Handbook Review: HOD Reference Committee B (Legislation)

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Recommended positions: Support, Active Support, Oppose, Active Oppose, Monitor

HOD resolution or report (sponsor)	Action requested	AMA-WPS recommended position
BOT Report 9: Council on Legislation Sunset Review of 2009 House Policies	The Board of Trustees recommends that the House of Delegates policies listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.	Monitor
BOT Report 14: Reforming the Orphan Drug Act (Resolution 217-A-18) An Optional National Prescription Drug Formulary (Resolution 227-A-18) Reform of Pharmaceutical Pricing: Negotiated Payment Schedules (Resolution 238-A-18)	RECOMMENDATION In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of Resolutions 217-A-18, 227-A-18, and 238-A-18, and the remainder of this report be filed. 1. That our AMA reaffirm Policy H-110.987, "Pharmaceutical Costs," which outlines a series of measures to address anti-competitive actions by pharmaceutical manufacturers as well as policies to promote increased transparency along the pharmaceutical supply chain including among PBMs. (Reaffirm HOD Policy) 2. That our AMA support legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations. (New HOD Policy) Fiscal Note: Less than $500	Support
BOT Report 17: Ban on Medicare Advantage "No Cause" Network Terminations	RECOMMENDATION The Board of Trustees recommends that the following recommendations be adopted and that the remainder of the report be filed: 1. That our American Medical Association (AMA) urge Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by: a. Requiring MA plans to submit provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network. b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies. c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder. d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may subject the MA plans to one of the following: 1.	**Active Oppose with Amendment**

	civil monetary penalties; 2. enrollment sanctions; or 3. incorporating the accuracy score into the Stars rating for each plan. e. Offering plans the option of using AMA/Lexis-Nexis VerifyHCP system to update provider directory information. (Directive to Take Action) 2. That our AMA urge CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: a. Requiring plans to report the percentage of the physicians in the network who actually provided services to plan members during the prior year. b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy. c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together. d. Evaluating alternative/additional measures of adequacy. (Directive to Take Action) 3. That our AMA urge CMS to ensure lists of contracted physicians are made more easily accessible by: a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form. (Directive to Take Action) b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. That our AMA urge CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: A. the number of contracted physicians in each specialty and county; B. the extent to which a plan's network exceeds minimum standards in each specialty and county; and C. the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network. (Directive to Take Action) 4. That our AMA urge CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder. (Directive to Take Action) 5. That our AMA urge CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network	

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	that may directly or indirectly impact patients; including updating the Medicare Plan Finder website. (Directive to Take Action) 6. That our AMA urge CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force. (Directive to Take Action) 7. That our AMA rescind Policy D-285.961, which directed the AMA to conduct the study herein. (Rescind AMA Policy) Fiscal Note: Less than $3,500.	
BOT Report 18: Increased Use of Body-Worn Cameras by Law Enforcement Officers (Resolution 208-I-17)	RECOMMENDATION The Board recommends that the following be adopted in lieu of Resolution 208-I-17, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase body-worn cameras, training for officers and technical assistance for law enforcement agencies. (Directive to Take Action); 2. That our AMA continue to monitor privacy issues raised by body-worn cameras in health care settings. (Directive to Take Action); and 3. That our AMA recommend that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from the medical community and not interfere with the patient-physician relationship. (Directive to Take Action) Fiscal Note: Less than $5,000	Support
BOT Report 19: FDA Conflict of Interest (Resolution 216-A-18)	RECOMMENDATION In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of Resolution 216-A-18 and the remainder of this report be filed: 1. That our AMA reaffirm Policy H-100.992, “FDA,” which supports that FDA conflicts of interest should not overrule scientific evidence in making policy decisions and the FDA should include clinical experts on advisory committees. (Reaffirm HOD Policy)	Support

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

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	undermine the independence of advisory committee member recommendations and whether policies should be adopted to address this issue. (New HOD Policy) Fiscal Note: Less than $500	
BOT Report 20: Safe and Efficient e-Prescribing	RECOMMENDATION The Board of Trustees recommends that the following be adopted in lieu of Resolution 237-A-18 and that the remainder of this report be filed: 1. That our American Medical Association (AMA) reaffirm the following policies: a. H-125.979, "Private Health Insurance Formulary Transparency" b. D-120.956, "Electronic Prescribing and Conflicting Federal Guidelines" c. H-120.941, "e-Prescribing of Scheduled Medications" d. D-120.958, "Federal Roadblocks to E-Prescribing" e. D-120.945. "Completing the Electronic Prescription Loop for Controlled Substances" (Reaffirm HOD Policy) 2. That the second paragraph of AMA Policy D-120.972, "Electronic Prescribing," be rescinded as having been fulfilled by this report. (Rescind HOD Policy) 3. That our AMA encourage health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages: • E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases. • Health care organizations and implementation teams to improve prescriber end-user training and on-going education. • Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues. • Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options. • Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.	Support

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	• Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process. • Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician. • Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions. • Organizational leadership to designate e-prescribing as the default prescription method. • The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication. • States to allow integration of PDMP data into EHR systems. • Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status. (New HOD Policy) Fiscal Note: Minimal - Less than $500	
BOT Report 21: Augmented Intelligence (AI) in Health Care	RECOMMENDATION In light of these considerations, your Board of Trustees recommends that the following be adopted in lieu of the recommendation and the remainder of this report be filed: Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that: 1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.	**Active Support**

	2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws. 3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) clinical evidence. 4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement. 5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability. 6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes: a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage. b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment. 7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:	

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	a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability. b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users. c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm. 8. Our AMA, national medical specialty societies, and state medical associations— a. Identify areas of medical practice where AI systems would advance the quadruple aim; b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts; c. Outline new professional roles and capacities required to aid and guide health care AI systems; and d. Develop practice guidelines for clinical applications of AI systems. 9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy) Fiscal Note: Less than $5000	
BOT Report 22: Inappropriate Use of CDC Guidelines for Prescribing Opioids	RECOMMENDATIONS The Board recommends that the following recommendations be adopted in lieu of the second resolve of alternate Resolution 235-I-18, and that the remainder of the report be filed. That our American Medical Association (AMA) support balanced opioid-sparing policies that are not based on hard thresholds, but on patient individuality, and help ensure safe prescribing practices, minimize workflow disruption, and ensure patients have access to their medications in a timely manner, without additional, cumbersome documentation requirements. (New HOD Policy)	Support

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	2. That our AMA oppose the use of "high prescriber" lists used by national pharmacy chains, pharmacy benefit management companies or health insurance companies when those lists do not provide due process and are used to blacklist physicians from writing prescriptions for controlled substances and preventing patients from having the prescription filled at their pharmacy of choice. (New HOD Policy) Fiscal Note: Less than $500.	
BOT Report 23: Prior Authorization Requirements for Post-Operative Opioids	RECOMMENDATIONS The Board recommends that the following recommendation be adopted in lieu of Resolution 208-A-18, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) advocate for state legislatures and other policymakers, health insurance companies and pharmaceutical benefit management companies to remove barriers, including prior authorization, to non-opioid pain care. (New HOD Policy) 2. That our AMA support amendments to opioid restriction policies to allow for exceptions that enable physicians, when medically necessary in the physician's judgment, to exceed statutory, regulatory or other thresholds for post-operative care and other medical procedures or conditions. (New HOD Policy) 3. That our AMA oppose health insurance company and pharmacy benefit management company utilization management policies, including prior authorization, that restrict access to post-operative pain care, including opioid analgesics, if those policies are not based upon sound clinical evidence, data and emerging research. (New HOD Policy) Fiscal Note: Less than $500.	Support
BOT Report 30: Opioid Treatment Programs Reporting to Prescription Monitoring Programs	RECOMMENDATION The Board of Trustees recommends that Resolution 507-A-18 not be adopted and the remainder of this report be filed. Fiscal Note: Less than $500.	**Active Suppor**t
Resolution 201: Assuring Patient Access to Kidney Transplantation	RESOLVED, That our American Medical Association work with professional and patient-centered organizations to advance patient and physician-directed coordinated care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further	Support

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Introduced by: American Society of Transplant Surgeons	RESOLVED, That our AMA actively oppose any legislative or regulatory efforts to remove patient choice and physician involvement in ESRD care decisions (Directive to Take Action); and be it further RESOLVED, That our AMA actively oppose any legislative or regulatory effort that would create financial incentives that would curtail the access to organ transplantation (Directive to Take Action); and be it further RESOLVED, That our AMA House of Delegates be advised in a timely fashion regarding any legislative or regulatory efforts to abrogate patient and physician-advised decision-making regarding modality of care for ESRD. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	
Resolution 202: Reducing the Hassle Factor in Quality Improvement Programs Introduced by: California	RESOLVED, That our American Medical Association recommend to the Centers for Medicare and Medicaid Services (CMS) and physician certifying boards, such as the American Board of Medical Specialties, that maintenance of certification (MOC) participation count toward satisfying the quality category of the Merit-Based Incentive Payment Program (MIPS) (Directive to Take Action); and be it further RESOLVED, That our American Medical Association also recommend that successful reporting in the quality category of the Merit-Based Incentive Payment Program (MIPS) count toward satisfying the practice performance assessment section of a certifying board's MOC requirements) (Directive to Take Action); and be it further RESOLVED, That our AMA study MOC and Medicare MIPS reciprocity and work with the state and national specialty societies to develop a plan to reduce quality measure duplication and administrative burdens in both the MIPS and MOC programs. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support
Resolution 203: Medicare Part B and Part D Drug Price Negotiation Introduced by: California	RESOLVED, That our American Medical Association advocate for Medicare to cover all physician-recommended adult vaccines in both the Medicare Part D and the Medicare Part B programs (Directive to Take Action); and be it further RESOLVED, That our AMA make it a priority to advocate for a mandate on pharmaceutical manufacturers to negotiate drug prices with the Centers for Medicare	Support

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	and Medicaid Services for Medicare Part D and Part B covered drugs (Directive to Take Action); and be it further RESOLVED, That our AMA explore all options with the state and national specialty societies to ensure that physicians have access to reasonable drug prices for the acquisition of Medicare Part B physician-administered drugs and that Medicare reimburse physicians for their actual drug acquisition costs, plus appropriate fees for storage, handling, and administration of the medications, to ensure access to high-quality, cost-effective care in a physician's office. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	
Resolution 204: Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs Introduced by: California	RESOLVED, That our American Medical Association advocate that the relevant pharmaceutical industry organizations be held financially responsible for the health care and other economic costs related to their unethical and deceptive misbranding, marketing, and advocacy of opioids. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 205: Use of Patient or Co-Worker Experience/Satisfaction Surveys Tied to Employed Physician Salary Introduced by: Illinois	RESOLVED, That our American Medical Association adopt policy opposing any association between anonymous patient satisfaction scores (e.g. "loyalty scores") or the coworkers' observation reporting system, and employed physicians' salaries (New HOD Policy); and be it further RESOLVED, That our AMA adopt policy opposing any publication of anonymous patient satisfaction scores or coworkers' observation reporting system information directed at an individual physician (New HOD Policy); and be it further RESOLVED, That our AMA adopt policy opposing the use of any anonymous patient satisfaction scores or any individually and anonymously posted patient or co-worker comments in formulating or impacting employed physician salaries or in relation to any other physician compensation program. (New HOD Policy) Fiscal Note: Minimal - less than $1,000.	**Active Support**
Resolution 206: Changing the Paradigm: Opposing Present and Obvious Restraint of Trade Introduced by: Illinois	RESOLVED, That our American Medical Association seek legislative or regulatory changes to allow physicians to collectively negotiate professional fees, compensation and contract terms without integration. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor

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Resolution 207: Direct-to-Consumer Genetic Tests Introduced by: Illinois	RESOLVED, That our American Medical Association regard research using consumer genome data derived from saliva or cheek swab samples as research on human subjects requiring consents in compliance with the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an "opt in" option to allow more consumer choice in the consent process (Directive to Take Action); and be it further RESOLVED, That our AMA amend Policy H-315.983, "Patient Privacy and Confidentiality," by addition to align with current research and privacy infringement findings, as follows: 1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received, while working with the Department of Health and Human Services (HHS) to stop the transfer of birthdates and state of residence by genetic testing companies and their affiliates, unless there is explicit user approval, to prevent re-identification of the test user by way of surname inference methods. 2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history	**Active Support with Amendment**

	to governmental agencies or other entities, beyond that which would be required by law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. 5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Wheher they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. Our AMA regards studies using consumer genome data derived from saliva, cheek swab, or other human tissue samples as research on human subjects requiring consents in compliance with the HHS Office for Human Research Protections (OHRP). An “opt in” option is recommended to allow more consumer choice in the consent process. 8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the	

	individual to whom the information pertains. These records should be subject to stringent security measures. 10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. 11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. 14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.	

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	16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. The AMA will work with Congress and HHS to modify the Genetic Information Nondiscrimination Act of 2008 (GINA), which bans genome-based policy and hiring decisions by health insurance companies and employers, by adding Long-Term Care, Life Insurance, and Disability Insurance to the Act to prevent applicant rejection based on their genetic make up. 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. a. Our AMA supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identified information with other parties without the consent of the user. An exception would be made when requested by law enforcement authorities or when keeping the information would seriously threaten their health or that of others. If a data security breach occurs with the Direct-To –Consumer genetic company or its collaborators, then the company has the responsibility to inform all users of the breach and the impact of the unprotected private data on those individuals; 19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. 21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation (Modify Current HOD Policy); and be it further RESOLVED, That our AMA work with the Department of Health and Human Services or other relevant parties to modify the rules to prevent genetic testing entities from transferring information about the user's date of birth and state of residence to third parties which may result in the re-identification of the user based on surname inference (Directive to Take Action); and be it further	

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	RESOLVED, That our AMA work with Congress and the Department of Health and Human Services to extend the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	
Resolution 208: Repeal or Modification of the Sunshine Act Introduced by: Illinois	RESOLVED, That our American Medical Association adopt as policy opposition to the Physician Payments Sunshine Act as it currently is written and implemented (New HOD Policy); and be it further RESOLVED, That our AMA support either repeal of the current Sunshine Act or significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the burden and "hassle factor" and support efforts at administrative simplification for physicians, which the Center for Medicare and Medicaid Services and the organized medical community has supported, if any portion of the Act is maintained. (New HOD Policy) Fiscal Note: Minimal - less than $1,000.	Monitor
Resolution 209: Mandates by ACOs Regarding Specific EMR Use Introduced by: Illinois	RESOLVED, That our American Medical Association adopt policy stating that Accountable Care Organizations cannot mandate their membership to use a single specific Electronic Medical Record (EMR) (New HOD Policy); and be it further RESOLVED, That our AMA move to effect legislation that prevents Accountable Care Organizations from imposing EMR mandates. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 210: Air Ambulances Introduced by: New York	RESOLVED, That our American Medical Association support federal legislation which would: 1. Establish an expedited independent dispute resolution system to resolve payment disputes between emergency air ambulance providers and health insurers; and 2. Ensure that such independent dispute resolution process would ensure the patient be "held harmless" except for applicable insurance policy in-network cost-sharing requirements. (New HOD Policy) Fiscal Note: Minimal - less than $1,000.	Monitor

Handbook Review: HOD Reference Committee B (Legislation)

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Resolution 211: Use of FAIR Health Introduced by: New York	RESOLVED, That our American Medical Association advocate that any legislation addressing surprise out of network medical bills use FAIR Health usual and customary data and not all payer database data. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 212: Pharmacy Benefit Managers Introduced by: New York	RESOLVED, That our American Medical Association advocate through all appropriate means to ensure that medications used to stabilize palliative and hospice patients for pain and delirium in the hospital continue to be covered by pharmacy benefit plans after patients are transitioned out of the hospital. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 213: Financial Penalties and Clinical Decision-Making Introduced by: New York	RESOLVED, That our American Medical Association oppose the practice of a payer utilizing statistical targets alone (and not outcomes data) to determine 'cost effectiveness' of a therapeutic choice (New HOD Policy); and be it further RESOLVED, That our AMA oppose the practice of a payer imposing financial penalties upon physicians and/or associated physicians based upon the use of statistical targets without first considering the clinical factors unique to each patient's claim. (New HOD Policy) Fiscal Note: Modest - between $1,000 - $5,000.	Support
Resolution 214: The Term Physician Introduced by: New York	RESOLVED, That our American Medical Association seek the passage of federal regulation and/or legislation that mandates that the term physician be limited to those people trained in accordance with Accreditation Council for Graduate Medical Education guidelines and have an MD, DO or a recognized equivalent physician degree and that the term not be used by any other organization or person involved in healthcare. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 215: Reimbursement for Health Information Technology Introduced by: New York	RESOLVED, That our American Medical Association seek the passage of federal regulation and/or legislation that mandates that third party payers allow physician practices to charge a technology fee equal to the copayment of the patient's plan. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor

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Resolution 216: Eliminate the Word "Provider" from Healthcare Contracts Introduced by: New York	RESOLVED, That our American Medical Association seek legislation to ensure that all references to physicians in government and insurance contracts, agreements, published descriptions, and printed articles eliminate the word "provider" and substitute the accurate and proper term "physician". (Directive to Take Action) Fiscal Note: Minimal - less than $1,000.	Support
Resolution 217: Medicare Vaccine Billing Introduced by: New York	RESOLVED, That our American Medical Association advocate that a physician's office can bill Medicare for all vaccines and that the patient shall only pay the applicable copay to prevent fragmentation of care. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support
Resolution 218: Payment for Medications Used Off Label for Treatment of Pain Introduced by: New York	RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services to allow reimbursement for off label use of medications like gabapentin or lidocaine patches at the lowest copayment tier for the indication of pain so that patients can be effectively treated for pain and decrease the number of opioid prescriptions written. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 219: Medical Marijuana License Safety Introduced by: Oklahoma	RESOLVED, That our American Medical Association draft model state legislation to amend states' prescription drug monitoring programs to include a medical marijuana license registry. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 220: Study of Confidentially and Privacy Protection in the Treatment of Substance Disorders Introduced by: Pennsylvania	RESOLVED, That our American Medical Association study whether the confidentiality protections of 42 CFR Part 2 outweigh the potential benefits of coordinating care with HIPAA privacy protections in the treatment of substance related disorders. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	**Active Oppose with Amendment**
Resolution 221: Extending Medicaid Coverage to 12-Months Postpartum Introduced by: American College of Obstetricians and Gynecologists, American Psychiatric Association, New Jersey,	RESOLVED That our American Medical Association support and actively work toward enactment of state legislation, Section 1115 waiver applications, and federal legislation to extend Medicaid coverage to 12-months postpartum. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	**Active Support**

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Illinois, American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry		
Resolution 222: Protecting Patients from Misleading and Potentially Harmful "Bad Drug" Ads Introduced by: Kentucky, Mississippi, Oklahoma, West Virginia	RESOLVED, That our American Medical Association encourage state legislatures to consider and adopt legislation that helps protect patient health by creating fair rules and regulations around attorney advertisements that: 1. Prohibit misuse of governmental logos or the term “recall” 2. Provide clear warning of the dangers in stopping a course of treatment without consulting with a physician and 3. Require written consent before sharing personal health information. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 223: Simplification and Clarification of Smoking Status Documentation in the Electronic Health Record Introduced by: Wisconsin	RESOLVED, That our American Medical Association support the streamlining of the SNOMED categories for smoking status and passive smoking exposure documentation in the electronic medical record so that the categories are discrete, non-overlapping, and better understood per The Association for the Treatment of Tobacco Use and Dependence 2019 recommendations as follows: **Smoking status categories:** Current Every Day Smoker, Current Some Day Smoker Former Smoker, Never Smoker, and Smoking Status Unknown **Passive smoking exposure:** Exposure to Second Hand Tobacco Smoke, Past Exposure to Second Hand Tobacco Smoke, No Known Exposure to Second Hand Tobacco Smoke (Directive to Take Action) Fiscal Note: Minimal - less than $1,000.	Support
Resolution 224: Extending Pregnancy Medicaid to One Year Postpartum Introduced by: Resident and Fellow Section	RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services to extend pregnancy Medicaid to a minimum of one year postpartum. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	**Active Support**
Resolution 225: DACA in GME Introduced by: Resident and Fellow Section	RESOLVED, That American Medical Association Policy D-255.991, “Visa Complications for IMGs in GME,” be reaffirmed (Reaffirm HOD Policy); and be it further	Support

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	RESOLVED, That AMA Policy D-350.986, "Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages," be reaffirmed. (Reaffirm HOD Policy) Fiscal Note: Minimal - less than $1,000.	
Resolution 226: Physician Access to their Medical and Billing Records Introduced by: New York	RESOLVED, That our American Medical Association advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination (Directive to Take Action); and be it further RESOLVED, That our AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to the medical and billing records such as treating these records as trade secrets or proprietary. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 227: Controlled Substance Management Introduced by: Alabama	RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services (CMS) and interested physician groups to strongly advocate for a mechanism by which physicians may be compensated for controlled substance management (Directive to Take Action); and be it further RESOLVED, That our AMA strongly encourage CMS and private payers to recognize and establish equitable payment for controlled substance management. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
Resolution 228: Truth in Advertising Introduced by: American Society of Anesthesiologists	RESOLVED, That our American Medical Association reaffirm support of the Scope of Practice Partnership's Truth in Advertising Campaign to ensure patients receive accurate information about who is providing their care (AMA Policy H-405.969) (Reaffirm HOD Policy); and be it further RESOLVED, That our AMA oppose any misappropriation of medical specialties' titles and work with state medical societies to advocate for states and administrative agencies overseeing nonphysician providers to authorize only the use of titles and descriptors that align with the nonphysician providers' state issued licenses and national board certification. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support

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Resolution 229: Clarification of CDC Opioid Prescribing Guidelines Introduced by: American Society of Clinical Oncology	RESOLVED, That our American Medical Association reaffirm Policy D-120.932, "Inappropriate Use of Centers for Disease Control and Prevention Guidelines for Prescribing Opioids"; (Reaffirm HOD Policy) and be it further RESOLVED, That our AMA incorporate into their advocacy that clinical practice guidelines specific to cancer treatment, palliative care, and end of life be utilized in lieu of the CDC's Guideline for Prescribing Opioids for Chronic Pain as per the CDC's clarifying recommendation. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support
*Resolution 230: State Legislation Mandating Electrocardiogram (ECG) and/or Echocardiogram Screening of Scholastic Athletes Introduced by: American College of Cardiology, American Society of Echocardiography, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions	RESOLVED, That our American Medical Association and state and specialty medical societies oppose legislation mandating echocardiograms or ECGs as a condition of participation in scholastic sports. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
*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 Introduced by: American Psychiatric Association, American Society of Addiction Medicine, American Academy of Child and Adolescent Psychiatry, American Academy	RESOLVED, That our American Medical Association support the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of "Part 2" substance use disorder records in criminal proceedings (New HOD Policy); and be it further RESOLVED, That our AMA support the sharing of substance use disorder patient records as required by the HIPAA Privacy Rule for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care. Fiscal Note: Minimal - less than $1,000.	Monitor

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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		
*Resolution 232: COPD National Action Plan Introduced by: American Thoracic Society	RESOLVED, That our American Medical Association support the inclusion of $25 million at NIH's National Heart, Lung, and Blood Institute (NHLBI) and an additional $2 million at the Centers for Disease Control and Prevention in the FY2020 Labor Health and Human Services and Education Appropriations Bill to implement the Chronic Obstructive Pulmonary Disease (COPD) National Action Plan (Directive to Take Action); and be it further RESOLVED, That our AMA send a letter to House and Senate Appropriators conveying its support for the COPD National Action Plan funding for fiscal year 2020. (Directive to Take 19 Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support
*Resolution 233: GME Cap Flexibility Introduced by: Georgia	RESOLVED, That our American Medical Association advocate for Centers for Medicare and Medicaid Services (CMS) to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to primary care residencies (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for CMS to provide funding to hospitals and/or universities prior to the arrival of any residents, removing the clause where "Medicare funding does not begin until the first resident is 'on-duty' at the hospital." (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor

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*Resolution 234: Improved Access to Non-Opioid Therapies Introduced by: Michigan	RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services to improve access to non-opioid treatment modalities including, but not limited to, physical therapy and occupational therapy as recommended by the patient's physician. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support
*Resolution 235: Prescription Coverage of the Lidocaine Transdermal Patch Introduced by: Michigan	RESOLVED, That our American Medical Association encourage the United States Food and Drug Administration to consider approving other indications in addition to post-herpetic neuralgia for transdermal lidocaine patches (Directive to Take Action); and be it further RESOLVED, That our American Medical Association urge the Centers for Medicare Medicaid Services and third-party payers to provide insurance coverage of lidocaine transdermal patches for other indications in addition to post-herpetic neuralgia. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
*Resolution 236: Support for Universal Basic Income Pilot Studies Introduced by: Medical Student Section	RESOLVED, That our American Medical Association support federal, state, local, and/or private Universal Basic Income pilot studies in the United States which intend to measure health outcomes and access to care for participants. (New HOD Policy) Fiscal Note: Minimal - less than $1,000.	Monitor
*Resolution 237: Opportunities in Blockchain for Healthcare Introduced by: Medical Student Section	RESOLVED, That our American Medical Association work with the Office of the National Health Information Technology to create official standards for the development and implementation of blockchain technologies in healthcare (Directive to Take Action); and be it further RESOLVED, That our AMA monitor the evolution of blockchain technologies in healthcare and engage in discussion with appropriate stakeholders regarding blockchain development. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Support

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*Resolution 238: Coverage Limitations and Non-coverage of Interventional Pain Procedures Correlating to the Worsening Opioid Epidemic and Public Health Crisis Introduced by: North American Neuromodulation Society	RESOLVED, That our American Medical Association support coverage of sacroiliac joint blocks and radiofrequency ablation, facet (spine joint) medial branch blocks and radiofrequency ablation, genicular blocks and radiofrequency ablation for non-operable knee arthritis or pain, femoral and obturator nerve blocks and radiofrequency ablations for non-operable hip arthritis or pain, suprascapular nerve blocks and radiofrequency ablations for non-operable shoulder arthritis or pain, and other arbitrarily limited non-covered interventional pain management procedures, by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans (Directive to Take Action), and be it further RESOLVED, That our AMA support coverage of spinal cord stimulation trials and implantation, and peripheral nerve stimulation trials and implantation by all private insurance carriers, third party review companies, Medicare and Medicaid contractors, and Medicare Advantage Plans by ICD-10 codes that have been linked to the respective Current Procedural Terminology (CPT) code set as outlined in the AMA CPT Manual. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
*Resolution 239: Improving Access to Medical Care through Tax Treatment of Physicians Introduced by: Gregory Pinto, MD, Delegate	RESOLVED, That our American Medical Association seek legislation and/or regulation that would permit physician practices to utilize ‘pass through’ tax treatment of practice income in the manner of other small businesses and professionals (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
*Resolution 240: Formation of Collective Bargaining Workgroup Introduced by: Hawaii	RESOLVED, That our American Medical Association form a workgroup to outline the legal challenge to federal antitrust statute for physicians (Directive to Take Action); and be it further RESOLVED, That this workgroup engage the state medical associations and other physician groups as deemed appropriate (Directive to Take Action); and be it further RESOLVED, That our AMA report back by the 2020 Annual meeting on the viability of a strategy for the formation of a federal collective bargaining system for all physicians and, to the extent viable, a related organizational plan. (Directive to Take Action). Fiscal Note: Modest - between $1,000 - $5,000.	Monitor

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*Resolution 241: Facilitation of Research with Medicare Claims Data Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	RESOLVED, That our American Medical Association, in an effort to advance the feasibility of population health research to fulfill the promise of value based care, request that the Centers for Medicare and Medicaid Services (CMS) and CMS's Centers for Medicare and Medicaid Innovation (CMMI) eliminate the prohibitions on sharing data outside of the accountable care organization contained in the CMS Data Use Agreement and allow sharing of that data: (1) in the form of de-identified data sets as permitted by HIPAA; and (2) for purposes of research as permitted by HIPAA. (Directive to Take Action) Fiscal Note: Not yet determined	Monitor

*Included in the Handbook Addendum
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