Defense Strategy that the Military Departments used in planning to reduce overall  
31 uniformed medical positions, as well as provide immediate clarification regarding the proposed  
32 cuts including the number of medical provider billet cuts and their distribution amongst  
33 specialties and services (Directive to Take Action); and be it further  
34

35 RESOLVED, That if no such Department of Defense assessments exist, are immediately  
36 released, or appear inadequate to the AMA to justify the proposed cuts to military billets, that  
37 our AMA urgently lobby the US Congress to implement legislation mandating a study in the next  
38 National Defense Authorization Act to assess the impact of potential cuts on cost and  
39 healthcare quality outcomes for military service members, dependents, and retirees before  
40 drastic cuts are executed (Directive to Take Action); and be it further  
41

42 RESOLVED, That our AMA strongly oppose any reductions to military GME residency or  
43 fellowship positions without dedicated congressional funding for parity civilian residency  
44 positions in addition to any other planned increases to civilian GME to avoid further  
45 exacerbating the United States’ physician shortage. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 06/08/19



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## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 323  
(A-19)

Introduced by: Texas

Subject: Improving Access to Care in Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model

Referred to: Reference Committee C  
(Nicole Riddle, MD, Chair)

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1 Whereas, There is a national shortage of physicians, and the Association of American Medical  
2 Colleges projects the shortage will only get worse, increasing to a deficit of 24,800 to 65,800  
3 physicians in specialty care by 2032; and  
4

5 Whereas, Project ECHO (Extension for Community Healthcare Outcomes) was established at  
6 the University of New Mexico Health Sciences Center in Albuquerque in 2003 to respond to a  
7 growing health crisis resulting from the lack of specialty physician services for patients with  
8 hepatitis C and a void of primary care physicians who felt qualified to treat this disease  
9 adequately; and  
10

11 Whereas, Project ECHO offers a unique response to specialty physician shortages by  
12 expanding the competencies and skills of physicians already engaged in patient care rather  
13 than assuming the only solution is to increase the physician workforce; and  
14

15 Whereas, This model provides a mentorship program that uses telecommunications to connect  
16 expert interdisciplinary specialist teams at academic health centers with primary care physicians  
17 in community practices; and  
18

19 Whereas, Project ECHO is not traditional telemedicine whereby the specialist assumes  
20 responsibility for the care of the patient. Conversely, community-based physicians participating  
21 in this program maintain responsibility for the management of their patients; and  
22

23 Whereas, The single program in Albuquerque has grown to include more than 170 U.S. partners  
24 and more than 100 partners in 34 countries, with mentorship programs in more than 100 high-  
25 need specialty services, including HIV-AIDS, tuberculosis, opioid use disorder, pain  
26 management, behavioral health, palliative care, and cervical cancer; and  
27

28 Whereas, A prospective patient cohort study on Project ECHO published in the *New England*  
29 *Journal of Medicine* in June 2011 showed that treatment for hepatitis C patients in New Mexico  
30 by ECHO-trained primary care physicians was as safe and effective as treatment provided by  
31 specialists at an academic medical center; and  
32

33 Whereas, Project ECHO not only addresses patient care disparities but also provides benefits to  
34 physicians through opportunities for continuing medical education credits and improved  
35 professional satisfaction and reduced isolation for those in rural areas; and

Whereas, There is a widespread shortage of child and adolescent psychiatrists in the United States, with only 9,000 to serve more than 91 million children and adolescents for a ratio of more than 10,000 children per child and adolescent psychiatrist; and

Whereas, Most mental illnesses begin in childhood, and early diagnosis and treatment can improve an individual's behavioral health, quality of life, and longevity; and

Whereas, Primary care pediatricians have a critically important role in identifying and treating children's mental and behavioral health care needs but often do not feel adequately prepared to do so; and

Whereas, The Massachusetts Child Psychiatry Access Project (CPAP) established in 2004 has strong similarities to Project ECHO's goals and methods for mitigating gaps in specialty care. Child and adolescent psychiatrists in this program provide training and mentoring of primary care pediatricians through regional consultation teams to assist with medication, treatment, and referral needs for children with behavioral health issues. The most high-risk and complex cases are referred to specialists; and

Whereas, CPAP is available to 95% of the children and adolescents in Massachusetts, and 80% of the well child visits with primary care pediatricians in the program result in a behavioral health screen; therefore be it

RESOLVED, That our American Medical Association 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 (Directive to Take Action); and be it further

RESOLVED, That our AMA work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States (Directive to Take Action); and be it further

RESOLVED, 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. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/24/19

## RELEVANT AMA POLICY

### US Physician Shortage H-200.954

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and

longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;

(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;

(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;

(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;

(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;

(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and

(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.

Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16

### **Educational Strategies for Meeting Rural Health Physician Shortage H-465.988**

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:

A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

Citation: CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18

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## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 324  
(A-19)

Introduced by: Resident and Fellow Section

Subject: Residency and Fellowship Program Director, Assistant/Associate  
Program Director, and Core Faculty Protected Time and Salary  
Reimbursement

Referred to: Reference Committee C  
(Nicole Riddle, MD, Chair)

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1 Whereas, The time constraints placed on faculty involved with resident and fellow education  
2 vary widely between and among specialties, in some cases exceeding an average of 6-8 hours  
3 per week per faculty member<sup>1</sup>; and  
4

5 Whereas, The May 8, 2018 ACGME Glossary of Terms define “core faculty” as “all physician  
6 faculty members in a specialty program who have a significant role in the education of  
7 resident/fellows and who have documented qualifications to instruct and supervise. Core faculty  
8 members devote at least 15 hours per week to resident education and administration. All core  
9 faculty members should evaluate the competency domains, work closely with and support the  
10 program director, assist in developing and implementing evaluation systems, and teach and  
11 advise residents<sup>2</sup>; and  
12

13 Whereas, The most recent ACGME program requirements for emergency medicine issued July  
14 1, 2017 require that core faculty have “salary support or protected time<sup>3</sup>,” and  
15

16 Whereas, The new ACGME Common Program Requirements only include protected time for  
17 program directors, not assistant/associate program directors or core faculty<sup>4</sup>; and  
18

19 Whereas, The Emergency Medicine community requested that the new Common Program  
20 Requirements be amended to allow specialty-specific review committees within the ACGME to  
21 include requirements for protected time for core faculty as they have done in the past; and  
22

23 Whereas, The ACGME Board of Directors met and decided to deny this request; and  
24

25 Whereas, Physician burnout has been steadily increasing in recent years, and many are  
26 attributing that burnout, in part, to increased demands on limited time, which could be mitigated  
27 by protecting time specifically for resident and fellow education; and  
28

29 Whereas, AMA Policy H-305.942 already states that our AMA supports “each medical school  
30 and residency program [identifying] the specific resources needed to support the clinical  
31 education of trainees,” and supports the inclusion of faculty in “resource planning for clinical  
32 education;” and  
33

34 Whereas, Our AMA already supports reimbursement for faculty involved in medical student and  
35 resident clinical education (H-305.929) but has no current provision for protecting faculty time  
36 for resident education; therefore be it

- 1 RESOLVED, That our American Medical Association work with the Accreditation Council for
- 2 Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME
- 3 Common Program Requirements to allow flexibility in the specialty-specific ACGME program
- 4 requirements enabling specialties to require salary reimbursement or “protected time” for
- 5 resident and fellow education by “core faculty,” program directors, and assistant/associate
- 6 program directors. (Directive to Action)

Fiscal Note: Minimal – less than \$1,000

Received: 06/08/19

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### Relevant AMA Policy:

#### Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.
6. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs: (CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 4, A-16; Modified: CME Rep. 6, I-18)

#### Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education:

(CME Rep. B, A-82; Amended: CLRPD Rep. A, I-92; Res. 331, I-95; Reaffirmed by Res. 322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep. 2, I-05; Appended: CME Rep. 5, A-11; Reaffirmed: CME Rep. 3, A-11; Modified: CME Rep. 01, I-17; Appended: Res. 961, I-18)

**Principles for Graduate Medical Education H-310.929**

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present: (CME Rep. 9 A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18.)

**The Ecology of Medical Education: The Infrastructure for Clinical Education H-305.942**

The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians. (CME Rep. 13, A-97; Modified: CME Rep. 2, I-05; Reaffirmed: CME Rep. 1, A-15.)

**Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929**

(CME Rep. 7, A-05; Reaffirmation I-6; Sub. Resolution 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep 15, A-10; Reaffirmation, A-11; Reaffirmation. A-13; Appended: CME 05, A-13; Appended: CME 05, A-16; Appended CME 05, A16; Appended: Res. 319; Reaffirmation, A-16)



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 531  
(A-19)

Introduced by: Medical Student Section

Subject: Support for Children of Incarcerated Parents

Referred to: Reference Committee E  
(Leslie H. Secrest, MD, Chair)

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1 Whereas, The United States has the highest rate of incarceration in the world with 2,162,400  
2 incarcerated persons as of year-end 2016<sup>1-2</sup>; and  
3

4 Whereas, The imprisoned population demographics are disproportionate with the U.S.  
5 population, comprised of 30.1% White non-Hispanic, 33.3% Black, and 23.3% Hispanic  
6 compared to the U.S. population at 60.7% White non-Hispanic, 13.4% Black/African American,  
7 and 18.1% Hispanic<sup>3-4</sup>; and  
8

9 Whereas, An estimated 2.7 million children in the United States have at least one parent  
10 incarcerated at any given time and approximately 10 million children have experienced parental  
11 incarceration at some point in their lives<sup>5</sup>; and  
12

13 Whereas, Worse health outcomes as a result of parental incarceration disproportionately impact  
14 minorities, where 1 in 9 children with incarcerated parents are African American, 1 in 18 are  
15 Hispanic, and 1 in 57 are White<sup>5</sup>; and  
16

17 Whereas, Parental incarceration has been found to be a strong risk factor for long-lasting  
18 psychopathology in children, including antisocial behaviors, high risk behaviors, substance use  
19 and abuse, and health problems including depression, post-traumatic stress disorder, anxiety,  
20 hyperlipidemia, obesity, asthma, migraines, HIV/AIDS, and overall fair/poor health<sup>6-9</sup>; and  
21

22 Whereas, The number of adverse childhood event (ACE) exposures has been shown to be  
23 directly correlated to increased likelihoods of specific negative health outcomes such as  
24 coronary disease, diabetes, asthma, disability, and mental distress<sup>10</sup>; and  
25

26 Whereas, Children with incarcerated parents experience up to five times as many additional  
27 ACEs as their counterparts without incarcerated parents, such as financial hardship and  
28 exposure to drug and alcohol abuse<sup>11-12</sup>; and  
29

30 Whereas, Early childhood interventions, such as high quality education programs which support  
31 parent-child relationships, improve health outcomes and health behaviors, particularly in at-risk  
32 youth<sup>13</sup>; and  
33

34 Whereas, Providing children with coping strategies and additional emotional resources, such as  
35 mentors, trained teachers, skilled counselors, and strong foster families can help children feel  
36 comforted and secure throughout a parent's incarceration<sup>14</sup>; and  
37

38 Whereas, Established intervention programs aimed at improving the interactions between  
39 children and their incarcerated parents include interventions such as having parents record

1 themselves reading their child a book and providing incarcerated parents, their children, and the  
2 child's interim caregiver with in-person visits, individual counseling and family skill sessions; and  
3

4 Whereas, Established intervention programs have shown to increase student performance and  
5 interest in school, improve familial functioning, and improve parental mental health<sup>15-16</sup>; and  
6

7 Whereas, Even increased telephone and written letter contact between children and their  
8 incarcerated parents resulted in fewer child behavioral problems and improved mental  
9 health<sup>17-18</sup>; and  
10

11 Whereas, Established intervention programs identify arranging visits, the privacy of the parent-  
12 child interactions, the need for more interaction with case workers, and the lack of sufficient  
13 training for program providers as barriers to providing better services<sup>19</sup>; and  
14

15 Whereas, The AMA policy H-430.990 has previously supported further research on and  
16 implementation of programs to promote maternal/child bonding among incarcerated mothers<sup>20</sup>;  
17 and  
18

19 Whereas, The 115th Congress introduced a House of Representatives resolution (H.Res.623)  
20 that recognizes the importance of providing services to children of incarcerated parents<sup>21</sup>; and  
21

22 Whereas, The House of Representatives passed H.Res.5682 passed which requires that  
23 federal prisoners to be placed within 500 miles of their families in an attempt to improve  
24 parental-child contact with the aim of reducing recidivism<sup>22</sup>; therefore be it  
25

26 RESOLVED, That our American Medical Association support legislation and initiatives that  
27 provide resources and support for children of incarcerated parents. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/09/19

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## RELEVANT AMA POLICY

### Family Violence-Adolescents as Victims and Perpetrators H-515.981

The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

Citation: (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

### Bonding Programs for Women Prisoners and their Newborn Children H-430.990

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.

Citation: CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

### Long-Term Care Residents With Criminal Backgrounds H-280.948

1. Our AMA encourages the long-term care provider and correctional care communities, including the American Medical Directors Association, the Society of Correctional Physicians, the National Commission on Correctional

Health Care, the American Psychiatric Association, long-term care advocacy groups and offender advocacy groups, to work together to develop national best practices on how best to provide care to, and develop appropriate care plans for, individuals with violent criminal backgrounds or violent tendencies in long-term care facilities while ensuring the safety of all residents of the facilities.

2. Our AMA encourages more research on how to best care for residents of long-term care facilities with criminal backgrounds, which should include how to vary approaches to care planning and risk management based on age of offense, length of incarceration, violent tendencies, and medical and psychiatric history.

3. Our AMA encourages research to identify and appropriately address possible liabilities for medical directors, attending physicians, and other providers in long-term care facilities caring for residents with criminal backgrounds.

4. Our AMA will urge the Society of Correctional Physicians and the National Commission on Correctional Health Care to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history.

Citation: (CMS Rep. 8, I-13)

#### **Disease Prevention and Health Promotion in Correctional Institutions H-430.989**

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

Citation: (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

#### **Improving Pediatric Mental Health Screening H-345.977**

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Citation: Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

#### **Drug Abuse in the United States - Strategies for Prevention H-95.978**

Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.

(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of drug and alcohol abuse prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.

(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of drug and alcohol abuse.

(4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.

(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.

(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of alcohol and drug abuse.

Citation: (BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 532  
(A-19)

Introduced by: Young Physicians Section

Subject: Dispelling Myths of Bystander Opioid Overdose

Referred to: Reference Committee E  
(Leslie H. Secrest, MD , Chair)

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Whereas, 70,237 people died of drug overdoses in the United States in 2017, and deaths related to synthetic opioids, such as fentanyl, have increased considerably in the last several years, accounting for 28,400 lives lost in 2017;<sup>1</sup> and

Whereas, Higher doses of the opioid-reversal agent naloxone may be needed to reverse the effects of potent synthetic opioids such as fentanyl and carfentanil, which often enter the illicit drug supply as contaminants of other drugs like heroin and cocaine;<sup>2</sup> and

Whereas, First-responders, such as police and firefighters, are often not aware of the potential harm posed by exposure to white powdered substances that may consist of heroin, cocaine, fentanyl, or other illicit drugs; and

Whereas, Self-administration of naloxone is contraindicated in individuals who are breathing independently and have not consumed opioids, which results in waste of a limited and costly resource that is essential to any public health response to the opioid epidemic; and

Whereas, Stigma of opioid abuse and overdose has already made first-responders reluctant to intervene in a timely manner when someone is suspected of overdosing, and further delays in administration of naloxone in the setting of opioid overdose can have fatal consequences; and

Whereas, There have been multiple media reports of police officers and firefighters falling ill, reportedly due to brief dermal exposure to an unknown white substance, which often leads to symptoms of panic and self-administration of intranasal naloxone, has misrepresented the science behind fentanyl while increasing paranoia among the lay public related to fentanyl;<sup>3 4 5</sup> and

Whereas, Fentanyl is so poorly absorbed through the skin that it required years of research to develop a fentanyl patch for topical delivery of the drug at extremely slow rates of absorption;<sup>6</sup> and

Whereas, Photos and videos purporting to show “the amount of fentanyl required to kill hundreds or thousands of people” are misleading and exaggerate the risk of bystander overdose and instead create fear among first-responders;<sup>7</sup> and

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<sup>1</sup> <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

<sup>2</sup> Moss RB, Carlo DJ. Higher doses of naloxone are needed in the synthetic opioid era. Subst Abuse Treat Prev Policy. 2019 Feb 18;14(1):6.

<sup>3</sup> <https://www.statnews.com/2017/08/09/fentanyl-falling-ill/>

<sup>4</sup> [https://tonic.vice.com/en\\_us/article/8xk4jk/touching-fentanyl-absorbed-through-skin](https://tonic.vice.com/en_us/article/8xk4jk/touching-fentanyl-absorbed-through-skin)

<sup>5</sup> <https://www.usatoday.com/story/news/nation/2019/04/29/fentanyl-overdose-police-accident-touching-drug/3615448002/>

<sup>6</sup> [https://www.acmt.net/\\_Library/Positions/Fentanyl\\_PPE\\_Emergency\\_Responders\\_.pdf](https://www.acmt.net/_Library/Positions/Fentanyl_PPE_Emergency_Responders_.pdf)

<sup>7</sup> How did enough fentanyl to kill “every man, woman and child in Cleveland” make it to the U.S.? 60 Minutes reports. <https://www.cbsnews.com/news/deadly-fentanyl-bought-online-from-china-being-shipped-through-the-mail-60-minutes-2019-04-28/>

1 Whereas, Companies have profited by marketing “fentanyl-resistant” gloves and respirators,  
2 despite a lack of evidence that fentanyl aerosolizes or poses an inhalation hazard in well-  
3 ventilated spaces;<sup>8</sup> and  
4

5 Whereas, A recent JAMA Viewpoint titled “Protecting the Value of Medical Science in the Age of  
6 Social Media and ‘Fake News’” identifies an important role for physicians in correcting  
7 misconceptions that can have dangerous public health implications;<sup>9</sup> and  
8

9 Whereas, A recent New York Times editorial, titled “Fear, Loathing, and Fentanyl Exposure,”  
10 notes that “misinformation has triggered a panic about the risks [of fentanyl exposure];”<sup>10</sup> and  
11

12 Whereas, The American College of Medical Toxicology and the American Academy of Clinical  
13 Toxicology issued a position paper on the topic in 2017, concluding that inhalation and dermal  
14 exposure risk for fentanyl and other synthetic analogues is extremely low in the absence of  
15 mucous membrane exposure;<sup>11</sup> and  
16

17 Whereas, Our AMA policy “encourages the education of health care workers and opioid users  
18 about the use of naloxone in preventing opioid overdose fatalities,” but does not address non-  
19 medical first-responders or the dangers of misinformation and stigma in impeding timely  
20 emergency response when opioid overdose is suspected; therefore be it  
21

22 RESOLVED, That our American Medical Association work with appropriate stakeholders to  
23 develop and disseminate educational materials aimed at dispelling the fear of bystander  
24 overdose via inhalation or dermal contact with fentanyl or other synthetic derivatives (Directive  
25 to Take Action); and be it further  
26

27 RESOLVED, That our AMA work with appropriate stakeholders to identify those professions,  
28 such as first responders, most impacted by opioid overdose deaths in order to provide targeted  
29 education to dispel the myth of bystander overdose via inhalation or dermal contact with  
30 fentanyl or other synthetic derivatives. (Directive to Take Action)

Fiscal Note: Modest: between \$1,000 - \$5,000.

Received: 06/08/19

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<sup>8</sup> [https://twitter.com/Devin\\_Reaves/status/1120821782926245888](https://twitter.com/Devin_Reaves/status/1120821782926245888)

<sup>9</sup> Merchant RM, Asch DA. Protecting the Value of Medical Science in the Age of Social Media and “Fake News”. JAMA. 2018 Nov 19. doi: 10.1001/jama.2018.18416. [Epub ahead of print]

<sup>10</sup> Fear, Loathing and Fentanyl Exposure. The New York Times Editorial Board. <https://www.nytimes.com/2019/04/04/opinion/fentanyl-opioids-exposure.html>

<sup>11</sup> [https://www.acmt.net/\\_Library/Positions/Fentanyl\\_PPE\\_Emergency\\_Responders\\_.pdf](https://www.acmt.net/_Library/Positions/Fentanyl_PPE_Emergency_Responders_.pdf)

## **RELEVANT AMA POLICY**

### **Prevention of Opioid Overdose D-95.987**

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death.

Citation: Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12;  
Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 618  
(A-19)

Introduced by: Integrated Physician Practice Section

Subject: Stakeholder Input to Reports of the House of Delegates

Referred to: Reference Committee F  
(Greg Tarasidis, MD, Chair)

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1 Whereas, House of Delegates (HOD) reports generated by the AMA Councils and Board of  
2 Trustees, produce important AMA policies which have potentially far-reaching impact in terms of  
3 AMA initiatives and advocacy efforts; and  
4

5 Whereas, The majority of AMA Council and Board reports originate from HOD resolutions that  
6 are “referred” for report or decision; and  
7

8 Whereas, Once an HOD resolution is referred, the Board of Trustees assigns the referred  
9 resolution to one of the seven AMA Councils (Council on the Constitution & Bylaws; Council on  
10 Ethical & Judicial Affairs; Council on Legislation; Council on Long Range Planning &  
11 Development; Council on Medical Education; Council on Medical Service; and Council on  
12 Science & Public Health) or to the AMA Board of Trustees; and  
13

14 Whereas, The assigned entity (council or Board) works with AMA staff to thoroughly research  
15 and prepare a comprehensive report for release to the HOD at a specified time, at which time  
16 the report will be debated and either adopted, adopted as amended, not adopted, or referred;  
17 and  
18

19 Whereas, AMA policy G-615.030 states in part that “[AMA] Councils should actively seek  
20 stakeholder input into all items of business. . . .and that councils make draft reports available  
21 online for comment when time and circumstances permit”; and  
22

23 Whereas, The AMA sections and representative societies in the HOD may be able to provide  
24 important perspectives and expertise; and  
25

26 Whereas, Some AMA councils proactively seek input from key stakeholders, others offer  
27 transparency and a role for engagement at stakeholders’ request, and others prefer a more  
28 closed process and categorically do not share any draft reports; and  
29

30 Whereas, There is no clear path for sections or other stakeholders represented in the HOD to  
31 know what council or Board reports are under development or to offer input until the reports are  
32 final and presented in the online forum, HOD handbook, reference committee or House floor at  
33 which time meaningful input is difficult to consider, possibly resulting in referral and delay in  
34 taking timely action on defining policy; therefore be it



- 1 RESOLVED, That our American Medical Association study and propose a process for
- 2 interested stakeholders represented in the House of Delegates to view an online list of AMA
- 3 Council and Board reports under development and a mechanism for stakeholder input on draft
- 4 reports, and report back at the 2019 Interim Meeting. (Directive to Take Action)

Fiscal Note: Minimal – less than \$1,000

Received: 06/07/19

## **RELEVANT AMA POLICY**

### **Council Activities G-615.030**

AMA policy on the activities of its Councils includes the following:

- (1) The Councils should actively seek stakeholder input into all items of business;
  - (2) Individual AMA Councils are allowed to prioritize tasks assigned to their respective work subject areas taking into consideration established AMA strategic priorities and the external regulatory, business, and legislative environment affecting our AMA membership and the health care system in which we provide care to our patients; and
  - (3) Online tools and the AMA web site will be used to provide ways for members of the HOD, other AMA parties (eg, councils, sections, etc.), AMA members, and other invited parties, to provide comments on the activities and work of the AMA councils on a timely basis, and that councils make draft reports available online for comment when time and circumstances permit.
- BOT Rep. 15, A-00 Consolidated: CLRPD Rep. 3, I-01 Rep. of the Speakers Special Advisory Committee on the House of Delegates, A-09 Modified: CCB/CLRPD Rep. 3, A-12

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 713  
(A-19)

Introduced by: American College of Rheumatology, American Academy of  
Ophthalmology, American Association of Clinical Endocrinologists,  
American Society of Clinical Oncology

Subject: Selective Application of Prior Authorization

Referred to: Reference Committee G  
(Rodney Trytko, MD, Chair)

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Whereas, Utilization management programs such as prior authorization can create significant barriers for patients by delaying the start or continuation of necessary treatment and negatively affecting patient health outcomes; and

Whereas, According to a 2018 AMA survey, 91% of physicians reported that prior authorization caused delays in their patients' care, and 75% reported that prior authorizations led to treatment abandonment; and

Whereas, The vast majority of requests are eventually approved, nearly 100% of some treatments or services, yet prior authorization can delay treatment for weeks or months; and

Whereas, Prior authorization burdens physicians who spend time away from patient care, or need to hire staff dedicated to seeking approval from insurers for medications they determined their patients need; and

Whereas, Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine can be helpful in reducing the administrative burden on health care providers; and

Whereas, Our AMA co-developed and joined a consensus statement that included representatives of physicians, pharmacists, medical groups, hospitals, and health plans, in which selective application of prior authorization was a key recommendation for improving the prior authorization process; therefore be it

RESOLVED, That our American Medical Association 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 (e.g. 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. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 05/25/19

## **RELEVANT AMA POLICY**

### **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.

Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18

### **Payer Accountability H-320.982**

- Our AMA: (1) Urges that state medical associations and national medical specialty societies to utilize the joint Guidelines for Conduct of Prior Authorization Programs and Guidelines for Claims Submission, Review and Appeals Procedures in their discussions with payers at both the national and local levels to resolve physician/payer problems on a voluntary basis. (2) Reaffirms the following principles for evaluation of preadmission review programs, as adopted by the House of Delegates at the 1986 Annual Meeting: (a) Blanket preadmission review of all or the majority of hospital admissions does not improve the quality of care and should not be mandated by government, other payers, or hospitals. (b) Policies for review should be established by state or local physician review committees, and the actual review should be performed by physicians or under the close supervision of physicians. (c) Adverse decisions concerning hospital admissions should be finalized only by physician reviewers and only after the reviewing physician has discussed the case with the attending physician. (d) All preadmission review programs should provide for immediate hospitalization, without prior authorization, of any patient whose treating physician determines the admission to be of an emergency nature. (e) No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review or solely on the fact that hospitalization occurred in the face of a denial for such admission. (3) Affirms as policy and advocates to all public and private payers the right of claimants to review by a physician of the same general specialty as the attending physician of any claim or request for prior authorization denied on the basis of medical necessity.

Citation: CMS Rep. O, A-89; Reaffirmation A-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation A-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, I-14; Reaffirmation: I-17

### **Web-Based Prior Authorization Process H-285.912**

Our AMA supports legislation requiring all health insurers to include web-based prior authorization services among options for granting prior authorization.

Citation: (Res. 725, A-09)

### **Remuneration for Physician Services H-385.951**

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: (Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14)

### **Prior Authorization Relief in Medicare Advantage Plans H-320.938**

Our AMA supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- a. List services and prescription medications that require a PA on a website and ensure that patient informational materials include full disclosure of any PA requirements.
- b. Notify providers of any changes to PA requirements at least 45 days prior to change.
- c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.
- d. Standardize a PA request form.
- e. Minimize PA requirements as much as possible within each plan and eliminate the application of PA to services and

prescription medications that are routinely approved.

f. Pay for services and prescription medications for which PA has been approved unless fraudulently obtained.

g. Allow continuation of medications already being administered or prescribed when a patient changes health plans, and only change such medications with the approval of the ordering physician.

h. Make an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.

i. Define a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans.

Citation: Res. 814, I-18

#### **Approaches to Increase Payer Accountability H-320.968**

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18

#### **Restoring High Quality Care to the Medicare Part D Prescription Drug Program D-330.933**

Our AMA will:

a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;

b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;

c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;

d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and prescription coverage denial.

Citation: (Res. 106, A-07; Reaffirmation A-08; Reaffirmation A-14

**Preauthorization D-320.988**

1. Our AMA will conduct a study to quantify the amount of time physicians and their staff spend on nonclinical administrative tasks, to include (a) authorizations and preauthorizations and (b) denial of authorization appeals.
2. There will be a report back to the House of Delegates at the 2015 Annual Meeting
3. Our AMA will utilize its advocacy resources to combat insurance company policies that interfere with appropriate laboratory testing by requiring advance notification or prior authorization of outpatient laboratory services.

Citation: Sub. Res. 215, I-14; Reaffirmed: CMS Rep. 07, A-16

**Opposition to Prescription Prior Approval D-125.992**

Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians.

Citation: (Sub. Res. 529, A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 822, I-11

**Private Health Insurance Formulary Transparency H-125.979**

1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.

Citation: Sub. Res. 724, A-14; Appended: Res. 701, A-16; Appended: Alt. Res. 806, I-17; Reaffirmed: CMS Rep. 07, A-18

**Preauthorization for Payment of Services H-320.961**

Our AMA supports legislation and/or regulations that would prevent the retrospective denial of payment for any claim for services for which a physician had previously obtained authorization, unless fraud was committed or incorrect information provided at the time such prior approval was obtained.

Citation: Res. 701, I-92; Reaffirmed by Res. 723, A-95; Modified by Sub. Res. 704, I-96; Reaffirmed: CMS Rep. 5, I-00; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 08, A-17

**Administrative Simplification in the Physician Practice D-190.974**

1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will expand its Heal the Claims process(TM) campaign as necessary to ensure that physicians are aware of the value of automating their claims cycle.

Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmation A-14; Reaffirmation: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmation: I-17

**Prescription Drug Plans and Patient Access D-330.910**

Our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare and Medicaid Services and other appropriate organizations to resolve them.

Citation: Res. 135, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714  
(A-19)

Introduced by: American College of Rheumatology, American Academy of  
Ophthalmology, American Association of Clinical Endocrinologists,  
American Society of Clinical Oncology

Subject: Medicare Advantage Step Therapy

Referred to: Reference Committee G  
(Rodney Trytko, MD, Chair)

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Whereas, The rescinded September 17, 2012 HPMS memo *Prohibition on Imposing Mandatory Step Therapy for Access to Part B Drugs and Services and the Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses* proposed rule by the Centers for Medicare & Medicaid Services threatens to reduce access to innovative and complex drugs including biologics and chemotherapy, which have been a lifeline for Medicare patients with chronic and life-threatening conditions including cancer, rheumatoid arthritis, Crohn's disease, ulcerative colitis, macular degeneration, multiple sclerosis, osteoporosis, primary immunodeficiency diseases, and others; and

Whereas, New guidance allows MA plans to use step therapy for Part B drugs, beginning January 1, 2019; and

Whereas, The CMS-proposed patient safeguards would not go into effect until 2020, leaving vulnerable patients unprotected from harmful step therapy practices; and

Whereas, The timing of the regulatory guidances and proposed rules creates a year gap of protections for patients in 2019; and

Whereas, Step therapy frequently disrupts continuity of care by requiring patients to stop an effective therapy and switch to another due to formulary or protocol changes; and

Whereas, Stopping and restarting certain medicines may cause the treatments to fail due to immunogenicity or cause dangerous reactions when the medication is re-initiated; and

Whereas, More details on exceptions to Step Therapy protocols are needed; and

Whereas, The recent Part D-MA final rule does not include additional safeguards for patients in the 2019 plan year; therefore be it

1 RESOLVED, That our American Medical Association work with the Centers for Medicare and  
 2 Medicaid Services (CMS) to immediately publish guidance to plans that lays out, at minimum,  
 3 the patient safeguards proposed/finalized in the *Modernizing Part D and Medicare Advantage to*  
 4 *Lower Drug Prices and Reduce Out-of-Pocket Expenses proposed rule* so that beneficiaries  
 5 have some protections in 2019, as well as additional clarifying language on exceptions not  
 6 limited to the following principles:

1. That the provider determines if a patient “fails” a treatment, not another entity such as the insurance company.
2. Exception if the treatment is contraindicated.
3. Exception if the provider determines the treatment is likely to be ineffective.
4. Exception if the provider determines the treatment is likely to cause a harmful reaction.
5. Exception for those whose life could be in jeopardy or physical or sensory function irreparably harmed.
6. Exception if the provider and patient believe the treatment is likely to impede the patient's ability to perform daily activities or responsibilities and/or adhere to the treatment plan.
7. Clarification that a patient with a second eye event should be considered an established patient and therefore should not be subject to step therapy policies for the second eye event.
8. Preclude any unwritten, implicit step therapy that is handled through a different utilization management process such as prior authorization.
9. Provide adequate safeguards to maintain coverage for patients currently stable on a medication, even if the last dose was over 6 months prior (Directive to Take Action); and be it further

RESOLVED, That if 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. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/25/19

## RELEVANT AMA POLICY

### Medicare Advantage Step Therapy D-320.984

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

Citation: Res. 810, I-18

### Clinical Practice Guidelines and Clinical Quality Improvement Activities H-320.949

Our AMA adopts the following principles for the development and application of utilization management guidelines:

- (1) The criteria or guidelines used for utilization management shall be based upon sound clinical evidence and consider, among other factors, the safety and effectiveness of diagnosis or treatment, and must be age appropriate.
- (2) These utilization management guidelines and the criteria for their application shall be developed with the participation of practicing physicians.
- (3) Appropriate data, clinical evidence, and review criteria shall be available on request.
- (4) When used by health plans or health care organizations, such criteria must allow variation and take

into account individual patient differences and the resources available in the particular health care system or setting to provide recommended care. The guidelines should also include a statement of their limitations and restrictions.

(5) Patients and physicians shall be able to appeal decisions based on the application of utilization management guidelines.

(6) The competence of non-physician reviewers and the availability of same-specialty peer review must be delineated and assured.

(7) Maintaining the best interests of the patient uppermost, the final decision to discharge a patient, or any other patient management decision, remains the prerogative of the physician.

Citation: BOT Rep. 6, A-99; Reaffirmed: Res. 820, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: Res. 708, A-16; Reaffirmed: CMS Rep. 08, A-17

#### **Emerging Trends in Utilization Management H-320.958**

The AMA will: (1) maintain a leadership role in coordinating private sector efforts to develop and refine utilization management and quality assessment programs; (2) establish an active role in the development of any national utilization management and quality assessment programs that are proposed in the ongoing health system reform debate; and (3) advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession.

Citation: CMS Rep. 9, I-93; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmation: A-17; Reaffirmation: I-17

#### **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.

Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715  
(A-19)

Introduced by: Texas

Subject: Managing Patient-Physician Relations Within Medicare Advantage Plans

Referred to: Reference Committee G  
(Rodney Trytko, MD, Chair)

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1 Whereas, Most Medicare Advantage (MA) plans require the patient to be assigned to a primary  
2 care physician's (PCP's) patient panel; and  
3

4 Whereas, Patients who do not select a PCP will be assigned to a PCP's patient panel by the MA  
5 plan; and  
6

7 Whereas, PCPs are responsible for their assigned patients completing visits to record  
8 Healthcare Effectiveness Data and Information Set (HEDIS) measures; and  
9

10 Whereas, PCPs may be given bonuses/incentives or be penalized based on their HEDIS star  
11 rating score; and  
12

13 Whereas, Assigned patients may be difficult for the PCP to locate or be noncompliant with their  
14 appointments; therefore be it  
15

16 RESOLVED, That our American Medical Association advocate that Medicare Advantage plans  
17 allow a primary care physician to remove patients from his or her patient panel if the physician  
18 has proven he or she has been unable to establish a patient-physician relationship, despite  
19 multiple documented attempts (Directive to Take Action); and be it further  
20

21 RESOLVED, That our AMA advocate that physicians' Healthcare Effectiveness Data and  
22 Information Set and other quality scores and ratings not be affected by patients with whom the  
23 physician has been unable to establish a patient-physician relationship. (Directive to Take  
24 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/24/19

## RELEVANT AMA POLICY

### **Retroactive Assignment of Patients by Managed Care Entities H-285.947**

Our AMA opposes the practice of "retroactive or late assignment" of patients by managed care entities, noting that "retroactive or late assignment" includes: (a) the practice of failing to require enrollees in a capitated plan to select a responsible physician(s) at the time of enrollment; (b) the practice of failing to inform the responsible physician(s) of the enrollment of the patient and the assignment of responsibility until the patient has sought care; and (c) the practice of failing to pay the responsible physician the capitated rate until after the patient has sought care.

Citation: (Sub. Res. 719, A-97; Reaffirmation I-01; Modified: CMS Rep. 7, A-11)

### **Pay-for-Performance Principles and Guidelines H-450.947**

1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

#### **PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS**

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

**1. Ensure quality of care** - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.

**2. Foster the patient/physician relationship** - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

**3. Offer voluntary physician participation** - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

**4. Use accurate data and fair reporting** - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

**5. Provide fair and equitable program incentives** - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

#### **GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS**

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

##### **Quality of Care**

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program.

1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.

2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.

3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.

4. Performance measures should be scored against both absolute values and relative improvement in those values.

5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.

6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.

7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

#### Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
- 1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
- 2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

#### Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
- 1. Programs should provide physicians with tools to facilitate participation.
- 2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

#### Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
- 1. Programs should use accurate administrative data and data abstracted from medical records.
- 2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
- 3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
  - Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
    1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
    2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
  - If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
  - The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
  - PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.
- Program Rewards
- Programs must be based on rewards and not on penalties.
  - Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
  - Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
  - Programs must finance bonus payments based on specified performance measures with supplemental funds.
  - Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
  - Programs must not reward physicians based on ranking compared with other physicians in the program.
  - Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
  - Programs must not financially penalize physicians based on factors outside of the physician's control.
  - Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
  - Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.
2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."
- Citation: BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13; Appended: BOT Rep. 1, I-14; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of Res. 216, I-15; Reaffirmation I-15; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716  
(A-19)

Introduced by: Texas

Subject: Health Plan Claim Auditing Programs

Referred to: Reference Committee G  
(Rodney Trytko, MD, Chair)

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Whereas, In recent years there has been an observable increase in health plans using third-party software to analyze and audit claims for payment based solely on the diagnosis code, Current Procedural Terminology (CPT) code(s) and modifier(s); and

Whereas, The patient's previous claims history with the health plan is sometimes used as part of the software "equation" to determine if the claim should be paid; and

Whereas, The physician's billing patterns compared with his or her peers' is another possible part of the software "equation"; and

Whereas, The review of a patient's medical record is necessary to determine if it clearly documents the necessity of the diagnosis code(s), CPT code(s), and/or modifier(s); and

Whereas, There are no nationally recognized billing, coding, and payment guidelines that support the use of these software programs; and

Whereas, These software programs should not be used as the sole determinant of claim payment or denial; therefore be it

RESOLVED, That our American Medical Association vigorously oppose the exclusive use of software or other methodologies, with no review of the patient's medical record, to determine payment and/or denial of a claim based solely on the CPT codes, ICD-10 codes, and modifiers submitted on the claim (Directive to Take Action); and be it further

RESOLVED, That our AMA vigorously oppose the exclusive use of the patient's medical claim history, with no review of the patient's medical record, as a tool to deny or pay a claim (Directive to Take Action); and be it further

RESOLVED, That our AMA vigorously support the use of coding methods that adhere to CPT guidelines, rules, and conventions. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 05/24/19

## RELEVANT AMA POLICY

### **Bundling and Downcoding of CPT Codes H-70.937**

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;

(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;

(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and

(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

Citation: Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

### **CPT Modifiers D-70.959**

AMA policy is that a CPT code representing a service or procedure that is covered and paid for separately should also be paid for when performed at the same time as another service or procedure, unless CPT coding guidelines specifically direct users not to report the service or procedure (i.e., separate procedure codes), and that if the service or procedure is reimbursed zero dollars, or otherwise not recognized by an insurer, the service or procedure should be considered uncovered and thus billable to the patient.

Citation: (BOT Action in response to referred for decision Res. 828, I-05; Modified: CMS Rep. 1, A-15

### **Uses and Abuses of CPT Modifier -25 D-70.971**

(1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers.

(2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate.

(3) Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans.

(4) Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers.

(5) Our AMA will include in its model managed care contract, provisions that will require managed care plans to adhere to CPT rules concerning modifiers.

(6) Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers.

(7) Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions.

(8) Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.

Citation: (BOT Rep. 10, I-03; Reaffirmation A-10

### **Third Party Payer Coverage Process Reform and Advocacy D-185.986**

1. Our AMA, working with interested state medical and national specialty societies, will develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies, and will actively seek the implementation of such model legislation and/or regulations at the national and state levels.

2. Our AMA will work with specialty and service organizations to advocate that private insurance plans and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant national physician organizations; and that such clinical coverage protocols should be easily and publicly accessible on their

websites, just as Medicare national and local coverage determinations are publically available.

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

Citation: (Res. 820, I-11; Appended: Res. 807, I-12)

### **Requiring Third Party Reimbursement Methodology be Published for Physicians H-185.975**

Our AMA:

(1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules;

(2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans;

(3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted.

(4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies;

(5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and

(6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.

Citation: (Sub. Res. 805, I-95; Appended: Res. 117, A-98; Reaffirmation A-99; Appended: Res. 219, and Reaffirmed: CMS Rep. 6, A-00; Reaffirmation I-01; Reaffirmed and Appended: Res. 704, A-03; Reaffirmation I-04; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: CMS Rep. 3, I-09; Reaffirmation A-14)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717  
(A-19)

Introduced by: Organized Medical Staff Section

Subject: Military Physician Reintegration into Civilian Practice

Referred to: Reference Committee G  
(Rodney Trytko, MD, Chair)

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1 Whereas, Many physicians and surgeons serve the United States through active duty service;  
2 and  
3

4 Whereas, Such service often requires extended time away from practicing medicine and/or  
5 performing surgical procedures in non-military settings; and  
6

7 Whereas, When once again available for taking up civilian practice, a medical serviceman or  
8 servicewoman may need to be recredentialed at local facilities; and  
9

10 Whereas, Particularly for surgeons, some procedures for which they are trained and had  
11 previously attained competency have not been performed during military service for an  
12 extended period of time given the demographics of their patient base; and  
13

14 Whereas, Most credentialing requirements require documentation of current competency in  
15 requested privileges, which usually includes documentation of volume of given services  
16 performed within the previous calendar year, which may have been substantially reduced in the  
17 case of a returning serviceman or servicewoman; and  
18

19 Whereas, There is a legitimate concern to assure competency, particularly for surgical  
20 procedures, of an applicant for privileges; and  
21

22 Whereas, There is a competing concern to honor personal contributions to society and minimize  
23 difficulties in returning to non-military practice; therefore be it  
24

25 RESOLVED, That our American Medical Association develop recommendations to inform local  
26 credentialing bodies of pathways to facilitate the process for military veteran physicians and  
27 surgeons to return to civilian practice without compromising patient care. (Directive to Take  
28 Action)

Fiscal Note: Modest – between \$1,000 and \$5,000

Received: 06/07/19



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 718  
(A-19)

Introduced by: Organized Medical Staff Section

Subject: Economic Discrimination In The Hospital Practice Setting

Referred to: Reference Committee G  
(Rodney Trytko, MD, Chair)

Whereas, The number of hospitals initiating volume-based metrics as a key element of physician privileging and credentialing is increasing; and

Whereas, These hospitals are hiring physician staff that are directly salaried by the hospital, and are creating surgical, obstetric, and medical teams with additional physician extenders to directly compete with affiliated—but independent—physician groups; and

Whereas, There are claims that these hospitals are giving preference to hospital-employed physicians to the detriment of independent physicians on staff; and

Whereas, While the AMA has a body of policy that opposes volume discrimination and the use of economic criteria not related to quality to determine a physician's qualifications for the granting or renewal of medical staff membership or privileges, these policies only partially address the issue of unfair use of volume metrics to artificially de-credential or limit independent physician groups; therefore be it

**RESOLVED**, That our American Medical Association 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. (New HOD Policy)

Fiscal Note: Modest – Between \$1,000 and \$5,000

Received: 06/07/19

### RELEVANT AMA POLICY

#### **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.

Citation: Sub. 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.

Citation: (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.

Citation: 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.

Citation: 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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 719  
(A-19)

Introduced by: Resident and Fellow Section

Subject: Interference with Practice of Medicine by the Nuclear Regulatory Commission

Referred to: Reference Committee G  
(Rodney Trytko, MD, Chair)

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1 Whereas, In 1995 the National Academy of Sciences Institute of Medicine (NAS-IOM)  
2 charged and paid by Nuclear Regulatory Commission (NRC) itself to conduct a thorough  
3 and independent external evaluation of NRC's medical use program, demonstrated  
4 significant inefficiencies and undue interference with practice of medicine by NRC<sup>1</sup>; and  
5

6 Whereas, The explicit recommendations of the 1995 NAS-IOM report have not been  
7 incorporated in NRC's regulatory framework in the last 25 years; and  
8

9 Whereas, NRC's regulatory framework has contributed directly and indirectly to put  
10 nuclear medicine as a specialty and its research and development in US at a  
11 disadvantage compared to many other countries in the world, despite nuclear medicine  
12 as a specialty being first incepted in US; and  
13

14 Whereas, There is increasing need in US for nuclear medicine diagnostic studies and  
15 therapies to the degree that even some patients in need of novel nuclear medicine  
16 therapies not offered in US have to travel to Europe to receive these therapies; and  
17

18 Whereas, The NRC as the regulatory federal body in US responsible for radiation safety,  
19 for the last 25 years has used old rudimentary training and experience requirements to  
20 determine eligibility to practice nuclear medicine; and  
21

22 Whereas, The training and experience requirement used by NRC are considerably less  
23 rigorous than the standards set forth by the American Board of Nuclear Medicine and/or  
24 American Board of Radiology board certification criteria; and  
25

26 Whereas, Many hiring institutions and practices perceive the licensure issued by NRC as  
27 sufficient to practice all aspects of nuclear medicine and thereby the ACGME accredited  
28 residency training programs are undermined in their mission and existential foundation;  
29 and  
30

31 Whereas, Our AMA opposes undue interference with medical practice, through  
32 governmental agencies or non-governmental entities (e.g. pharmaceutical industry or  
33 insurance companies); and

1 Whereas, Our AMA supports a regulatory environment that is scientifically informed  
2 which allows all medical specialties to thrive and meet the need of patients; and  
3 Whereas, Our AMA upholds the goal of equitable and readily available access to  
4 qualified medical care; and

5  
6 Whereas, NRC recently announced proposals reducing training and experience  
7 requirements for use of therapeutic radiopharmaceuticals published in the Federal  
8 Register on May 2, 2019 with currently open extended public comment period ending  
9 July 3, 2019; therefore be it

10  
11 RESOLVED, That our American Medical Association advocate for a follow-up review by  
12 the Institute of Medicine of the Nuclear Regulatory Commission's medical use program,  
13 specifically evaluating effects of the Nuclear Regulatory Commission's regulatory policy  
14 in the last 25 years on the current state of nuclear medicine in the U.S. and patients'  
15 access to care. (Directive to Action)

Fiscal note: Modest – between \$1,000 - \$5,000

Received: 06/08/19

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#### REFERENCE:

<sup>1</sup> Gottfried KD, Penn G: Radiation in medicine. A need for regulatory reform. National Academy Press. Washington DC. 1996. ISBN-13: 9780309053860

#### RELEVANT AMA POLICY:

##### **AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959**

1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.

2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:

A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.

B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.

C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.

D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

Citation: (Res. 523, A-06; Appended: Res. 706, A-13)

##### **Government Controlled Medicine H-165.916**

Our AMA strongly reaffirms its unwavering opposition against the encroachment of government in the practice of medicine as well as any attempts to covertly change the American health care

system to a government program with the subsequent loss of precious personal freedoms, including the right of physicians and patients to contract privately for health care without government interference.

Citation: (Res. 141, I-93; Reaffirmed: Sub. Res. 132, A-94; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation I-07; Reaffirmation A-09; Reaffirmation I-09

#### **Government Regulations H-390.994**

Our AMA vigorously opposes regulations and legislation which would: (1) interfere with and/or redefine the practice of medicine;

(2) substitute hourly wages or annual salaries for present reimbursement mechanisms for physicians' services to patients;

(3) base physician reimbursement on any system which does not give recognition to knowledge, skill, time and effort; or

(4) otherwise impinge significantly upon the practice of medicine.

Citation: (Sub. Res. 28, I-82; Amended: CLRPD Rep. A, I-92; Reaffirmed by Sub. Res. 203, A-98; Reaffirmation A-00; Reaffirmation I-01; Reaffirmed: Res. 704, A-10

#### **Interference in the Practice of Medicine D-125.997**

Our AMA shall initiate action by whatever means to bring a halt to the interference in medical practice by pharmacy benefit managers and others.

Citation: Res. 529, A-02; Reaffirmation A-10; Reaffirmed: CMS Rep. 04, A-16

#### **Nuclear Regulatory Commission Medical Use Program H-455.978**

The AMA encourages the efforts of the Nuclear Regulatory Commission to assure that any regulations that affect the practice of nuclear medicine and radiology be science-based.

Citation: Sub. Res. 516, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17