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REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-I-19

Subject:	Legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (Resolution 205-I-18)
Presented by:	Jesse M. Ehrenfeld, MD, MPH, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 205-I-18, "Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)" for study. Resolution 205-I-18 was introduced by the International Medical Graduates (IMG) Section. Resolution 205 asked that our AMA support legalization of DALCA; and that our AMA work with the appropriate agencies to allow DALCA children to start and finish medical school and/or residency training until these DALCA children have officially become legal.

BACKGROUND

DALCA is a new policy term not widely used by immigration attorneys or Members of Congress, and it is not a legally recognized term. The term was created to distinguish children of H-1B visa holders who legally entered the U.S. from Deferred Action for Childhood Arrivals (DACA) recipients. The term DACA applies only to children who were brought to the United States illegally and thus does not apply to children of H-1B visa holders, including International Medical Graduates (IMGs).

Under current U.S. immigration law, the spouse and children of a H-1B visa holder can accompany the worker to the U.S. by obtaining an H-4 visa. Each family member must obtain his or her own H-4 visa. There are a number of extensions for H-1B holders once an I-140 application (i.e., petition for green card) is approved. For those on H-4 spousal visas, there are no limitations as long as the related H-1B visa is valid. Additionally, in 2015 the Obama Administration issued a final rule allowing those on H-4 spousal visas to work if their H-1B visa spouse is applying to become a lawful permanent resident (i.e., green card holder). According to the U.S. Citizenship and Immigration Services (USCIS), there have been close to 91,000 initially approved employment authorization applications for H-4 spousal visas. However, children lose their H-4 visa status once they turn 21. These children have only two choices: they can have their H-4 visa changed to an international student visa, also called the student F-1 visa, so they can attend college/university in the U.S., or they can return to their home country and then return to the U.S. after their H-1B visa physician parent obtains permanent residency. Once these children finish their education while on the F-1 visa, they would need to seek H-1B employment sponsors of their own so they can work in the U.S. and eventually obtain their own green cards.

DISCUSSION

The sponsors of Resolution 205 assert that many DALCA children are in medical school or have already graduated from U.S. medical schools, but are subject to deportation because they are considered illegal once they are over age 21. Many of the DALCA children have matched in residency programs but are unable to attend due to their lack of proper legal status.

It is well known that there is expected to be a physician shortage in the U.S. The projected shortage of between 46,900 and 121,900 physicians by 2032 includes both primary care (between 21,100 and 55,200) and specialty care (between 24,800 and 65,800). Among specialists, the data project a shortage of between 1,900 and 12,100 medical specialists, 14,300 and 23,400 surgical specialists, and 20,600 and 39,100 other specialists, such as pathologists, neurologists, radiologists, and psychiatrists, by 2032. Supporting permanent legal status for DALCA children could help in reducing the impact of the expected physician shortage and support the families of H-1B visa physicians.

The AMA has extensive policy supporting DACA students as well as permanent residence status for physicians; however, there is no policy directly supporting children on H-4 visas that have aged out waiting for their physician-parent to receive their green card. The Board concludes that Resolution 205 is consistent with existing AMA policy and should be adopted by appropriately amending existing policy to incorporate the intent of the resolution.

RECCOMENDATION

The Board recommends that our AMA amend Policy D-255.979, "Permanent Residence Status for Physicians on H1-B Visas," by addition to read as follows, in lieu of Resolution 205-I-18 and that the remainder of the report be filed:

> Our AMA will work with all relevant stakeholders to: 1) clear the backlog for conversion from H1-B visas for physicians to permanent resident status, and 2) allow the children of H-1B visa holders, who have aged out of the H-4 non-immigrant classification, to remain in the U.S. legally while their parents' green card applications are pending. (Modify Current HOD Policy)

Fiscal Note: Less than $500

RELEVANT AMA POLICIES

Policy D-255.979, "Permanent Residence Status for Physicians on H1-B Visas"
Our AMA will work with all relevant stakeholders to clear the backlog for conversion from H1-B visas for physicians to permanent resident status.
Res. 229, A-18

Policy D-255.980, "Impact of Immigration Barriers on the Nation's Health"
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine. 2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion. 3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion. 4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care. 5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and

physicians in independent practice. 6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
Alt. Res. 308, A-17 Modified: CME Rep. 01, A-18

Policy H-255.988, "AMA Principles on International Medical Graduates"
Our AMA supports: 1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada. 2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE. 3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body. 4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada. 5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees. 6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools. 7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care. 8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs. 9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure. 10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower. 11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor. 12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. 13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities. 14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs. 15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members. 16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools. 17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine. 18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations. 19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return. 20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States. 21. U.S. medical schools offering admission with

advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation. 22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16 Appended: Res. 304, A-17 Modified: CME Rep. 01, I-17

Policy D-255.99, "Visa Complications for IMGs in GME"
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position. 2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs. 3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training. 4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.
Res. 844, I-03 Reaffirmation A-09 Reaffirmation I-10 Appended: CME Rep. 10, A-11 Appended: Res. 323, A-12

Policy D-350.986, "Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages"
1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates. 2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.
Res. 305, A-15 Appended: Late Res. 1001, I-16

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-I-19

Subject:	Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings (Resolution 202-I-18)
Presented by:	Jesse M. Ehrenfeld, MD, MPH, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2018 Interim Meeting, the House of Delegates referred Resolution 202-I-18, "Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings," introduced by the Pennsylvania Delegation, which asked:

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

Testimony on Resolution 202 was generally supportive of having the AMA study the implications of removing barriers that hamper the ability of physician practices to dispense methadone, one of the three main drug classes commonly referred to as medication-assisted treatment (MAT). There also was testimony that the AMA does not need to study working with state and specialty societies regarding the issues raised in Resolution 202 but instead should work directly with the Federation on supporting greater access to methadone treatment for opioid use disorder, including removing stigma. There was some confusion about what educational resources may exist to further these goals—one of the areas which this report seeks to resolve.

DISCUSSION

Background

As outlined in Board of Trustees Report 5-I-18, "Exclusive State Control of Methadone Clinics," the AMA has been a strong supporter of methadone maintenance treatment (MMT) as an evidence-based option to help treat patients with an opioid use disorder. MMT has been used for more than 40 years to help patients, having been approved in 1972 by the U.S. Food and Drug Administration (FDA) for treatment of heroin addiction. The health and safety of methadone has been studied extensively and ample evidence exists supporting its use to aid in mortality and crime reduction.[1]

There are 1,685 certified opioid treatment programs (OTPs) offering methadone in the United States.[2] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the number of persons receiving methadone increased by 34 percent from 2006 (258,752) to 2016 (345,443).[3] With respect to opioid-related mortality, deaths attributed to methadone increased rapidly from 1999 (784 deaths) to their peak in 2007 (5,518) and have steadily declined since. In the past five years, for example, methadone-related mortality has decreased from 3,493 (2015) to 3,078 (2019), according to the Centers for Disease Control and Prevention.[4] It is beyond the scope of this report, however, to detail whether the methadone use in these deaths was for the treatment of pain, for opioid use disorder, related to illicit use or was a complicating polypharmacy factor. It is further beyond the scope of this report to try and ascertain how many of those persons were under the care of a physician or being treated in an OTP.

Administrative/legal requirements for dispensing methadone

SAMHSA has broad regulatory authority concerning MMT and OTPs. This includes the authority to certify an OTP, which is defined as "a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication registered under 21 USC 823(g)(1)."[5]

Regulations governing OTPs are generally contained in 42 CFR Part 8, which provides that the definition of "dispense" means "to deliver a controlled substance to an ultimate user by, or pursuant to, the lawful order of, a practitioner, including the prescribing and administering of a controlled substance." Any medication dispensed at an OTP must be dispensed by a health care professional licensed to do so under state law as well as registered under applicable state and/or federal law.[6] In most cases, methadone is dispensed on a daily basis to the patient at the OTP, and OTP staff must observe the patient taking the medication. Take-home use is permitted under federal regulations in certain situations—subject to considerable additional oversight, documentation and monitoring for appropriate use and preventing diversion.

Federal rules also provide that "methadone shall be administered or dispensed only in oral form and shall be formulated in such a way as to reduce its potential for parenteral abuse." 42 CFR Part 8 also requires that for each new patient enrolled in a program, the initial dose of methadone shall not exceed 30 milligrams and the total dose for the first day shall not exceed 40 milligrams, unless the program physician documents, in the patient's record, that 40 milligrams did not suppress opioid abstinence symptoms.

A study of primary care practices outside of an OTP providing MMT has been conducted.[7] For the study to take place, prior approval from state and county officials and the Drug Enforcement Administration (DEA) and extensive additional documentation was required. In addition, significant controls were required, including a highly motivated group of physicians, patients who were stable for at least one year on MMT and multiple administrative requirements including regular and random toxicology screens, patient assessments, close affiliation with a cooperative OTP, close relationships with pharmacists, counselors and other staff as necessary. Notably, the primary care practice was required to have an ongoing relationship with the community OTP.

Patient selection and care coordination were two additional keys to the program's positive outcomes. Of the 684 patients in the community OTP, 30 qualified and agreed to the primary care provider program managing their ongoing care. Of these, 445 of 449 urinalysis tests were negative, and all random callback urinalysis tests were positive for methadone and negative for other drugs of abuse. For at least this one study and primary care practice, adding 30 patients with complex medical needs may not cause undue strain on the practice—and even likely adds many benefits. In

other words, experimental primary care models to provide MMT are possible, but whether this study can be a model for other practices is not clear.

Other studies also found that patients stable on long-term MMT have benefited from having their care provided in a primary care setting outside of an OTP.[8] These studies also found that, in addition to low relapse and successful provision of additional primary care services (e.g., tobacco cessation, treatment for hypertension), there were increased services provided for treatment of infectious disease. Studies also found patient and physician satisfaction levels increased during the course of the study. In addition, physician education increased and there was a reduction in stigma.

Thus, while federal law has strict controls that methadone only be dispensed from an OTP, there have been experimental programs—subject to prior federal approval—that have demonstrated benefits of having MMT provided in a primary care setting outside of a traditional OTP. These experimental programs, however, are highly structured and still must comply with state and federal rules (including who can dispense, take-home rules for stable patients, patient monitoring, strict record-keeping, etc.) governing the provision of MMT.

Educational resources to support the provision of MMT

The AMA has broadly supported efforts to enhance physicians' education with respect to many aspects of the nation's opioid epidemic, including broad support for all forms of MAT. The AMA has broadly supported legislative and regulatory efforts at the state and federal levels to expand access to MAT. AMA model state legislation calls for all payers to make all forms of MAT available without prior authorization and placed on a formulary's lowest cost-sharing tier. AMA advocacy has led to more than one dozen states removing prior authorization for MAT, including methadone, in the commercial and/or Medicaid markets in 2019.

At the same time, a review of educational resources focused on methadone shows that the AMA opioid microsite (accessible here: www.end-opioid-epidemic.org) only has three titles focused on methadone education in its library of more than 400 resources.[9] There are, however, several physician-led organizations that have considerable education and training resources on a wide variety of areas related to methadone, including induction, ongoing maintenance, stigma and more. This includes the Providers Clinical Support System (PCSS), which is led by the American Academy of Addiction Psychiatry (and of which the AMA is a steering committee member), American Society of Addiction Medicine, the *Journal of the American Medical Association* and other trusted organizations and resources.

While it is speculative to know whether the identification and promotion of these resources would lead to increased numbers of primary care physicians either determining to open their own OTP, providing services in an OTP or even pursuing office-based opioid treatment options that do not include MMT, the Board strongly supports additional educational efforts to, at the very least, reduce the stigma of MMT and increase general knowledge about MMT.

AMA POLICY

AMA policy supports MMT as an evidence-based treatment for opioid use disorder and supports having stable patients treated in a traditional office-based setting (Policy H-95.957, "Methadone Maintenance in Private Practice"). AMA policy also supports the types of investigational studies described above to further efforts to enable office-based physicians to use MMT "to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols" (Policy H-95.957, "Methadone

Maintenance in Private Practice"). AMA policy also calls for broad support to expand MMT services (Policy D-95.999, "Reduction of Medical and Public Health Consequences of Drug Abuse: Update"). This includes broad support of OTPs (Policy H-95.921, "Exclusive State Control of Methadone Clinics"). With respect to physician dispensing, the AMA "supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines" (Policy H-120.990, "Physician Dispensing").

RECOMMENDATIONS

The Board recommends that the following recommendations be adopted in lieu of Resolution 202-I-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support further research into how primary care practices can implement MAT into their practices and disseminate such research in coordination with primary care specialties; (New HOD Policy)

2. That our AMA support efforts to expand primary care services to patients receiving methadone maintenance therapy (MMT) for patients receiving care in an Opioid Treatment Program or via office-based therapy; (New HOD Policy)

3. That the AMA Opioid Task Force increase its evidence-based educational resources focused on MMT and publicize those resources to the Federation. (Directive to Take Action)

Fiscal Note: $2,500

REFERENCES

[1] See, for example, Kleber HD. Methadone Maintenance 4 Decades Later. JAMA. 2008;300(19):2303–2305. doi:10.1001/jama.2008.648. Available at https://jamanetwork.com/journals/jama/fullarticle/182898
[2] Opioid Treatment Program Directory. Substance Abuse and Mental Health Services Association. Available at https://dpt2.samhsa.gov/treatment/directory.aspx https://dpt2.samhsa.gov/treatment/directory.aspx; last reviewed July 17, 2019.
[3] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2016 Data on Substance Abuse Treatment Facilities. Available at https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf
[4] https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-type-of-opioid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7DThe data points are from the predicted January 12-month total as reported by the National Vital Statistics System. Available at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#dashboard
[5] 42 CFR Part 8, available at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=3&SID=7282616ac574225f795d5849935efc45&ty=HTML&h=L&n=pt42.1.8&r=PART#se42.1.8_12
[6] 42 CFR Part 8.12(h)
[7] See, for example Joseph O Merrill, MD, MPH, et al, “Methadone Medical Maintenance in Primary Care, An Implementation Evaluation.” J Gen Intern Med. 2005 Apr; 20(4): 344–349.
[8] See, for example, Fiellin DA, O'Connor PG, Chawarski M, Pakes JP, Pantalon MV, Schottenfeld RS. Methadone Maintenance in Primary Care: A Randomized Controlled Trial. JAMA. 2001;286(14):1724–1731. doi:10.1001/jama.286.14.1724
[9] The resources that include “methadone” in the title on the microsite are from the American Society of Addiction Medicine and Providers Clinical Support System.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-19

Subject:	Restriction on IMG Moonlighting (Resolution 204-I-18)
Presented by:	Jesse M. Ehrenfeld, MD, MPH, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 204-I-18, "Restriction on IMG Moonlighting." Resolution 204 was introduced by the Resident and Fellow Section.

> Resolution 204 asks that our AMA advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight.

This report provides a brief background on the J-1 visa program and discusses the issues that are raised when considering changes to federal legislation that would allow physicians with a J-1 visa in fellowship training programs the ability to moonlight.

BACKGROUND

The U.S. generally requires citizens of foreign countries to obtain a U.S. visa prior to entry. Based on the purpose of travel, an individual may receive one of two types of visas: immigrant and non-immigrant. Immigrant visas are issued to individuals who wish to live in the U.S. permanently, while non-immigrant visas are issued to individuals with permanent residence outside the U.S. who wish to be in the U.S. temporarily for tourism, business, temporary work, or other specified purposes.

The Exchange Visitor (J) non-immigrant visa category is for individuals approved to participate in work- and study-based exchange visitor programs. The first step in pursuing an exchange visitor visa is to apply through a designated sponsoring organization in the U.S. Physicians may be sponsored for J-1 status by the Educational Commission for Foreign Medical Graduates (ECFMG) for participation in accredited clinical programs or directly associated fellowship programs. These sponsored physicians have J-1 "alien physician" status and pursue graduate medical education or training at a U.S. accredited school of medicine or scientific institution, or pursue programs involving observation, consultation, teaching, or research. The J-1 classification is explicitly reserved for educational and cultural exchange.

J-1 status physicians are participants in the U.S. Department of State (DoS) Exchange Visitor Program. The primary goals of the Exchange Visitor Program are to allow participants the opportunity to engage broadly with Americans, share their culture, strengthen their English language abilities, and learn new skills or build skills that will help them in future careers.

According to the DoS, for Calendar Year 2018, there were 2,738 new J-1 physicians participating in the exchange program. For CY 2018 the top three "sending countries" for J-1 physicians were: Canada 689; India 489; and Pakistan 248. The top three "receiving U.S. states" for J-1 physicians were: New York 556; Michigan 182; and Texas 163.[1]

DISCUSSION

A J-1 visa holder may only perform the curricular activity listed on his/her Form DS-2019, or as provided for in the regulations for the specific category for which entry was obtained and with the approval of the Sponsor's Responsible or Alternate Responsible Officer. As a result, J-1 physician participants are not currently permitted to engage in any work outside of their approved program of graduate medical education. If the proposed activity by the J-1 physician falls outside of the normal scope and/or is not a required component of the training program, then it is deemed to be "work outside of the approved training program" and not permitted for J-1 physicians.

In June 1999, the U.S. Information Agency issued a statement of policy on the Exchange Visitor Program. In the statement of policy, the agency specifically comments on the ability of J-1 physicians to moonlight, stating that, "…a foreign medical graduate is not authorized to 'moonlight' and is without work authorization to do so. A foreign medical graduate may receive compensation from the medical training facility for work activities that are an integral part of his or her residency program. The foreign medical graduate is not authorized to work at other medical facilities or emergency rooms at night or on weekends. Such outside employment is a violation of the foreign medical graduate's program status and would subject the foreign medical graduate to termination of his or her program."[2]

The Administration has further outlined its rationale on this issue in a formal Notice of Proposed Rulemaking (NPRM) and later a final rule which strengthens the program's oversight by requiring management reviews for Private Sector Program sponsors of, for instance, alien physicians. The final rule confirmed the policy prohibiting moonlighting as outlined in 22 U.S. Code of Federal Regulations (CFR) §62.16:

> 22 CFR (§62.16) – Employment
> (a) An exchange visitor may receive compensation from the sponsor or the sponsor's appropriate designee, such as the host organization, when employment activities are part of the exchange visitor's program.
> (b) An exchange visitor who engages in unauthorized employment shall be deemed to be in violation of his or her program status and is subject to termination as a participant in an exchange visitor program.
> (c) The acceptance of employment by the accompanying spouse and dependents of an exchange visitor is governed by Department of Homeland Security regulations.

Currently, 42 CFR §415.208 provides substantial regulations for the services of moonlighting residents who are not foreign nationals. Again, the particular purpose of the J-1 program is to increase mutual understanding between the people of the U.S. and the people of other countries by means of educational and cultural exchanges. Thus, because J-1 physicians are foreign nationals participating in an educational/cultural exchange program offered by the DoS, they are not permitted to moonlight or receive additional compensation outside of the J-1 visa program.

DoS' final rule states that strict oversight of the exchange program is critical as an affirmative step "to protect the health, safety and welfare of foreign nationals." When problems occur, "the U.S. Government is often held accountable by foreign governments for the treatment of their nationals,

regardless of who is responsible." Any changes to program policy that may weaken protections could have "direct and substantial adverse effects on the foreign affairs of the U.S.."[3]

In accordance with the DoS policy, the AMA also has strong and lengthy policy outlining the rights of residents/fellows and limiting duty hours to ensure patient safety and an optimal learning environment for these physicians.

Those in support of Resolution 204 argue that moonlighting will improve access to care for underserved populations in certain areas around the U.S. facing a physician shortage. Allowing J-1 physicians to moonlight would provide these physicians with an increased opportunity to provide care to underserved populations while at the same time garner increased training and education during their time in the U.S. However, under the current program's purpose and restrictions, as set out by the Administration, this activity is not possible without significant changes to the J-1 program.[4]

Both the DoS and ECFMG ultimately desire that the J-1 visa program remain as a training/education program for which participants are paid. According to the DoS and ECFMG, if the alien physician program shifts to something other than a training/education program, then it will receive increased scrutiny (as is the case regarding the au pair and summer work travel programs) and could potentially be absorbed into the current immigration discussions between the U.S. Congress and the Administration. While the Board understands and appreciates the intent of the sponsors of Resolution 204, we conclude that the focus of the J-1 program should remain on the training and education of the physicians in the program and that our AMA should not pursue changes that could create a risk to those physicians and potentially the entire program.

RECOMMENDATION

The Board recommends that our American Medical Association not adopt Resolution 204-I-18, "Restriction on IMG Moonlighting," and that the remainder of the report be filed.

Fiscal Note: Less than $500

[1] https://j1visa.state.gov/wp-content/uploads/2019/03/Alien-Physician-Flyer-2018-web.pdf
[2] https://www.govinfo.gov/content/pkg/FR-1999-06-30/pdf/99-16757.pdf, 64 Federal Register 34983
[3] https://www.govinfo.gov/content/pkg/FR-2014-10-06/pdf/2014-23510.pdf, 79 Federal Register 60305
[4] Id.

RELEVANT AMA POLICY

CME Report on Duty Hours, CME Report 5, A-14

Policy H-255.970, "Employment of Non-Certified IMGs"
Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs. Citation: (Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)

Policy H-310.907, "AMA Duty Hours Policy"
Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training: 1. Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards. 2. Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. 3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice. 4. Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities. 5. Our AMA encourages the ACGME to: a) Decrease the barriers to reporting of both duty hour violations and resident intimidation. b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits. c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules. d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours.6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: a) Offer incentives to programs/institutions to ensure compliance with duty hour standards. b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor. c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home. d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue. 7. Our AMA supports the following statements related to duty hours: a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-week period (Note: Total duty hours' includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients). b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period." f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident

education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of duty hours when need is demonstrated. g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty. h) Duty hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians. i) Scheduled time providing patient care services of limited or no educational value should be minimized. j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics. k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians. l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy. m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. n) The costs of duty hour limits should be borne by all health care payers. o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations. 8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety. CME Rep. 5, A-14

Policy H-310.912, “Residents and Fellows' Bill of Rights”
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines. 2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills. 3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows' Bill of Rights. 4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended. 5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. 6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENTS AND FELLOWS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice. With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings. B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. C. Regular and timely feedback and evaluation based on valid assessments of resident performance. With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request. D. A safe and supportive workplace with appropriate facilities. With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract. E. Adequate compensation and benefits that provide for resident well-being and health. (1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal. (2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences. (3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act. F. Duty hours that protect patient safety and facilitate resident well-being and education. With regard to duty hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-hour requirements are effectively circumvented. G. Due process in cases of allegations of misconduct or poor performance. With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA. H. Access to and protection by institutional and accreditation authorities when reporting violations. With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program

for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16

Policy H-310.979, "Resident Physician Working Hours and Supervision"
(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care. (b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents. (c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution's GME Committee must [m]onitor programs' supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements. (d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident. (e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times. (f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards. (g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services." (h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), "The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents' work that is extraneous to their GME programs' educational goals and objectives." These include patient support services, laboratory/pathology/radiology services, and medical records. (i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) "the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities." (j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. (2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.
CME Rep. C, I-87 Modified: Sunset Report, I-97 Modified and Reaffirmed: CME Rep. 2, A-08

Policy D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety"
Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.
Res. 314, A-03 Reaffirmation A-12

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-I-19

Subject: Opioid Mitigation
(Resolution 919-I-18)

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2018 Interim Meeting, the House of Delegates referred Resolution 919-I-18, "Opioid Mitigation," introduced by the Indiana Delegation, which asked:

> That our American Medical Association review the following opioid mitigation strategies based on their effectiveness in Huntington, WV, and Clark County, IN, and provide feedback concerning their utility in dealing with opioids:
>
> (1) The creation of an opioid overdose team that decreases the risk of future overdose and overdose death, increases access to opioid-related services and increases the likelihood that an individual will pursue drug rehabilitation.
>
> (2) A needle exchange program that is open multiple days a week and is mobile offers not only a source for needles but also Narcan, other supplies, health care and information.
>
> (3) The creation of a drug court that allows a judge to have greater flexibility in determining the legal consequences of an arrest for an opioid-related crime. It also allows for the judicial patience necessary to deal with the recidivism of this population.
>
> (4) Offering more acute-care inpatient drug rehab beds, although those ready for treatment need to be willing to travel significant distances to get to a treatment bed.
>
> (5) Make available Narcan intranasal spray OTC through pharmacies and the syringe exchange, overdose team, etc.
>
> (6) Encourage prevention education in K-12 programs that uses multiple media with anti-drug messaging delivered in the school system but also in the home.

This report takes each element of Resolution 919-I-18 and discusses relevant information. Additional discussion of the programs in Huntington, West Virginia and Clark County, Indiana is provided, as well as the relationship between the programs and existing AMA policy, ongoing AMA advocacy and other activities. This report makes several recommendations.

DISCUSSION

At a threshold level, determining the "effectiveness" of any program, initiative, treatment or policy aimed at ending the nation's opioid epidemic must focus on three main areas. First, does the program, initiative, treatment or policy result in improved care for patients with pain and/or evidence-based treatment for opioid use disorder? Second, does the program, initiative, treatment or policy increase access to evidence-based care for patients with pain and/or care for a person with pain or with a substance use disorder? And third, does the program, initiative, treatment or policy result in fewer people overdosing and dying?

This is not to suggest that these three areas are the only important metrics to consider, but they are three that are uniquely focused on improving patient outcomes and reversing the nation's opioid-related death toll. Using these three metrics, however, provides a consistent lens through which an evaluation can be made. At the same time, it is challenging to suggest that the programs underway in Huntington, West Virginia and Clark County, Indiana can easily be replicated in other jurisdictions. This is due to a variety of factors including support from policymakers and the general public, availability of state and federal resources and the unique socioeconomic, demographic, racial and ethnic differences between communities. In other words, what works in one community may provide lessons, but it may not be easily transferable to another community.

The AMA commends the efforts of Clark County, Indiana and Huntington, West Virginia, for their efforts to enhance access to treatment for opioid use disorder and reduce opioid-related morbidity and mortality.

Opioid overdose response teams

The City of Huntington, West Virginia was awarded a $2 million federal grant in January 2017 to support, among other things, a "Quick Response Team" (QRT) to help address the city's opioid epidemic.[1] The QRT is a multidisciplinary team that includes representatives from law enforcement, a paramedic, a faith-based leader and a health care provider. After an individual experiences an overdose and lives, the QRT visits the individual at the person's home. (Individuals also can be referred to the QRT without having to first experience an overdose.) According to news reports, the QRT provides non-judgmental information and assessment to provide referrals to treatment or other services. Data suggest that overdose has declined in Huntington, and the QRT is one of the reasons.[2] The use of QRTs is not unique to the City of Huntington, and in the communities where it has been used, the results appear positive.[3] One of the common features of the QRTs and similarly named efforts is that they are largely funded as grant or pilot programs. It is not clear whether the QRT model could be scaled to larger communities.

Needle and syringe exchange programs

The AMA has clear policy in support of the establishment of needle and syringe exchange programs, including encouraging state medical societies to support legislation and other efforts to provide injection drug users with needles and syringes without a prescription. This also includes protecting those who distribute needles and syringes from prosecution. The Clark County, Indiana Health Department correctly states "[p]ersons who inject drugs can substantially reduce their risk of getting and transmitting HIV, viral hepatitis and other blood borne infections by using a sterile needle and syringe for every injection."[4] According to the National Institute on Drug Abuse (NIDA):

> People who engage in drug use or high-risk behaviors associated with drug use put themselves at risk for contracting or transmitting viral infections such as human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or hepatitis. This is because viruses spread through blood or other body fluids. It happens primarily in two ways: (1) when people inject drugs and share needles or other drug equipment and (2) when drugs impair judgment and people have unprotected sex with an infected partner. This can happen with both men and women.[5]

NIDA also encourages use of the North American Syringe Exchange Network to help identify where needle and syringe exchange programs are available.[6] The Centers for Disease Control and Prevention (CDC) points to numerous benefits of needle and syringe service programs (SSP), including reducing the risk of infection, preventing outbreaks and preventing viral hepatitis, HIV, endocarditis and other infections. The CDC also notes that SSPs "serve as a bridge to other health services including, hepatitis C virus and HIV diagnosis and treatment and MAT for substance use." In addition, according to the CDC, "people who inject drugs who regularly use an SSP are more than five times as likely to enter treatment for a substance use disorder and nearly three times as likely to report reducing or discontinuing injection as those who have never used an SSP. SSPs do not increase illegal drug use or crime."[7]

One of the issues that has arisen with needle and syringe exchange services is that while some states and municipalities may allow distribution of sterile needles and syringes, the law may be less clear about the harm reduction organization possessing used needles and syringes.[8] The AMA has model legislation promoting needle and syringe exchange, but it has not been updated since May 2000, and would benefit from revisions to reflect current public health research and AMA policy.

Legal consequences for an opioid-related crime

The AMA Opioid Task Force (Task Force) recently issued a new recommendation that emphasizes that:

> all persons entering jails or prisons (both for men's and women's facilities), while incarcerated, and upon release, will benefit from enhanced opioid use disorder screening protocols to identify those persons arrested if they are currently on medication assisted treatment (MAT), or would like to begin treatment.

Furthermore, the Task Force also "supports the use of evidence-based protocols for maintaining continuity of care for persons released from jail or prison, including—as necessary—enrollment in Medicaid, coordination with peer counseling or other services to ensure the person has linkages to treatment providers in the community, and other such services so as to maintain access to and a continuum of care to sustain and promote recovery." Directly relevant to Resolution 919-I-18, the Task Force recommendation states, "[t]his recommendation also applies drug courts and other diversion services to support evidence-driven care for persons with an opioid use disorder."[9]

The Board strongly agrees with the need for the judicial system and correctional settings to view those with an opioid use disorder through a public health and medical lens. For example, AMA policy supports pregnant women who use drugs to receive treatment rather than be subject to criminal sanctions. Moreover, recent AMA advocacy has included strong support for increased access to MAT in jails and prisons[10] and the AMA was the lead amicus in a case supporting a person's right to receive MAT in a correctional facility.[11] Thus, it is not just an "opioid-related crime" that should be part of this discussion, but protection for evidence-based medical treatment for those with an opioid use disorder.

Sites of care for persons with a substance use disorder

One of the primary challenges in ending the nation's opioid epidemic remains the inability of most patients to obtain evidence-based care for a serious mental illness or substance use disorder. Of the nearly 57 million adults in the United States with a mental or substance use disorder, nearly 40 million did not receive any treatment in the previous year, according to the 2017 National Survey on Drug Use and Health (NSDUH).[12] More than 92 percent of those 12 and older did not receive treatment for a substance use disorder, according to the NSDUH.[13]

The fourth element of Resolution 919-I-18 raises multiple issues concerning sites of care, capacity of insurance networks, available addiction medicine and psychiatric care providers and related geographic realities of the availability of treatment providers. It would be challenging for any report to sufficiently address these complicated issues. In Huntington, West Virginia, securing enough local beds for acute or long-term care is an ongoing challenge.[14] In Clark County, Indiana, for example, local emergency departments work to either admit medically unstable patients for treatment, or a patient may be assessed to be cleared for outpatient management.

Capacity to treat all patients who require it, however, is an issue that affects the nation. While network adequacy laws require a sufficient number of addiction medicine and psychiatric physicians in a patient's network, health insurance companies are falling far short of their obligation and enforcement of these requirements is lacking. Moreover, payers also are falling short of compliance with state and federal mental health and substance use disorder parity laws.[15]

AMA advocacy in this regard has been substantial and multipronged—focusing on both increasing capacity and increasing payers' demand for mental health and substance use disorder providers. The AMA is working at the state and federal levels to strengthen network adequacy requirements and enforcement and promote meaningful oversight and enforcement of mental health and substance use disorder parity laws. AMA has partnered with the American Psychiatric Association, American Society of Addiction Medicine and many other organizations in the Federation to simultaneously address capacity and access and will continue to do so.

Naloxone has saved tens of thousands of lives

Naloxone is a lifesaving opioid antagonist that can reverse the effects of an opioid-related overdose. It has no potential for abuse. Naloxone is a 40-year old medication used mainly by first responders and medical staff. Due to its history of safe and effective use, states have enacted standing orders and other laws that permit anyone to obtain a naloxone prescription. The aim of such laws is to provide civilian bystanders who witness an overdose the ability to utilize the overdose reversing medication and save a life. Hundreds of towns and cities have seen the benefits of naloxone firsthand.

A 2017 study found that of opioid overdoses, bystanders were present 40 percent of the time, but naloxone was rarely administered until first responders arrived.[16] Between 2012 to 2016, the rate of emergency medical services (EMS) administered naloxone events increased by 75.1 percent (from 573.6 to 1004.4 administrations per 100,000 EMS events).[17] It is not known how often EMS or others administer multiple doses to a person experiencing an opioid-related overdose. Additionally, in 2018, the number of naloxone prescriptions reached a record high in the United States to more than 598,000 prescriptions, a 107 percent increase from 2017 and a 338 percent increase from 2016.[18] While it has been documented that naloxone can save lives, it is unknown how often it is used by all stakeholders or the number of naloxone administrations that are saving lives.[19]

AMA advocacy and partnership with harm reduction advocates and other stakeholders has resulted in every state enacting laws to increase availability of naloxone to patients, bystanders, first responders and others who may be in a position to help someone experiencing an overdose. AMA policy also supports standing orders, strong Good Samaritan protections, needle and syringe exchange and other harm reduction efforts. The AMA supports all forms of naloxone being made available—and does not endorse any specific brand or route of administration. Further, the AMA has called for naloxone manufacturers to submit applications for naloxone to receive over-the-counter status from the U.S. Food and Drug Administration. Moreover, the Task Force has been urging physicians to co-prescribe naloxone as one of its first recommendations in 2015[20], and AMA leadership emphasizes this message in nearly every public speaking engagement. These efforts must continue.

Education and prevention efforts for children and young adults

In reviewing the effectiveness of programs that "[e]ncourage prevention education in K-12 programs that uses multiple media with anti-drug messaging delivered in the school system but also in the home," two main themes emerge. First, education programs in Huntington, West Virginia and Clark County, Indiana do not exist in a vacuum. That is, the youth-focused education programs are part of both county- and state-wide efforts to increase awareness of the dangers of drug use. Second, it is not clear whether the programs are having a targeted and beneficial effect on reducing youth drug use or mortality. The State of Indiana does, however, promote a wide range of resources for parents ranging from "What every parent needs to know about Indiana's Opioid Epidemic" to "Indiana State Department of Health's Tips on Substance Use During Pregnancy: How to Have a Healthier Baby" to a "National Institute of Health 2017 National Drug & Alcohol IQ Challenge."[21] Huntington, West Virginia is also engaged in a wide number of areas ranging from programs aimed at high school and local college students, providing resources for parents, and working with multiple public health and law enforcement stakeholders.[22]

It is worth highlighting that AMA already has clear policy in support of a public health approach to: reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications; increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction (Policy D-95.981, "Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction").

AMA POLICY

Each of the areas covered in this report also has broad support in current AMA policy. This includes policy that "encourages all communities to establish needle exchange programs," and supports "legislation providing funding for needle exchange programs for injecting drug users" (Policy H-95.958, "Syringe and Needle Exchange Programs"). Current policy (and AMA model state legislation) also includes "support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level" (Policy D-95.977, "911 Good Samaritan Laws").

AMA also supports a public health—not criminal—approach to treatment for those who use illicit drugs or misuse prescription medication. This includes policy whereby "transplacental drug transfer should not be subject to criminal sanctions or civil liability" (Policy H-420.962, "Perinatal Addiction - Issues in Care and Prevention"). It also includes support for "the establishment of drug

courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; and encourages legislators to establish drug courts at the state and local level in the United States" (Policy H-100.955, "Support for Drug Courts").

AMA has extensive policy in support of widespread access to naloxone, including support for "legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery" (Policy H-95.932, "Increasing Availability of Naloxone").

Current AMA policy also broadly covers parity issues, including support for "health care reform that meets the needs of all Americans including people with mental illness and substance use/addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use/addiction disorders in all national health care reform legislation." (Policy H-165.888, "Evaluating Health System Reform Proposals") (Also see Policy D-180.998, "Insurance Parity for Mental Health and Psychiatry," Policy H-185.974, "Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs.")

RECOMMENDATIONS

The Board recommends that the following recommendation be adopted in lieu of Resolution 919-I-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) encourage relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and that the AMA share that information with the Federation; (Directive to Take Action)

2. That our AMA update model state legislation regarding needle and syringe exchange to state and specialty medical societies; (Directive to Take Action)

3. That our AMA amend Policy H-100.955, "Support for Drug Courts;"

   Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; ~~and~~ (2) encourages legislators to establish drug courts at the state and local level in the United States~~.~~<u>;</u> <u>and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.</u> (Modify Current HOD Policy)

4. That our AMA urge state and federal policymakers to enforce applicable mental health and substance use disorder parity laws; (Directive to Take Action)

5. That our AMA reaffirm Policy H-95.932, "Increasing Availability of Naloxone;" and (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-95.981, "Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction." (Reaffirm HOD Policy)

Fiscal Note: Less than $500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-19)

Introduced by: Medical Student Section

Subject: Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities

Referred to: Reference Committee B

Whereas, Substance Use Disorder (SUD) affects over 20.2 million people in America and have been shown to cause detrimental effects on mental and physical health[1]; and

Whereas, The Centers for Disease Control and Prevention declared the opioid epidemic a public health crisis, with over 200,000 deaths resulting from the epidemic in 2018[2]; and

Whereas, There are minimal standards for outpatient addiction rehabilitation facilities on a state and national level, which is uncharacteristic in other outpatient settings[3]; and

Whereas, There is a lack of evidence-based practices within outpatient addiction rehabilitation centers despite solid evidence of the efficacy of alternative treatments[4, 5]; and

Whereas, The fraudulent activity of outpatient addiction rehabilitation centers is a problem that faces many states across the country and has led to federal prosecutions in California and Florida[6, 7]; and

Whereas, The lack of regulation of outpatient addiction rehabilitation centers has led to facilities promoting unconventional and non-evidence-based therapies as effective and proven methods for treating SUDs[3, 8]; and

Whereas, The lack of regulation of outpatient addiction rehabilitation centers and their affiliates has led to the exploitation of patients and their insurance for monetary gain in the form of disbursements for sober homes who send patients to the respective facilities[6, 7, 9]; and

Whereas, The success of patients maintaining sobriety and improved social outcomes is largely dependent on continuing outpatient care following initial treatment[10]; and

Whereas, Meta-analysis and systematic review suggest that addiction rehabilitation can be made substantially more efficacious by increasing availability of simultaneous psychosocial and medication-based interventions[11, 12]; and

Whereas, Providing medication assisted treatment for SUDs after an inpatient stay or detoxification stay may help prevent future readmissions[13]; therefore be it

RESOLVED, That our American Medical Association advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000

Received: 08/28/19

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RELEVANT AMA POLICY

Substance Use and Substance Use Disorders H-95.922
Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.
Citation: CSAPH Rep. 01, A-18;

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981
1. Our AMA:
a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;
d. will consult with relevant agencies on potential strategies to actively involve physicians in being a part of the solution to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.
2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:
a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;
b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and
c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.
Citation: (CSAPH Rep. 2, I-08; Appended: Res. 517, A-15; Reaffirmed: BOT Rep. 5, I-15)

Medicaid Substance Use Disorder Coverage H-290.962
1. Our AMA will advocate that the Centers for Medicare and Medicaid Services provide expanded Medicaid payment coverage for the medical management and treatment of all substance use disorders.
2. Our AMA will advocate for clear billing and coding processes regarding the medical management and treatment of all substance use disorders.
3. Our AMA recognizes the expertise of addiction specialist physicians and the importance of improving access to management and treatment of addiction services with Medicaid payment for all physician specialties.
Citation: Res. 125, A-17;

Modernizing Privacy Regulations for Addiction Treatment Records H-315.965
Our AMA supports: (1) regulatory and legislative changes that better balance patients' privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders; (2) regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders; and (3) continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system.
Citation: Res. 224, I-17

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968
Our AMA will: (1) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (2) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.

Citation: Res. 222, A-18;

Substance Use Disorders During Pregnancy H-420.950
Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected.
Citation: Res. 209, A-18; Modified: Res. 520, A-19

Survey of Addiction Treatment Centers' Availability H-95.926
Our AMA: (1) encourages the Substance Abuse and Mental Health Services Administration (SAMHSA) to use its national surveys to increase the information available on the type of insurance (e.g., Medicaid, Medicare, private insurance) accepted by substance use disorder treatment programs listed in SAMHSA's treatment locators; (2) encourages physicians who are authorized to provide medication assisted treatment to opt in to be listed publicly in SAMHSA's treatment locators; and (3) encourages SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities.
Citation: CMS Rep. 04, A-17

Role of Self-Help in Addiction Treatment H-95.951
The AMA: (1) recognizes that (a) patients in need of treatment for alcohol or other substance use disorders should be treated for these medical conditions by qualified professionals in a manner consonant with accepted practice guidelines and patient placement criteria; and (b) self-help groups are valuable resources for many patients and their families and should be utilized by physicians as adjuncts to a treatment plan; and (2) urges managed care organizations and insurers to consider self-help as a complement to, not a substitute for, treatment directed by professionals, and to refrain from using their patient's involvement in self-help activities as a basis for denying authorization for payment for professional treatment of patients and their families who need such care.
Citation: Res. 713, A-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 01, A-18

Federal Drug Policy in the United States H-95.981
The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.

Perinatal Addiction - Issues in Care and Prevention H-420.962
Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and

breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.
Citation: (BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13)

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic.
2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts.
3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages.
4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines.
5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality.
Citation: Res. 321, A-08; Appended: Res. 522, A-10; Reaffirmed in lieu of Res. 518, A-12; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Appended: Res. 927, I-16; Appended: Res. 526, A-17; Modified: BOT Action in response to referred for decision Res. 927, I-16; Reaffirmed: Res. 235, I-18; Reaffirmed in lieu of: Res. 228, I-18; Reaffirmation: A-19;

Community-Based Treatment Centers H-160.963
Our AMA supports the use of community-based treatment centers for substance abuse, emotional disorders and developmental disabilities.
Citation: (BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-19)

Introduced by: Medical Student Section

Subject: Support for Veterans Courts

Referred to: Reference Committee B

Whereas, Veterans Courts are specialized state and local courts that provide alternatives to incarceration for veterans in the criminal justice system[1,2,3]; and

Whereas, Alternatives to incarceration can include treatment for medical illnesses that may be related to a veteran's military service and that may have caused the veteran to commit a criminal offense[1,2,3]; and

Whereas, These illnesses can include neurological and psychiatric conditions such as cognitive impairment, traumatic brain injury (TBI), depressive disorders, anxiety disorders, post-traumatic stress disorder (PTSD), chronic fatigue syndrome, attention-deficit and hyperactivity disorders, intermittent explosive disorder, and substance use disorders (SUDs)[1,3,4,5]; and

Whereas, Veterans Courts are based on the model provided by mental health treatment courts and drug courts, but they also provide specialized programs, resources, and personnel to support veterans based on their unique life experiences[3]; and

Whereas, The US Department of Veterans Affairs (VA) found 551 Veterans Court programs nationwide in 2018[2]; and

Whereas, The VA requires every VA-affiliated medical center in the US to have a Veterans Justice Outreach specialist to work with veterans in the criminal justice system, including with Veterans Courts[2]; and

Whereas, Veterans comprise approximately 8% of all federal and state prison inmates[6]; and

Whereas, 64% of incarcerated veterans were sentenced for violent offenses, compared to 48% of incarcerated non-veterans[6]; and

Whereas, Over 25% of a sample of non-deployed Army personnel were found to have psychiatric disorders, and over 11% were found to have multiple psychiatric disorders[4]; and

Whereas, 11-30% of veterans of the Iraq, Afghanistan, Gulf, and Vietnam wars have experienced PTSD, and 27% of veterans with PTSD have co-occurring SUDs[7,8]; and

Whereas, Over 20% of a sample of veterans of Iraq and Afghanistan were found to have mental illness, and over 10% were found to have co-occurring TBI and PTSD[9]; and

Whereas, PTSD and alcohol misuse were found to be associated with violent and physically aggressive behavior in a sample of veterans of Iraq and Afghanistan[10]; and

Whereas, Studies have found that treatment offered by Veterans Courts results in declines in recidivism rates by 12%; decreased symptoms of PTSD, depression, substance use, and sleep disturbances; and improvements in emotional and social well-being[11,12,13]; and

Whereas, Existing AMA policy "supports the establishment of drug courts" for individuals with SUDs[14]; therefore be it

RESOLVED, That our American Medical Association support the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 08/28/19

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; and (2) encourages legislators to establish drug courts at the state and local level in the United States. Citation: (Res. 201, A-12)

Court-Initiated Medical Treatments in Criminal Cases E-9.7.2
Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:
(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given. AMA Principles of Medical Ethics: I, III; Issued: 2016; Mod: 2017.

Expansion of US Veterans' Health Care Choices H-510.983
1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.
2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.
3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.
4. Our AMA will support consolidation of all the VA community care programs.
5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.
6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.
7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.
8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.
9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.
10. Our AMA will advocate for new funding to support expansion of the Veterans Choice. Citation: CMS Rep. 06, A-17

Access to Health Care for Veterans H-510.985
Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans. Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

Ensuring Access to Care for our Veterans H-510.986
1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
5. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.
Citation: Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15; Modified: Res. 820, I-18

Health Care Policy for Veterans H-510.990
Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).
Citation: (Sub. Res.115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

Veterans Administration Health System H-510.991
Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.
Citation: CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: CMS Rep. 01, A-19

Ethics Reform Act of 1989 (PL 101194) H-510.994
It is the policy of the AMA to work with representatives of [the] Central Office, Department of Veterans Affairs, to develop provisions to exclude either by regulation or by legislation part-time Department of Veterans Affairs physicians (as well as attending and consulting physicians) from the provisions of the Ethics Reform Act of 1989.
Citation: (Res. 254, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)

Budgetary and Management Needs of the Veterans Health Administration H-510.995
Our AMA urges Congress and the President to provide the VHA: (1) with funding sufficient to allow its hospitals and clinics to provide proper care to the patients the VHA is mandated to treat; and (2) with maximum flexibility in eliminating unneeded or duplicative services and in closing clinics or hospitals.
Citation: (BOT Rep. EE, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10)

Veterans Health Administration Health Care System D-510.999
Our AMA will: (1) urge state medical associations to encourage their members to advise patients who qualify for Veterans Health Administration (VHA) care of the importance of facilitating the flow of clinical information among all of the patient's health care providers, both within and outside the VHA system; (2) facilitate collaborative processes between state medical associations and VHA regional authorities, aimed at generating regional and institutional contacts to serve as single points of access to clinical information about veterans receiving care from both private physicians and VHA providers; and (3) continue discussions at the national level with the VHA and the Centers for Medicare and Medicaid Services (CMS), to explore the need for and feasibility of legislation to address VHA's payment for prescriptions written by physicians who have no formal affiliation with the VHA.
Citation: (CMS Rep. 1, A-03; Reaffirmed: CMS Rep. 4, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-19)

Introduced by: Medical Student Section

Subject: Support Expansion of Good Samaritan Laws

Referred to: Reference Committee B

Whereas, In 2016, drug overdoses killed 63,632 Americans, the leading cause of preventable death in the USA[1–3]; and

Whereas, Opioid overdose can be effectively reversed using the opioid antagonist naloxone[4,5]; and

Whereas, Between 21-68% of overdose bystanders call 911, but many delay or refrain from calling 911 altogether often due to fear of arrest[6,7]; and

Whereas, 46 states have passed some form of a “Good Samaritan Law” (GSL) as endorsed by our AMA (D-95.977) to provide limited immunity from drug-related offenses to people who seek medical assistance in the event of an overdose[8]; and

Whereas, Many people who use drugs are not aware these laws exist, one study found that two-thirds of those surveyed were unaware of GSLs[6]; and

Whereas, A study in New York found that bystanders with a correct understanding of GSLs were three times more likely to call 911 in the event of an overdose than those who had incorrect knowledge about GSLs[9]; and

Whereas, GSLs provide variable legal protection by state, which may confer protection against prosecution for specific crimes such as the possession of illicit/controlled substances, paraphernalia, and/or parole/pretrial/probation violations[6,10,11]; and

Whereas, A drug-induced homicide is defined as a crime in which a person delivered or provided drugs to another person that resulted in their death[12]; and

Whereas, GSLs do not provide protections for drug-induced homicide[7,13]; and

Whereas, Only Vermont and Delaware have specific laws that provide immunity for drug-induced homicide if a person seeks medical assistance[10]; and

Whereas, Some states have enacted “911 Medical Amnesty Laws” to protect individuals from arrest, prosecution or conviction of certain drug offenses if the evidence results from seeking medical assistance for someone thought to be suffering from a drug overdose[14]; and

Whereas, The enactment of aforementioned medical amnesty policies in cases of underage drinking have been shown to not increase consumption[15]; and

Whereas, As of 2016, 40 states had implemented medical amnesty laws protecting minors in alcohol related emergencies[16]; and

Whereas, Implementation of Medical Amnesty Protocols (MAP) did not result in increased drinking, overall consumption, or the incidence of physiological consequences[17]; and

Whereas, After the creation of MAP, Cornell students showed an increased willingness to seek help for alcohol related emergencies, and there was a 61% decrease in the students who cited fear of getting in trouble as the reason they did not call for help[15]; and

Whereas, The number of prosecutions of drug-induced homicide across the country has increased over 300% since 2011, with the Midwest accounting for a large portion of this increase; family members, friends, and partners are the frequent victims of these prosecutions[10,18–20]; and

Whereas, Increases in drug-induced homicide prosecutions are correlated with increases in fatal overdose rates and studies suggest this may be due to increased fear of calling for help[7,10,18]; and

Whereas, Research suggests that a lack of Good Samaritan laws can lead to conditions in which there are higher opioid-related deaths and decreased medical interventions--representing a real public health concern[21]; therefore be it

RESOLVED, That our American Medical Association amend Policy D-95.977 by addition and deletion to read as follows:

911 Good Samaritan Laws, D-95.977
Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; ~~and~~ (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan Laws. (Modify Current HOD Policy)

Fiscal note: Minimal - less than $1,000

Received: 08/28/19

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RELEVANT AMA POLICY

911 Good Samaritan Laws D-95.977

Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; and (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level.
Citation: (Res. 225, A-14)

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

Harm Reduction Through Addiction Treatment H-95.956

The AMA endorses the concept of prompt access to treatment for chemically dependent patients, regardless of the type of addiction, and the AMA will work toward the implementation of such an approach nationwide. The AMA affirms that addiction treatment is a demonstrably viable and efficient method of reducing the harmful personal and social consequences of the

inappropriate use of alcohol and other psychoactive drugs and urges the Administration and Congress to provide significantly increased funding for treatment of alcoholism and other drug dependencies and support of basic and clinical research so that the causes, mechanisms of action and development of addiction can continue to be elucidated to enhance treatment efficacy.
Citation: (Res. 411, A-95; Appended: Res. 405, I-97; Reaffirmation I-03; Reaffirmed: CSAPH Rep. 1, A-13)

Increasing Availability of Naloxone H-95.932
1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.
Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19

Support for Medical Amnesty Policies for Underage Alcohol Intoxication H-30.938
Our AMA supports efforts among universities, hospitals, and legislators to establish medical amnesty policies that protect underage drinkers from punishment for underage drinking when seeking emergency medical attention for themselves or others.
Citation: (Res. 202, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-19)

Introduced by New York

Subject: AMA Position on Payment Provisions in Health Insurance Policies

Referred to: Reference Committee B

Whereas, Certain health insurance policies require payments be sent to patients rather than physicians; and

Whereas, These policies occur primarily in out-of-network care settings, making it more difficult for the physician to collect payment for service rendered to the patient; and

Whereas, Health insurance companies are more frequently inserting provisions into their plan documents that prevent a patient from assigning their benefits to their doctor; and

Whereas, Such 'anti-assignment' provisions significantly harm both doctor and patient, are fundamentally unfair and have benefit only for the insurance company; therefore be it

RESOLVED, That our American Medical Association seek legislation to ban anti-assignment provisions in health insurance plans (Directive to Take Action); and be it further

RESOLVED, That our AMA support legislation requiring health insurers to issue payment directly to the physician when the patient or patient representative signs an agreement which permits payment directly to the physician. (Directive to Take Action)

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

Received: 09/19/19

RELEVANT AMA POLICY

Health Plan Payment of Patient Cost-Sharing D-180.979
Our AMA will: (1) support the development of sophisticated information technology systems to help enable physicians and patients to better understand financial obligations; (2) encourage states and other stakeholders to monitor the growth of high deductible health plans and other forms of cost-sharing in health plans to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability; (3) advocate for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing financial obligations (eg, deductibles, co-payments, and co-insurance) at the time of service; and (4) monitor programs wherein health plans and insurers bear the responsibility of collecting patient co-payments and deductibles.
CMS Rep. 09, A-19;

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.

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

Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans H-165.849

1. Our AMA opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering cash discounts for expedited payment, particularly for patients enrolled in health savings accounts (HSAs), health reimbursement arrangements (HRAs), and other consumer-directed health care plans.
2. Our AMA will engage in a dialogue with health plan representatives (e.g., America’s Health Insurance Plans, Blue Cross and Blue Shield Association) about the increasing difficulty faced by physician practices in collecting co-payments and deductibles from patients enrolled in high-deductible health plans.

CMS Rep. 3, I-05; Reaffirmed: CMS Rep. 1, A-15; Appended: BOT Action in response to referred for decision Res. 805, I-16; Reaffirmed: CMS Rep. 09, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-19)

Introduced by: Virginia, American Association of Clinical Urologists, West Virginia, New Jersey, Maryland, Alabama, Georgia, District of Columbia, Kentucky, Oklahoma, American Urological Association, Mississippi, Delaware, Illinois

Subject: Co-Pay Accumulators

Referred to: Reference Committee B

Whereas, Virginia is the first state in the nation to pass legislation regulating Co-Pay Accumulators. Under a Co-Pay Accumulator program the value of a manufacturer's copay coupon is unable to be counted towards the beneficiary's deductible or out of pocket maximum. Once the coupon's value is exhausted, the beneficiary is still responsible for the deductible before plan benefits commence; and

Whereas, Virginia Law, effective January 1, 2020, states "When calculating an enrollee's overall contribution to any out of pocket maximum, deductible, copayment, coinsurance, or other cost-sharing requirement under a health plan, a carrier shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person"; and

Whereas, Two other states, including West Virginia and Arizona, have passed similar legislation in Spring of 2019 prohibiting health insurance plans from enacting co-pay accumulator policies that do not count third-party financial assistance toward a patient's out-of-pocket expenses; and

Whereas, Several other states, including Illinois, Connecticut, Indiana, Kentucky, and North Carolina are considering passing their own laws to ban copay accumulator programs; therefore be it

RESOLVED, That our American Medical Association develop model state legislation based on the recent law enacted in Virginia regarding Co-Pay Accumulators. (Directive to Take Action)

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

Received: 08/29/19

VIRGINIA ACTS OF ASSEMBLY -- 2019 SESSION

CHAPTER 661

An Act to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.20, relating to health plans; calculation of enrollee's contribution to out-of-pocket maximum or cost-sharing requirement.

[H 2515]

Approved March 21, 2019

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.20 as follows:

§ 38.2-3407.20. Calculation of enrollee's contribution to out-of-pocket maximum or cost-sharing requirement.

A. As used in this section:

"Carrier" shall have the meaning set forth in § 38.2-3407.10; however, "carrier" also includes any person required to be licensed under this title that offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or that provides or arranges for the provision of health care services, health plans, networks, or provider panels that are subject to regulation as the business of insurance under this title.

"Cost sharing" means any coinsurance, copayment, or deductible.

"Enrollee" means any person entitled to health care services from a carrier.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury, or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract, or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, that is subject to state regulation and that is required to be offered, arranged, or issued in the Commonwealth by a carrier licensed under this title. "Health plan" does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

B. To the extent permitted by federal law and regulation, when calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a carrier shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person.

C. This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 2020.

D. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through ~~38.2-3407.19~~ *38.2-3407.20*, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541 through 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), §§ 38.2-3600 through 38.2-3607, Chapter 52

(§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) of this title shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through ~~38.2-3407.19~~ *38.2-3407.20*, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

PAN Foundation

Access to Healthcare: Info to Know

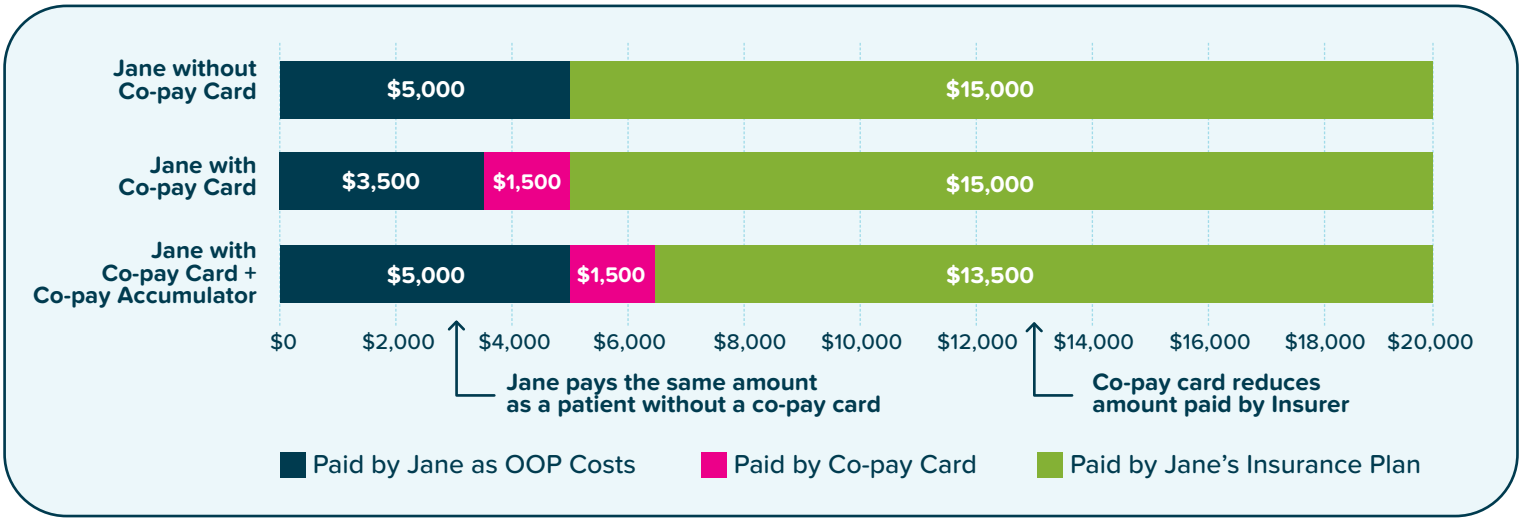
Co-pay Accumulator Programs

What is a Co-pay Accumulator Program?

» A co-pay accumulator program—also known as an accumulator adjustment program—is a new kind of policy being adopted by some insurance plans.
» These programs change the way a patient's out-of-pocket (OOP) medication costs are added up (accumulated) and applied toward meeting the OOP maximum under their insurance policy.
» OOP drug costs are the part of a patient's medication expenses not covered by insurance.
» **Deductibles**, **co-payments** and **coinsurance** are three types of OOP drug costs:
  • A **deductible** is the amount that a patient must pay before their insurance plan begins covering the cost of their medications.
  • A **co-payment** is a flat fee (ex: $10) that patients pay each time they fill a prescription.
  • **Coinsurance** is a percentage of the cost of each prescription that is filled.
  • Depending on the cost of the drug, some insurance plans have levels or "tiers" of co-payments/coinsurance, with higher OOP costs for more expensive drugs.

What Are Co-pay Cards and How Have They Been Used in the Past?

» Some drug manufacturers offer co-pay cards to help underinsured patients afford their prescription medications.
  • Only patients with commercial insurance can use these cards.
» Many patients use co-pay cards to help pay their deductibles, co-pays or coinsurance, and reduce their OOP drug costs.
» The illustration below shows the impact of a $1,500 co-pay card on the OOP drug costs for a hypothetical patient, Jane, with multiple sclerosis, who has:
  • $20,000 in drug costs for the year.
  • An insurance policy with maximum OOP costs of $5,000 (deductible + co-pays + coinsurance).
» Without a co-pay card, Jane would need to pay $5,000 in OOP costs to access her medications, with insurance covering the remaining $15,000.
» With a co-pay card, she would need to pay only $3,500 in OOP costs for the year.



What Happens to Patients Under Co-pay Accumulator Programs?

» Co-pay accumulator programs prevent patients from using co-pay cards to cover their OOP drug costs.

» In the example above, Jane no longer benefits from her $1,500 co-pay card.
- She must pay the full $5,000 in OOP costs to access her medications.
- These are the same OOP costs that would be paid by Jane without a co-pay card.

» For some patients, the extra OOP drug costs that are incurred under co-pay accumulator programs will make their prescription medications unaffordable. Many of these patients will:
- Stop their treatment.
- Reduce their dose, skip doses or cut pills to make their medication last longer.
- Be forced to choose between staying on their medication and covering other costs such as food, housing and utilities.

Who is Affected by Co-pay Accumulator Programs?

» Patients with commercial insurance—especially those who get insurance through their employers or through the Affordable Care Act.

» Co-pay accumulator programs are especially challenging for patients who:
- Require expensive medications.
- Have health insurance plans with high deductibles or high co-payments/coinsurance.
- Are economically vulnerable.

» *Many patients do not know that their health plans have co-pay accumulator programs until they get to the pharmacy counter and are confronted with unexpected OOP drug expenses.*

Steps You Can Take

- Find out if your health insurance plan has a co-pay accumulator program.
- Be sure you know your plan's annual deductible and the co-payments/coinsurance for the medications you take so that you understand what your OOP drug costs will be for your prescription medications.
- Talk to your benefits manager or health plan about how the co-pay accumulator program impacts your ability to remain on your treatment.
- Inform your healthcare provider that your insurance plan has a co-pay accumulator program, and how the program impacts your ability to cover the OOP costs for your medications.
- Share your story with a patient advocacy group.

The PAN Foundation

The mission of the PAN Foundation is to help underinsured people with life-threatening, chronic and rare diseases get the medications and treatment they need by paying for their out-of-pocket costs and advocating for improved access and affordability.

For more information about the PAN Foundation, visit www.panfoundation.org.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-19)

Introduced by: International Medical Graduates Section
Minority Affairs Section

Subject: Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians

Referred to: Reference Committee B

Whereas, One in four of the practicing physician workforce in the United States of America are trained at an international medical school[1]; and

Whereas, 41% of the international medical graduates (IMG) serve in the primary care disciplines, as defined by the Association of American Medical Colleges (AAMC), including internal medicine, family medicine, pediatrics and geriatrics[2]; and

Whereas, An American Medical Association and American Osteopathic Association database study showed that the IMGs are more likely to serve in the rural persistent poverty areas in primary care, compared to their U.S, counterparts and DOs[3]; and

Whereas, By 2030, an estimated shortage of between 14,800 and 49,300 primary care physicians has been projected by a recent American Association of Medical Colleges report[4]; and

Whereas, The U.S. population aged over 65 is estimated to grow over 50% by 2030 and one third of the currently active physicians will be older than 65 in the next decade[4]; and

Whereas, If people in the underserved and rural areas and people without insurance would use healthcare the same way as the people with insurance and the people in the metropolitan areas; an additional 31,600 physicians were needed in 2016[4]; and

Whereas, Critical access hospitals in underserved areas continue to face a crisis due to uncompensated care and limited retention of physicians; and

Whereas, The residents of the rural and underserved areas tend to be older, more chronically ill, of a lower socioeconomic background and uninsured[5], resulting in significant disparities in rural and urban health care status and life expectancy[6]; and

Whereas, The overall number of U.S. medical graduates choosing careers as general internist has declined over many years and retention of general practice physicians remained a persistent challenge in improving health care access in these areas[7]; and

Whereas, A current Conrad 30 Reauthorization Bill (Senate Bill S948) has proposed a pathway for IMGs to serve in the federally designated health professional shortage area (HPSA) with a majority of Medicare/Medicaid and uninsured population for a longer duration, an increased number of IMGs to be available in each state to serve in these areas and have incentives to serve and settle in these areas; therefore be it

RESOLVED, That our American Medical Association support efforts to retain and incentivize international medical graduates serving in federally designated health professional shortage areas after the current allocated period. (Directive to Take Action).

Fiscal Note: Minimal - less than $1,000

Received: 10/01/19

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4. Dall T, Reynolds R, Jones K, Chakrabarti R, Lacobuci W. Center for Workforce Studies. *The Complexities of Physician Supply and Demand: Projections from 2017-2032.* Washington, DC; Association of American Medical Colleges; 2019. https://aamc-black.global.ssl.fastly.net/production/media/filer_public/31/13/3113ee5c-a038-4c16-89af-294a69826650/2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf. Accessed August 14, 2019.
5. Rosenblatt RA, Chen FM, Lishner DM, et al.. The future of family medicine and implications for rural primary care physician supply. University of Washington, School of Medicine 2010; Available at: http://depts.washington.edu/uwrhrc/uploads/RHRC_FR125_Rosenblatt.pdf. Accessed August 14, 2019
6. Singh GK, Siahpush M. Widening rural-urban disparities in life expectancy, U.S., 1969-2009. Am J Prev Med. 2014
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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.
(12) will: (a) 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; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) 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.
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; Appended: Res. 323, A-19

Principles of and Actions to Address Primary Care Workforce H-200.949
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these

efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these

and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
Citation: CME Rep. 04, I-18

Improving Rural Health H-465.994
1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:

- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Study efforts to optimize rural public health.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-19)

Introduced by: Medical Student Section

Subject: Pharmaceutical Advertising in Electronic Health Record Systems

Referred to: Reference Committee B

Whereas, In certain Electronic Health Records (EHR) systems, there exist subtle, yet noticeable advertisements for pharmaceutical drugs; and

Whereas, Pharmaceutical advertising in EHRs generally appears in the administrative, consultation, or prescribing interface of EHR software as text-based advertisements or image-based banners[1]; and

Whereas, Advertisements in EHRs can include various types of information, such as treatment suggestions, recommendations for drug initiation and titration protocols, common side effects of medications, formulary coverage information, pictures of devices, and clinical trial-based evidence of a drug's efficacy; and

Whereas, Advertisements can be targeted based on physician specialty, target list, geography, past prescribing behavior, patient demographic, current therapy, or patient diagnosis on ICD-10 codes[2]; and

Whereas EHR infrastructure raises the obvious concern of whether advertising viewed by a physician within an EHR either consciously or unconsciously influences the physician's treatment[3]; and

Whereas, Patients may receive suboptimal care if there is physician bias in prescribing medications or treatments advertised in EHRs[3]; and

Whereas, Advertisements may lead to overprescribing of medications or treatments advertised or under prescribing of a less heavily advertised drug with better efficacy or lower cost[3]; and

Whereas, There exist a variety of revenue models for EHR systems, including but not limited to upfront costs for software, pay-to-play, data selling and boutique services; and

Whereas, Pharmaceutical advertising can be aimed at either patients (direct to consumer or DTC) or at physicians (direct to physician); and

Whereas, DTC advertising is regulated by the Food and Drug Administration (FDA) Division of Drug Marketing, Advertising and Communications via the Federal Food, Drug and Cosmetic Act of 1938[7]; and

Whereas, In 1969 regulations were passed specifically addressing pharmaceutical advertising to physicians, stating that ads may not be false or misleading, must present balanced

information of risks and benefits, include facts that are essential to the product's advertised uses, and must present a brief summary that mentions every risk in the product labeling[8]; and

Whereas, In 2002, the Secretary of Health and Human Services (HHS) passed a ruling that required all draft regulatory letters be reviewed by the FDA's office of chief counsel before they were sent to pharmaceutical companies, resulting in a decrease of warning letters[9]; and

Whereas, The AMA has nuanced existing policy regarding pharmaceutical companies' interactions with physicians; and

Whereas, The AMA recognizes that pharmaceutical marketing can unethically influence physicians and endanger the patient/physician relationship if done inappropriately, but when done appropriately may provide benefits to patients; and

Whereas, Existing AMA policies outline that pharmaceutical influence is only acceptable through certain avenues, and that the point of care deserves special consideration; and

Whereas, These existing policies underscore that pharmaceutical advertising with the potential to bias physicians must provide a benefit to the patient in order to be acceptable; and

Whereas, A 2013 review by Manchanda and Honka concludes that detailing (personal advertisement or sales of drugs to physicians by pharmaceutical sales representatives) does change physician prescribing practices in the short-term, however, there is not enough data to conclude whether these prescribing decisions positively or negatively affect patient health outcomes, or how large this effect my be[10]; and

Whereas, The U.S. Food and Drug Administration is limited in their oversight of pharmaceutical advertising practices that may unduly affect patient health and may lack sufficient resources to even complete the regulatory activities that are contained within their mandate; therefore be it

RESOLVED, That our American Medical Association encourage the Centers for Medicare and Medicaid Services to study the effects of direct-to-physician advertising at the point of care, including advertising in Electronic Health Record Systems (EHRs), on physician prescribing, patient safety, health care costs, and EHR access for small practices (Directive to Take Action); and be it further

RESOLVED, That our AMA study the ethics of direct-to-physician advertising at the point of care, including advertising in EHRs. (Directive to Take Action)

Fiscal Note: not yet determined

Date Received: 10/01/19

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RELEVANT AMA POLICY

Support of American Drug Industry H-100.995
Our AMA continues to support the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people.
Citation: (Sub. Res. 20, A-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10)

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988
1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.
2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:
(a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.
(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.
(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.
(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
(h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.
(i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.
3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.
4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.
5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.
6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.
7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.
8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.
10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.
12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.
13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).
14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer’s suggested retail price of those drugs.
Citation: BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07; BOT Action in response to referred for decision: Res. 927, I-15; Modified: BOT Rep. 09, I-16; Appended: Res. 236, A-17; Reaffirmed in lieu of: Res. 223, A-17; Reaffirmed in lieu of: Res. 112, A-19;

E-9.6.7 Direct-to-Consumer Advertisement of Prescription Drugs
Direct-to-consumer advertising may raise awareness about diseases and treatment and may help inform patients about the availability of new diagnostic tests, drugs, treatments, and devices. However, direct-to-consumer advertising also carries the risk of creating unrealistic expectations for patients and conflicts of interest for physicians, adversely affecting patientshealth and safety, and compromising patient physician relationships.

In the context of direct-to-consumer advertising of prescription drugs, physicians individually should:
(a) Remain objective about advertised tests, drugs, treatments, and devices, avoiding bias for or against advertised products.
(b) Engage in dialogue with patients who request tests, drugs, treatments, or devices they have seen advertised to:
(i) assess and enhance the patients understanding of the test, drug or device;
(ii) educate patients about why an advertised test, drug, or device may not be suitable for them, including providing cost-effectiveness information about different options.
(c) Resist commercially induced pressure to prescribe tests, drugs, or devices that may not be indicated.
(d) Obtain informed consent before prescribing an advertised test, drug, or device, in keeping with professional standards.
(e) Deny requests for an inappropriate test, drug, or device.
(f) Consider reporting to the sponsoring manufacturer or appropriate authorities direct-to-consumer advertising that:
(i) promotes false expectations;
(ii) does not enhance consumer education;
(iii) conveys unclear, inaccurate, or misleading health education messages;
(iv) fails to refer patients to their physicians for additional information;
(v) does not identify the target population at risk;
(vi) encourages consumer self-diagnosis and treatment.
Collectively, physicians should:
(g) Encourage and engage in studies that examine the impact of direct-to-consumer advertising on patient health and medical care.
(h) Whenever possible, assist authorities to enforce existing law by reporting advertisements that do not:
(i) provide a fair and balanced discussion of the use of the drug product for the disease, disorder, or condition;
(ii) clearly explain warnings, precautions, and potential adverse reactions associated with the drug product;
(iii) present summary information in language that can be understood by the consumer
(iv) comply with applicable regulations;
(v) provide collateral materials to educate both physicians and consumers.
AMA Principles of Medical Ethics: II,III
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

E-9.6.2 Gifts to Physicians from Industry
Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.
Gifts to physicians from industry create conditions that carry the risk of subtly biasingor being perceived to biasprofessional judgment in the care of patients.
To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:
(a) Decline cash gifts in any amount from an entity that has a direct interest in physicianstreatment recommendations.
(b) Decline any gifts for which reciprocity is expected or implied.
(c) Accept an in-kind gift for the physicians practice only when the gift:
(i) will directly benefit patients, including patient education; and
(ii) is of minimal value.
(d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students, residents, and fellowsparticipation in professional meetings, including educational meetings, provided:
(i) the program identifies recipients based on independent institutional criteria; and
(ii) funds are distributed to recipients without specific attribution to sponsors.
AMA Principles of Medical Ethics: II
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

Sample Medications H-120.991
Our AMA (1) continues to support the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge;
(2) reiterates that samples of prescription drug products represent valuable benefits to the patients;
(3) continues to support the availability of drug samples directly to physicians through manufacturers' representatives and other means, with appropriate safeguards to prevent diversion; and
(4) endorses sample practices that: (a) preclude the sale, trade or offer to sell or trade prescription drug samples; (b) require samples of prescription drug products to be distributed only to licensed practitioners upon written request; and (c) require manufacturers and commercial distributors of samples of prescription drug products and their representatives providing such samples to licensed practitioners to: (i) handle and store samples of prescription drug products in a manner to maintain potency and assure security; (ii) account for the distribution of prescription drug samples by maintaining records of all drug samples distributed, destroyed or returned to the manufacturer or distributor; and (iii) report significant thefts or losses of prescription drug samples.
Citation: (Sub. Res. 17, I-86; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed: Res. 516, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

E-9.2.7 Financial Relationships with Industry in Continuing Medical Education
In an environment of rapidly changing information and emerging technology, physicians must maintain the knowledge, skills, and values central to a healing profession. They must protect the independence and commitment to fidelity and service that define the medical profession.
Financial or in-kind support from pharmaceutical, biotechnology or medical device companies that have a direct interest in physicians recommendations creates conditions in which external interests could influence the availability and/or content of continuing medical education (CME). Financial relationships between such sources and individual physicians who organize CME, teach in CME, or have other roles in continuing professional education can carry similar potential to influence CME in undesired ways.
CME that is independent of funding or in-kind support from sources that have financial interests in physicians recommendations promotes confidence in the independence and integrity of professional education, as does CME in which organizers, teachers, and others involved in educating physicians do not have financial relationships with industry that could influence their participation. When possible, CME should be provided without such support or the participation of individuals who have financial interests in the educational subject matter.
In some circumstances, support from industry or participation by individuals who have financial interests in the subject matter may be needed to enable access to appropriate, high-quality CME. In these circumstances, physician-learners should be confident that vigorous efforts will be made to maintain the independence and integrity of educational activities.
Individually and collectively physicians must ensure that the profession independently defines the goals of physician education, determines educational needs, and sets its own priorities for CME. Physicians who attend CME activities should expect that, in addition to complying with all applicable professional standards for accreditation and certification, their colleagues who organize, teach, or have other roles in CME will:
(a) Be transparent about financial relationships that could potentially influence educational activities.
(b) Provide the information physician-learners need to make critical judgments about an educational activity, including:
(i) the source(s) and nature of commercial support for the activity; and/or
(ii) the source(s) and nature of any individual financial relationships with industry related to the subject matter of the activity; and
(iii) what steps have been taken to mitigate the potential influence of financial relationships.
(c) Protect the independence of educational activities by:
(i) ensuring independent, prospective assessment of educational needs and priorities;
(ii) adhering to a transparent process for prospectively determining when industry support is needed;
(iii) giving preference in selecting faculty or content developers to similarly qualified experts who do not have financial interests in the educational subject matter;
(iv) ensuring a transparent process for making decisions about participation by physicians who may have a financial interest in the educational subject matter;
(v) permitting individuals who have a substantial financial interest in the educational subject matter to participate in CME only when their participation is central to the success of the educational activity; the activity meets a demonstrated need in the professional community; and the source, nature, and magnitude of the individuals specific financial interest is disclosed; and
(vi) taking steps to mitigate potential influence commensurate with the nature of the financial interest(s) at issue, such as prospective peer review.
AMA Principles of Medical Ethics: I,V

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

E-10.6 Industry Representatives in Clinical Settings
Representatives of medical device manufacturers can play an important role in patient safety and quality of care by providing information about the proper use of their companiesdevices or equipment and by offering technical assistance to physicians. However, allowing industry representative to be present in clinical settings while care is being given also raises concerns. Their presence can raise pose challenges for patient autonomy, privacy, and confidentiality as well as safety and professionalism in care-giving.
Physicians have a responsibility to protect patient interests and thus have a corresponding obligation to exercise good professional judgment in inviting industry representatives into the clinical setting. Physicians should recognize that in this setting appropriately trained industry representatives function as consultants. Participation by industry representatives should not be allowed to substitute for training physicians to use devices and equipment safely themselves.
Physicians who invite industry representatives into the clinical setting should ensure that:
(a) The representatives participation will improve the safety and effectiveness of patient care.
(b) The representatives qualifications to provide the desired assistance have been appropriately screened.
(c) The patient is aware that an industry representative will facilitate care, has been informed about the scope and nature of the representatives role in care, and has agreed to the representatives participation.
(d) The representative understands and is committed to upholding medical standards of respect for patient privacy and confidentiality.
(e) The representative has agreed to abide by the policies of the health care institution governing his or her presence and clinical activities.
(f) The representative does not exceed the bounds of his or her training, is adequately supervised, and does not engage in the practice of medicine.
AMA Principles of Medical Ethics: I,IV,V
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

Use of Physician and Patient Prescribing Data in the Pharmaceutical Industry D-315.988
Our AMA will (1) work to control the use of physician-specific prescribing data by the pharmaceutical industry as follows: (a) implement a suitable "opt-out" mechanism for the AMA Physician Masterfile governing the release of physician-specific prescribing data to pharmaceutical sales reps by including appropriate restrictions in the AMA data licensing agreements; (b) communicate to physicians the resources available to them in reporting inappropriate behavior on the part of pharmaceutical sales representatives and the work the AMA has done and will continue to do on their behalf; and (c) work with Health Information Organizations (HIOs) to describe to physicians how their prescribing data are used and work to create access for physicians to view reports on their own prescribing data to enhance their clinical practice; and (2) assume a leadership position in both developing a Prescribing Data Code of Conduct for the Pharmaceutical Industry that dictates appropriate use of pharmaceutical data, behavior expectations on the part of industry, and consequences of misuse or misconduct, and in convening representatives from HIOs and the pharmaceutical companies to promulgate the adoption of the code of conduct in the use of prescribing data.
Citation: (BOT Rep. 24, I-04; Reaffirmed in lieu of Res. 624, A-05; Reaffirmation A-09; Reaffirmed: Res. 233, A-11)

Impact of Pharmaceutical Advertising on Women's Health D-105.996
1. Our AMA urges the US Food and Drug Administration (FDA) to assure that all direct-to-consumer advertising of pharmaceuticals includes information regarding differing effects and risks between the sexes.
2. Our AMA urges the FDA to assure that advertising of pharmaceuticals to health care professionals includes specifics outlining whether testing of drugs prescribed to both sexes has included sufficient numbers of women to assure safe use in this population and whether such testing has identified needs to modify dosages based on sex.
Citation: Res. 509, A-14;

Hospital Policies on Interactions with Industry H-225.948
1. Our AMA encourages all hospitals to adopt policies governing the interaction of hospital personnel--including both employed physicians and independent members of the medical staff, as well as other hospital staff--with pharmaceutical, medical device, and other industry representatives within the hospital setting. Such policies should: (a) be developed through a collaborative effort of the hospital's organized medical staff, administration,

and governing body, and approved by the organized medical staff; and (b) be consistent with applicable AMA policy and ethical opinions on the subject of medicine-industry interaction, including but not limited to:
E-1.001 Principles of Medical Ethics
E-5.0591 Patient Privacy and Outside Observers to the Clinical Encounter
E-8.03 Conflicts of Interest: Guidelines
E-8.031 Conflicts of Interest: Biomedical Research
E-8.0315 Managing Conflicts of Interest in the Conduct of Clinical Trials
E-8.047 Industry Representatives in Clinical Settings
E-8.06 Prescribing and Dispensing Drugs and Devices
E-8.061 Gifts to Physicians from Industry
E-9.0115 Financial Relationships with Industry in Continuing Medical Education
H-460.981 University-Industry Cooperative Research Ventures.
2. Our AMA will inform the American Hospital Association of the AMA's position on hospital policies governing the interaction of hospital personnel with pharmaceutical, medical device, and other industry representatives within the hospital setting.
Citation: (BOT Rep. 27, A-14)

E-3.2.4 Access to Medical Records by Data Collection Companies
Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicianstreatment recommendations, such as pharmaceutical or medical device companies.
Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.
Physicians who propose to permit third-party access to specific patient information for commercial purposes should:
(a) Only provide data that has been de-identified.
(b) Fully inform each patient whose record would be involved (or the patients authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.
Physicians who propose to permit third parties to access the patients full medical record should:
(c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.
(d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.
(e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.
AMA Principles of Medical Ethics: I,II,IV
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-19)

Introduced by: Medical Student Section

Subject: Net Neutrality and Public Health

Referred to: Reference Committee B

Whereas, Net neutrality is the principle that Internet Service Providers (ISPs) should treat all content on the internet equally, without discriminating based on the content provided[1]; and

Whereas, In 2010, the Open Internet Order was passed by the FCC, which revolved around three basic tenets: transparency, no blocking and no unreasonable discrimination[1]; and

Whereas, In 2015, the FCC voted to reclassify broadband internet services as telecommunication services under Title II of the Communications Act, thereby subjecting services to more stringent regulation including bans on content throttling and paid prioritization; and

Whereas, Bandwidth throttling occurs when ISPs intentionally slow down the speed of a specific internet service[3]; and

Whereas, Paid prioritization occurs when ISPs provide faster internet services to companies who are willing to pay more based off a tiered system for data delivery speed[3]; and

Whereas, In December 2017, the FCC voted to reverse its prior decision and subsequently passed the Restoring Internet Freedom Initiative,[4] which removed the classification of broadband services as a telecommunication platform in Title II; and

Whereas, In 2019, the Save the Internet Act of 2019 was introduced in the House of Representatives[6] and if passed, the bill would reverse the Restoring Internet Freedom Initiative of 2017; and

Whereas, Advocates for the Restoring Internet Freedom Initiative argue that the repeal of net neutrality will promote investment and broadband implementation[4]; and

Whereas, Advocates of the Save the Internet Act express concern that the repeal of net neutrality may stifle competition and give ISPs a disproportionate amount of control over internet access and its functions[3]; and

Whereas, Existing AMA policy generally promotes increasing patient access to electronic health data, encouraging innovation and competition amongst technology vendors, and removing barriers to internet-based care; and

Whereas, The AMA supports increasing patient access to healthcare information and encourages innovation and competition in electronic healthcare; and

Whereas, The repeal of net neutrality could allow companies to place limits on how, where, and when patients and providers are able to access this healthcare data and allow companies to pursue policies that lessen both innovation and competition in healthcare technology, or increase the cost of healthcare delivery, thus negatively impacting both providers and patients; and

Whereas, Repealing net neutrality creates the possibility that internet service providers could potentially begin charging an additional fee to transmit health data which could add significant costs that may ultimately be passed on to patients, and potentially further cripple the fiscal viability of Medicare and Medicaid; and

Whereas, A non-neutral internet has the potential to raise the barrier of entry for new firms wishing to operate in the healthcare space and to disrupt the natural process of innovation by placing established, well-funded companies at an inherent advantage over those which are smaller and less funded; and

Whereas, The potential exists for internet service providers to establish “fast lanes” which would prioritize delivery of specific data over that of others; and

Whereas, In a non-neutral internet, there would be no compelling force to stop an ISP from giving preference to traffic related to its own companies or services over those of competing firms; and

Whereas, Hospitals could be charged a premium to access these premium networks and costs could potentially get passed on to patients; and

Whereas, Patients, healthcare providers, insurance companies, and taxpayers could face fewer options, lower quality service, and higher costs; and

Whereas, The FCC has yet to make a statement on how a non-neutral internet would specifically impact telehealth and there are no current guidelines or rules from the FCC that will ensure affordability and accessibility of telemedicine; and

Whereas, Although the FCC argued in defense of the net neutrality repeal stating that paid prioritization would benefit latency-sensitive telemedicine, these technologies were already specifically highlighted as eligible for paid prioritization waivers under the previous Open Internet ruling[14]; and

Whereas, Paid prioritization has the potential to further drive up cost requirements for mobile health, thus becoming prohibitive for many app developers and users; therefore be it

RESOLVED, That our American Medical Association advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose internet data transmission practices that reduce market competition in the health ecosystem. (Directive to Take Action)

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

Date Received: 10/01/19

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RELEVANT AMA POLICY:

Health Information Technology Principles H-478.981
Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:
1. Enhance physiciansability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.
Our AMA will AMA utilize HIT principles to:
1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of Information Blocking.
Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.
Citation: BOT Rep. 19, A-18; Reaffirmation: A-19;

Promoting Internet-Based Electronic Health Records and Personal Health Records D-478.979
Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.
Citation: (BOT Rep. 11, I-11)

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.
Citation: Res. 208, I-18;

Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians D-478.976
1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs-open source and proprietary-to create more transparency and support more informed decision making in the selection of EHRs.
2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.
3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.
4) Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.
Citation: BOT Rep. 23, A-13; BOT Rep. 24, A-13; Reaffirmed: BOT Rep. 17, A-15; Appended: Res. 603, I-16; Modified: BOT Rep. 20, A-17;

Opposition to Nationalized Health Care H-165.985
Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:
(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.
(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services.
(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.
(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.
(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.
(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.
(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care,

and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.
(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.
Citation: BOT Rep. U, I-88; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 110, A-94; Reaffirmed: CMS Rep. 7, I-97; Reaffirmed by CMS Rep. 9, A-98; Reaffirmed: CMS Rep. 4, A-99; Reaffirmation I-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 112, A-09; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Modified: Speakers Rep., A-14; Reaffirmed: CMS Rep. 09, A-19;

Information Technology Standards and Costs D-478.996
1. Our AMA will:(a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;(b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;(c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems;(d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and(e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2.Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.
Citation: Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-19)

Introduced by: American Society of Transplant Surgeons

Subject: Federal Government Regulation and Promoting Patient Access to Kidney Transplantation

Referred to: Reference Committee B

Whereas, Kidney transplantation is the best and most cost-effective treatment for many patients with End Stage Renal Disease (ESRD); and

Whereas, Executive Order on Advancing American Kidney Health[1], issued on July 10, 2019, seeks to increase patient choice through affordable ESRD therapy by encouraging higher value care; and

Whereas, The Executive Order intent is to increase access to kidney transplants by modernizing the organ recovery and transplantation systems and updating outmoded and counterproductive regulations; and

Whereas, There exist comprehensive patient-oriented care models[2] designed with physician input to promote access to transplantation; and

Whereas, Dialysis and transplant professional[3-5] as well as patient-centered groups[5,6] favor physician-advised patient choice of kidney transplantation in ESRD treatment; and

Whereas, Payment models creating incentives for greater use of kidney transplants for ESRD Medicare beneficiaries have been proposed; therefore be it

RESOLVED, That our American Medical Association engage US government regulatory and professional organ transplant organizations to advance patient and physician-directed care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further

RESOLVED, That our AMA actively promote regulatory efforts to assure physician and patient involvement in the design of any ESRD federal demonstration program (Directive to Take Action); and be it further

RESOLVED, That our AMA actively advocate for legislative and regulatory efforts which create incentives for dialysis providers, transplant centers, organ donors, and ESRD patients to increase organ donation and improve access to kidney transplantation in the United States. (Directive to Take Action).

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

Received: 10/02/19

References:
1. Executive Order on Advancing American Kidney Health, Issued on July 10, 2019
2. Center for Medicare and Medicaid Innovation Comprehensive ESRD Care Model: https://innovation.cms.gov/initiatives/comprehensive-esrd-care/
3. American Society of Transplant Surgeons: The ASTS-AST-AOPO-AAKP Joint Letter on Dialysis PATIENTS Demonstration Act of 2017: https://asts.org/docs/default-source/legislative/joint-letter-on-the-house-patients-act-december-1-2017.pdf?sfvrsn=94227ed3_2
4. DCI: Letter 2 November, 2017: http://asts.org/docs/default-source/test-document-library/dci-h-r-4143-letter-11-02-17.pdf?sfvrsn=83987fd3_2
5. American Association of Kidney Patients and the American Society of Nephrology: Letter 28 February, 2018: http://asts.org/docs/default-source/test-document-library/asn-aakpletter-patientact-housesenate_2018-2-18.pdf?sfvrsn=82987fd3_4
6. The FAIR Foundation: www.FAIRfoundation.org : Policy adopted 28 January, 2018

RELEVANT AMA POLICY

Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962
Our AMA supports federal funding of organ transplants for Medicaid patients.
Citation: (BOT Rep. 15, A-13)

Ethical Procurement of Organs for Transplantation H-370.967
Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary.
Citation: BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18;

UNOS Kidney Paired Donation Program H-370.960
Our AMA: (1) encourages the continued expansion of the United Network for Organ Sharing's (UNOS) Kidney Paired Donation program which provides a national registry of living donors, carries out ongoing data collection on key issues of concern in transplantation from living donors, and through its operational guidelines provides consistent, national standards for the transplant community; and (2) encourages voluntary coordination among private donor registries and UNOS to enhance the availability of organs for transplantation.
Citation: (BOT Action in response to referred for decision Res. 2, A-13)

Cost-Saving Public Coverage for Renal Transplant Patients H-370.963
1. Our AMA supports private and public mechanisms that would extend insurance coverage for evidence-based treatment of renal transplant care for the life of the transplanted organ.
2. Our AMA will continue to offer technical assistance to individual state and specialty societies when those societies lobby state or federal legislative or executive bodies to implement evidence-based cost-saving policies within public health insurance programs.
Citation: (Res. 104, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-19)

Introduced by: American Society of Transplant Surgeons

Subject: Federal Government Regulation and Promoting Renal Transplantation

Referred to: Reference Committee B

Whereas, Kidney transplantation is the best and most cost-effective treatment for many patients with End Stage Renal Disease (ESRD); and

Whereas, The Executive Order on Advancing American Kidney Health[1], issued on July 10, 2019, seeks to increase patient choice through affordable ESRD therapy by encouraging higher value care; and

Whereas, The Executive Order intent is to increase access to kidney transplants by modernizing the organ recovery and transplantation systems while updating outmoded and counterproductive regulations[2]; and

Whereas, Factors leading to deceased donor kidney discard in the US have been identified to include donors who are older and or have co morbidities such as diabetes and hypertension[3]; and

Whereas, Recent studies have shown that more than 2500 kidneys (>17% of those recovered from deceased donors) were discarded in 2013 despite evidence that many of these kidneys would provide a survival benefit to certain wait-listed patients[4]; and

Whereas, Studies have documented that excessive regulation and oversight have led transplant centers to risk-aversion donor criteria which exclude kidneys which could benefit many patients[5-7]; therefore be it

RESOLVED, That our American Medical Association actively advocate for US organ transplant legislative and regulatory policies that would advance kidney transplantation by modifying or eliminating arbitrary transplant center outcomes measures that currently discourage sound clinical judgment by physicians and surgeons to accept and transplant kidneys suitable for many patients. (Directive to Take Action)

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

Received: 10/02/19

References:
1. Executive Order on Advancing American Kidney Health, Issued on July 10, 2019
2. American Society of Transplant Surgeons: The ASTS Letter re: CMS-3346-P; Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CoPs) (Proposed Rule); RIN 0938- https://asts.org/docs/default-source/regulatory/asts-comments-on-pfs-qpp-2019-proposed-rule-september-10-2018.pdf?sfvrsn=14b040d3_
3. Mohan S, Chiles MC, Patzer RE, Pastan SO, Husain SA, Carpenter DJ, Dube GK, Crew RJ, Ratner LE, Cohen DJ. Factors leading to the discard of deceased donor kidneys in the United States. Kidney Int. 2018 Jul;94(1):187-198.
4. Reese PP, Harhay MN, Abt PL, Levine MH, Halpern SD. New Solutions to Reduce Discard of Kidneys Donated for Transplantation. J Am Soc Nephrol. 2016 Apr;27(4):973-80.
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6. Kadatz M, Gill JS. Compelling Evidence of the Need for Policy Change to Decrease Deceased Donor Kidney Discard in the United States: Waste Not Want Less. Clin J Am Soc Nephrol. 2018 Jan 6;13(1):13-15
7. Ouayogodé MH. Quality-based ratings in Medicare and trends in kidney transplantation. Health Serv Res. 2019 Feb;54(1):106-116.

RELEVANT AMA POLICY

Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962
Our AMA supports federal funding of organ transplants for Medicaid patients.
Citation: (BOT Rep. 15, A-13)

Ethical Procurement of Organs for Transplantation H-370.967
Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary.
Citation: BOT Rep. 13, A-08; Reaffirmed: CEJA Rep. 06, A-18;

Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool H-370.958
1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation.
2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates.
3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation.
Citation: (Res. 7, I-15)

6.2.1 Guidelines for Organ Transplantation from Deceased Donors
Transplantation offers hope to patients with organ failure. As in all patient-physician relationships, the physicians primary concern must be the well-being of the patient. However, organ transplantation is also unique in that it involves two patients, donor and recipient, both of whose interests must be protected. Concern for the patient should always take precedence over advancing scientific knowledge.
Physicians who participate in transplantation of organs from deceased donors should:
(a) Avoid actual or perceived conflicts of interest by ensuring that:
(i) to the greatest extent possible that the health care professionals who provide care at the end of life are not directly involved in retrieving or transplanting organs from the deceased donor. Physicians should encourage health care institutions to distinguish the roles of health care professionals who solicit or coordinate organ transplantation from those who provide care at the time of death;
(ii) no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death.

(b) Ensure that death is determined by a physician not associated with the transplant team and in accordance with accepted clinical and ethical standards.
(c) Ensure that transplant procedures are undertaken only by physicians who have the requisite medical knowledge and expertise and are carried out in adequately equipped medical facilities.
(d) Ensure that the prospective recipient (or the recipients authorized surrogate if the individual lacks decision-making capacity) is fully informed about the procedure and has given voluntary consent in keeping with ethics guidance.
(e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment.
(f) Ensure that organs for transplantation are treated as a national, rather than a local or regional, resource.
(g) Refrain from placing transplant candidates on the waiting lists of multiple local transplant centers, but rather place candidates on a single waiting list for each type of organ.
AMA Principles of Medical Ethics: I,III,V
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

Methods to Increase the US Organ Donor Pool H-370.959
In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs, including educational programs that address identified factors influencing attitudes toward organ donation and targeted to populations with historically low organ donation rates; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues.
Citation: BOT Rep. 13, A-15; Reaffirmed in lieu of: Res. 002, I-16; Modified: CSAPH Rep. 02, I-17;

Organ Donation D-370.985
Our AMA will study potential models for increasing the United States organ donor pool.
Citation: Res. 1, A-14; Reaffirmed in lieu of Res. 5, I-14; Reaffirmed in lieu of: Res. 002, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-19)

Introduced by: Michigan

Subject: Effects of Net Neutrality on Public Health

Referred to: Reference Committee B

Whereas, “Net neutrality” is the principle that, “all traffic on the Internet should be treated the same,” by preventing interference of the flow of content, services, and applications by internet service providers (ISPs); and

Whereas, ISPs are business entities who provide internet services and host websites; and

Whereas, Federal Communications Commission (FCC) Order 15-24 (2015) classified ISPs as Title II information providers per the Telecommunications Act of 1996, thereby subsuming ISPs to “common carrier” categorization; and

Whereas, A “common carrier” is a private entity that facilitates the free flow of commerce by transportation, communications, and other services, with the legal obligation of doing so in a non-discriminatory and censorship free manner; and

Whereas, Recent repeal of comprehensive net neutrality rules now removes Title II regulations on ISPs, and by extension, their “common carrier” classification; and

Whereas, ISPs are now able to block content from websites or apps, throttle--slow---bandwidth, and prioritize hosting sites, i.e. “fast lane” programs, for entities willing to pay premiums; and

Whereas, Throttling and regulating quality of service (QoS) would alter end user choice of service, thereby increasing discrimination and segmentation of internet access for consumers; and

Whereas, “Health” loosely describes a compendium of disparate themes (e.g., myriad health, commerce, and technology such as internet services); and

Whereas, Individuals with greater internet access are more likely to use eHealth and eHealth users are more likely to visit a doctor, use preventative health measures, have shorter hospital stays, and have overall better health outcome; and

Whereas, Net neutrality, in facilitating “health,” potentially improves patient services, reduces health care costs, and improves population health; and

Whereas, Individual pricing of internet access could lead to the favorability of certain services and contents, including but not limited to, health insurance options, telehealth services, and electronic health record services; and

Whereas, Telehealth has been shown to improve health care for those with limited access to health care through services such as remote rehabilitation and maternal and child health; and

Whereas, ISPs such as Verizon and Comcast are heavily invested in health care companies such as Oncare and Onpatient respectively; and

Whereas, Net neutrality repeal may decrease consumer access to health care and insurance providers, and further contribute to the increasing prices of pharmaceutical products via the prioritization of certain drug providers; and

Whereas, Net neutrality repeal may lead to deficits in medical training, insofar as net neutrality promotes open access resources to which physicians-in-training turn; therefore be it

RESOLVED, That our American Medical Association amend current policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities," by addition and deletion as follows:

> Increasing ~~Access to Broadband~~ Internet Access to Reduce Health Disparities
> Our AMA: (1) will advocate for net neutrality; and (2) will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/03/19

Sources:
1. Susanto, C. Net Neutrality and a Fast Lane for Health. Journal of Legal Medicine. 2017; 37(1-2), 105-131.
2. Firmin, Maloba Mbuya. Net Neutrality and Scenarios of Internet Pricing. International Journal of Computer Science Issues. 2017; 14.1: 108-14
3. Report and Order on Remand, Declaratory Ruling, and Order, 30 FCC Rcd 5601 (7). 2015
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5. Declaratory Ruling, Report and Order, and Order, 33 FCC Rcd. 311. 2018
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8. Gaynor, M. et al. It's Hard To Be Neutral About Network Neutrality For Health. Health Affairs Blog. August 18, 2014.
9. Demirci J, Kotzias V, Bogen D, Ray K, Uscher-Pines L. Virtual Breastfeeding Support via Mobile App: Perspectives of Rural Mothers, Their Care Providers, and Lactation Consultants. Telemedicine and eHealth. 2018; doi:10.2196/preprints.10103.
10. Ihrig C. Travel Cost Savings and Practicality for Low-Vision Telerehabilitation. Telemedicine and e-Health. 2018. doi:10.1089/tmj.2018.0092.
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RELEVANT AMA POLICY

Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.
Citation: Res. 208, I-18;

Promoting Internet-Based Electronic Health Records and Personal Health Records D-478.979
Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.
Citation: (BOT Rep. 11, I-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-19)

Introduced by: Michigan

Subject: Centers for Medicare and Medicaid Services Open Payments Program

Referred to: Reference Committee B

Whereas, The Physician Payments Sunshine Act (Sunshine Act) was enacted along with the 2010 Patient Protection and Affordable Care Act; and

Whereas, The Sunshine Act is a law that was designed to increase transparency of financial relationships between physicians, teaching hospitals, and manufacturers of drugs, medical devices, biologics, and medical supplies and to uncover potential conflicts of interest by disclosing this information to the public; and

Whereas, The Sunshine Act requires manufacturers of drugs, medical devices, biologics, and medical supplies covered by the three federal health care programs, Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP), to collect and track all financial relationships with physicians and teaching hospitals and to report these data to the Centers for Medicare and Medicaid Services (CMS); and

Whereas, The Centers for Medicare and Medicaid Services (CMS) fulfills the law's mandate through the CMS Open Payments Program as a national disclosure program; and

Whereas, On September 30, 2014, CMS reported payment information on its Open Payments Program website for the first time, reporting attribution of payments data from 2012; and

Whereas, The CMS Open Payments Program data may be inaccurate due to erroneous reporting of the payment amount, payment reason, and/or name of the physician receiving the payment; and

Whereas, Inaccurate reporting may reflect unfairly on a physician's reputation and/or employment arrangement, including inaccurate reporting of potential conflicts of interest; and

Whereas, Understanding how payments are attributed and what may be legally recorded by the pharmaceutical companies is important to protect physicians; and

Whereas, In 2013, the American Medical Association (AMA) offered physicians training to understand the Sunshine Act and its implications; and

Whereas, Many physicians are unaware of the potential need to check the CMS Open Payments Program website and review any attributed payments to avoid any inaccurate potential conflicts of interest; and

Whereas, The available time frame to review and dispute these payments is limited to the calendar year in which the attributed payment is reported; and

Whereas, The process for disputing payments is time consuming to complete; and

Whereas, The pharmaceutical companies are listed on the site with only payments to physicians or teaching hospitals listed; and

Whereas, Some states are allowing pharmacists to prescribe some medications, either as a direct legal change in the laws of that state or as a potential delegated option by physicians, and

Whereas, The prescribing of medications and/or the prior authorization process may increasingly be directly influenced by pharmacists and Pharmacy Benefit Managers (PBMs); and

Whereas, Pharmacists and PBMs are not reported for the attribution of any payments within the CMS Open Payments Program in spite of the increasing influence of pharmacists and/or PBMs on the prescribing habits of physicians and teaching hospitals; therefore be it

RESOLVED, That our American Medical Association amend current policy H-140.848, "Physician Payments Sunshine Act," by addition and deletion to read as follows:

Our AMA will: (1) continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by the Centers for Medicare & Medicaid Services (CMS) and will recommend to the CMS that a physician comment section be included on the "Physician Payments Sunshine Act" public database; (2) lobby Congress to amend the Sunshine Act to limit transfer of value reporting to items with a value of greater than $100; (3) advocate that: (a) (i) any payment or transfer of value reported as part of the Physician Payments Sunshine Act should include whether the physician acknowledged receipt of said payment or transfer of value, and (ii) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value; and (b) a contested reported payment or transfer of value should be removed immediately from the Open Payments website until the reporting company validates the compensation with verifiable documentation; ~~and~~ (4) support significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the regulatory and administrative burden on physicians, protect physician rights to challenge false and misleading reports, change the dispute process so that successfully disputed charges are not included publicly on the Open Payments database, and provide a meaningful, accurate picture of the physician-industry relationship; (5) urge the Centers for Medicare and Medicaid Services to expand the definition of "covered recipients" to include pharmacists and Pharmacy Benefit Managers; and (6) continue to educate physicians about the Sunshine Act and its implications in light of publicly available data on the Centers of Medicare and Medicaid (CMS) Open Payments Program website. (Modify Current HOD Policy)

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

Received: 10/03/19

Sources:
1. Sunshine Act: "S.301 - Physician Payments Sunshine Act of 2009 - 111th Congress (2009-2010)". Library of Congress (Congress.gov). 2009. Accessed 02-16-2019.
2. Centers for Medicare and Medicaid Services (CMS) Open Payments Act: https://www.cms.gov/openpayments.

RELEVANT AMA POLICY

Physician Payments Sunshine Act H-140.848
Our AMA will: (1) continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by the Centers for Medicare & Medicaid Services (CMS) and will recommend to the CMS that a physician comment section be included on the "Physician Payments Sunshine Act" public database; (2) lobby Congress to amend the Sunshine Act to limit transfer of value reporting to items with a value of greater than $100; (3) advocate that: (a) (i) any payment or transfer of value reported as part of the Physician Payments Sunshine Act should include whether the physician acknowledged receipt of said payment or transfer of value, and (ii) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value; and (b) a contested reported payment or transfer of value should be removed immediately from the Open Payments website until the reporting company validates the compensation with verifiable documentation; and (4) support significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the regulatory and administrative burden on physicians, protect physician rights to challenge false and misleading reports, change the dispute process so that successfully disputed charges are not included publicly on the Open Payments database, and provide a meaningful, accurate picture of the physician-industry relationship.
Citation: Res. 233, A-12; Appended: Res. 222, A-14; Appended: Res. 241, A-18; Appended: Res. 208, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-19)

Introduced by: Colorado

Subject: Data Completeness and the House of Medicine

Referred to: Reference Committee B

Whereas, The AMA, through its founding of the AMA Integrated Health Model Initiative, its creation of the External Advisory Committee for Value-Based Care, and its collaboration with multiple other data projects and initiatives has demonstrated its understanding that use and control of health data by physicians is essential to the profession and to our patients' health; and

Whereas, Our AMA has explicit policy (policy entitled "Price Transparency, D-155.987") endorsing one particular type of health care data organization, All-Payer Claims Databases (APCDs), specifically stating that, "Our AMA will work with states to support and strengthen the development of all-payer claims databases"; and

Whereas, APCDs are rapidly becoming an essential part of health care data infrastructure throughout the US, having been established in 17 states, with 5 other states currently in the process of implementing APCDs, and 5 additional states participating in voluntary claims-based submission efforts[1]; and

Whereas, In places where APCDs have examined cost/utilization/quality measures, they have often absolved physicians of primary culpability for the current ills of American healthcare, centered physicians as the solution to such ills, and will likely increase in utilization for, and by, physicians in the future; and

Whereas, The Supreme Court decision in the case *Gobeille v. Liberty Mutual Insurance Company* has limited the ability of APCDs to maintain their comprehensive data completeness, by preventing states from compelling self-funded group health plans defined under the Employee Retirement Income Security Act (ERISA) to submit their data to APCDs, but left open the possibility that the United States Department of Labor (DOL) may fix the loss of data to state APCDs by imposing a federal requirement that ERISA plans submit health care claims data[2]; and

Whereas, The DOL issued a Notice of Proposed Rulemaking on July 21, 2016 requesting public comments on its proposed reporting requirements for group health plans (called Schedule J) seeking specific comments in light of the *Gobeille* decision, with the National Academy for State Health Policy (NASHP), the All-Payer Claims Database Council (APCD Council), and the National Association of Health Data Organizations (NAHDO) all responding in efforts to encourage a rulemaking process that would allow sharing of data from ERISA plans in a

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[1] State-by-State APCD Establishment Analysis. *Interactive State Report Map*, All-Payer Claims Database Council, https://www.apcdcouncil.org/state/map.
[2] Riley, Trish. *Gobeille v. Liberty Mutual: Decision*, National Academy for State Health Policy, https://nashp.org/gobeille-vs-liberty-mutual-decision/.

consistent manner with consistent definitions as defined by a methodology called the Common Data Layout[3]; and

Whereas, Despite efforts by multiple organizations to advance the rule making process as regards Schedule J by the DOL in matters related to the *Gobeille v. Liberty Mutual Insurance Company* decision, such is currently "stalled out" at the federal level secondary to current federal departmental vacancies and work backlogs due to current political gridlock as regards filling such vacancies within cabinet departments; and

Whereas, A "squeaky wheel phenomenon" currently exists in Washington, D.C., where only those federal initiatives deemed most critical to government and stakeholders are likely to be prioritized within cabinet departments; and

Whereas, The AMA, by lending its voice to an already extant effort to improve the capacity of APCDs, could achieve maximal impact for its physician members with a very small and finite outlay of personnel, resources, and political capital to ensure that a rapidly growing piece of health care infrastructure, that might potentially benefit physicians, will be as complete and comprehensive as possible; therefore be it

RESOLVED, That our American Medical Association amend section 4 of policy D-155.987, "Price Transparency," by addition to read as follows:

> 4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with the National Academy for State Health Policy (NASHP), the All-Payer Claims Database Council (APCD Council), the National Association of Health Data Organizations (NAHDO), and other interested organizations to speed promulgation of final rule making as regards Schedule J by the United States Department of Labor (DOL) in matters related to the *Gobeille v. Liberty Mutual Insurance Company* decision (Directive to Take Action); and be it further

RESOLVED, That, in supporting a rule making process by the DOL in matters related to the *Gobeille v. Liberty Mutual Insurance Company* decision, our AMA support the adoption of a standardized set of health care claims data such as the Common Data Layout, support that any DOL requirement for plans to submit health care claims data must be tied to current rule making processes (such as its proposed Schedule J), and support that the DOL implement a pilot program to collect health care claims data in cooperation with state APCDs. (Directive to Take Action)

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

Received: 10/04/19

[3]NASHP Staff. *Next Steps for APCDs: US Department of Labor (DOL) Rulemaking*, National Academy for State Health Policy, https://nashp.org/next-steps-for-apcds-us-department-of-labor-dol-rulemaking/.

RELEVANT AMA POLICY

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-19)

Introduced by: New York

Subject: AMA Should Provide a Summary of Its Advocacy Efforts on Surprise Medical Bills

Referred to: Reference Committee B

Whereas, There has recently been very significant legislative activity in regards to surprise medical bills and balance billing, critically important issues for physicians; and

Whereas, Insurance companies have tried to use the issue of surprise medical bills to essentially outlaw all physician billing, which would be devastating to the medical profession; and

Whereas, The AMA goal of improved physician satisfaction with professional activity is enhanced by supporting various modes of practice; and

Whereas, Coordination of messaging and engagement of various organizations is critical to success in our advocacy efforts on behalf of our members, patients, and profession; and

Whereas Member and non-member engagement should be improved by a better understanding of our efforts; therefore be it

RESOLVED, That our American Medical Association Board of Trustees provide a detailed report of its efforts and those of allies and opponents around the issue of surprise medical bills in 2019; this discussion should include the following points comparing the AMA and partners activity vs that of its opponents (the insurance companies):

1) What testimony was provided at various committee meetings?
2) What letters were written to various legislators?
3) What grass roots efforts were performed?
4) What other groups supported the efforts
5) What other groups were recruited to support the efforts?
6) What media efforts were performed?
7) What television ads were run?
8) What radio ads were run?
9) What print ads were run?
10) What op-ed pieces were run, in national journals, Washington journals, and regional publications?
11) What meetings occurred with various legislators?
12) What meetings occurred with members of the administration?
13) How much money was spent on the various efforts?
14) What studies were published in insurance journals, medical journals, and other journals on this matter?
15) Which senators and representatives and administration members could either side count on as solid supporters?
16) What level of collaboration was there with other national, state, and specialty societies and how was this carried out? (Directive to Take Action)

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

Received: 10/04/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-19)

Introduced by: American Academy of Dermatology, American College of Mohs Surgery, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology, American Society of Dermatopathology, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American College of Emergency Physicians, Iowa, Maryland, Wisconsin, Virginia, Florida, International Society of Hair Restoration Surgery, Arizona

Subject: Board Certification of Physician Assistants

Referred to: Reference Committee B

Whereas, In 2019, state legislatures considered over 1,000 bills seeking to expand the scope of practice of non-physicians; and

Whereas, Physician assistants sought legislation consistent with elements of the optimal team practice act, which was adopted by the American Academy of Physician Assistants. While many states attempted to remove direct physician supervision or allow PAs to perform certain functions without physician supervision, most of the legislation was defeated or made minimal change in practice; and

Whereas, Physician assistants are a valuable member of the physician-led team; and

Whereas, Physician assistants complete a 26-month physician assistant program followed by 2,000 hours of clinical rotations, which emphasize primary care in ambulatory clinics, physician offices and acute or long-term care facilities; and

Whereas, After finishing a rigorous undergraduate academic curriculum, physicians receive an additional four years of education in medical school, followed by 3-7 years of residency and 12,000-16,000 hours of patient care training; and

Whereas, There are substantial differences in the education of physician assistants and physicians, both in depth of knowledge and length of training; and

Whereas, According to four nationwide surveys, 84% of respondents prefer a physician to have primary responsibility for diagnosing and managing their health care, and 91% of respondents said that a physician’s years of medical education and training are vital to optimal patient care, especially in the event of a complication or medical emergency; and

Whereas, A recent survey conducted by the American Medical Association’s Scope of Practice Partnership confirms increasing patient confusion regarding the many types of health care providers - including physicians, nurses, physician assistants, technicians and other varied providers. The survey revealed that 55 percent of patients believe it is difficult to identify who is a licensed medical doctor and who is not by reading what services they offer, their title and other licensing credentials in advertising or other marketing materials; and

Whereas, An organization independent of the National Commission on Certification of Physician Assistants is providing board certification exams for physician assistants working within dermatology; and

Whereas, This certification can deceive the public and allow physician assistants to advertise themselves as being “board certified;” and

Whereas, This can lead to significant patient safety issues; therefore be it

RESOLVED, That our American Medical Association amend Policy H-35.965, “Regulation of Physician Assistants,” by addition and deletion to read as follows:

Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; ~~and~~ (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by independent organizations to board certify physician assistants in a manner that misleads the public to believe such certification is equivalent to medical specialty board certification. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend Policy H-275.926, “Medical Specialty Board Certification Standards,” by addition to read as follows

Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Opposes any action, regardless of intent, by independent organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/16/19

RELEVANT AMA POLICY

Regulation of Physician Assistants H-35.965
Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; and (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate, and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview. Citation: Res. 233, A-17

Physician Assistants H-35.989
1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.
3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.
4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the

patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.
5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
6.In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.
7.Our AMA opposes legislation or regulation that allows physician assistant independent practice.
Citation: BOT/CME/CMS Joint Rep., I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmation A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 230, I-17

Medical Specialty Board Certification Standards H-275.926
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-19)

Introduced by: American Association of Public Health Physicians

Subject: Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid

Referred to: Reference Committee B

Whereas, Our AMA has established policy in item 6 of Policy H-430.986, "Health Care While Incarcerated," to "urge the Center for Medicare and Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities"; and

Whereas, Medicare and Medicaid are legally prohibited by the inmate exclusion provision, section 1905(a)(29)of the Social Security Act[1], from paying for expenses incurred while a beneficiary is incarcerated, thus requiring Congressional action before CMS and states can implement the policy that our AMA supports in H-430.986; and

Whereas, A bipartisan Congressional bill, H.R. 1329, introduced to the 116th Congress by Rep. Paul Tonko (D-NY) & Rep. Michael Turner (R-OH)[2] and known as the Medicaid Reentry Act, would amend the inmate exclusion provision to grant states flexibility to restart benefits for Medicaid-eligible incarcerated individuals during the 30 day period preceding the date of release; and

Whereas, The AMA has not yet announced support for the Medicaid Reentry Act as of October 13, 2019; therefore be it

RESOLVED That our American Medical Association amend item #6 of HOD Policy H-430.986, "Health Care While Incarcerated," by addition of the word "Congress" to read as follows:

6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/17/19

[1] https://www.ssa.gov/OP_Home/ssact/title19/1905.htm, accessed October 14, 2019.
[2] H.R. 1329, The Medicaid Reentry Act, https://www.congress.gov/bill/116th-congress/house-bill/1329, accessed October 14, 2019.

RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-19)

Introduced by: Women Physicians Section

Subject: Promoting Salary Transparency Among Veterans Health Administration Employed Physicians

Referred to: Reference Committee B

Whereas, Gender inequities among health care providers exist and are receiving increasing scrutiny; and

Whereas, Inequities may be associated with a lack of mentors, discrimination, gender bias, imposter syndrome, and difficulties with work-life balance; and

Whereas, Pay disparities exists as an example of gender inequity; and

Whereas, Pay disparity impacts women's morale and their ability to attain economic stability; and

Whereas, Pay disparity also creates barriers to workforce participation for women, slowing the growth of the U.S. economy, according to a Brookings Institute study;[1] and

Whereas, Following a steady increase between 1950-1999, female U.S. labor force participation rates began to decline in the next decade;[2] and

Whereas, Most recent data demonstrate male physicians earn 9 to 40 percent more than female physicians, controlling for age, experience, specialty, faculty rank, and clinical revenue;[3] and

Whereas, This leads to an estimated $36K-$95K annual difference in earnings; and

Whereas, Pay scales should be easily quantifiable metrics and therefore ready targets for intervention to improve equity; and

Whereas, There are no published data regarding Veterans Health Administration physician pay differences; therefore be it

RESOLVED, That our American Medical Association encourage physician salary transparency within the Veterans Health Administration. (Directive to Take Action)

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

Received: 10/08/19

References:
1. Dews, F. Charts of the Week: The gender wage gap. *Brookings Now*. March 22, 2019. Available at www.brookings.edu/blog/brookings-now/2019/03/22/charts-of-the-week-the-gender-wage-gap/.
2. Toossi M. and Morisi TL. Women in the Workforce Before, During, and After the Great Recession. Available at www.bls.gov/spotlight/2017/women-in-the-workforce-before-during-and-after-the-great-recession/pdf/women-in-the-workforce-before-during-and-after-the-great-recession.pdf.
3. Kacik, Alex. Large gap remains between male, female physician pay. *Modern Healthcare*. March 26, 2019. Available at www.modernhealthcare.com/finance/large-gap-remains-between-male-female-physician-pay.

RELEVANT AMA POLICY

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.
Citation: BOT Rep. 27, A-19;

Advancing Gender Equity in Medicine D-65.989

1. 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 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.

2. 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.
3. 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.
4. 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; Modified: BOT Rep. 27, A-19;

Inequity in Military Pay for Physicians D-40.993
Our AMA will work, as appropriate, with other interested organizations, to support immediate reintroduction of a bill based on H.R. 5353 (107th Congress) in this Congress.
Citation: (BOT Action in response to referred for decision Res. 901, I-03; Reaffirmed: BOT Rep. 28, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-19)

Introduced by: American College of Rheumatology, American Academy of Neurology, American Association of Clinical Endocrinologists, Endocrine Society, North American Neuro-Ophthalmology Society

Subject: Private Payers and Office Visit Policies

Referred to: Reference Committee B

Whereas, Recently commercial payers have implemented polices for evaluation and management (E/M) services that discontinue payments for consultations, in that they will deny claims billed with CPT codes for consultation services as not valid; and

Whereas, Consultation is requested by primary care and other referring physicians to address patients' most challenging and complex medical problems, and this work often includes extensive review of prior records as well as communication and coordination with referring providers. The expertise of the consulting physician is often cost-saving to the insurance carrier, as these specialists can often diagnose and treat the condition without ordering unnecessary tests or treatments; and

Whereas, Failing to acknowledge the difference in work between a consultation and the relative simplicity of assuming the care of a patient with a known diagnosis is misguided and will predictably limit the ability of providers to consult on complex cases; and

Whereas, When the Centers for Medicare and Medicaid Services discontinued payment for consultation codes in 2010, the medical community raised significant concerns because in its decision the agency failed to recognize the expertise and additional collaboration that is reflected in the use of consultation codes; and

Whereas, In its CY 2020 Medicare physician fee schedule proposed rule the Centers for Medicare and Medicaid services proposed adopting the American Medical Association RVS Update Committee (RUC) recommended values for the office and outpatient evaluation and management (E/M) visit codes for CY 2021, which would more appropriately value complex E/M services; and

Whereas, Given that healthcare policy makers are moving toward a more appropriate valuation of office visits and E/M services, it is alarming that commercial payers would move to stop recognizing consultation services at this time; therefore be it

RESOLVED, That our American Medical Association with all haste directly engage and advocate with commercial insurance companies that discontinue payment for consultation codes or that are proposing to or considering eliminating payment for such codes, requesting that the companies reverse or delay such policy changes while the Centers for Medicare and Medicaid Services (CMS) updates its approach to valuation of office visits (Directive to Take Action); and be it further

RESOLVED, That if in the CY 2020 Medicare physician fee schedule final rule CMS finalizes its proposal to increase payments for evaluation and management services, then our American Medical Association will advocate publicly and with all private payers that those private payers mirror and follow CMS' lead in more appropriately valuing office visits, by increasing payments for evaluation and management services in their reimbursement schedules. (Directive to Take Action)

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

Received: 10/17/19

RELEVANT AMA POLICY

Consultation Codes and Private Payers D-385.955
1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.
2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.
Citation: Res. 819, I-17

Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953
1. Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.
Citation: Res. 807, I-09; Appended: Sub. Res. 212, I-10; Reaffirmation A-12; Appended: Res. 216, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-19)

Introduced by: American Society of Clinical Oncology

Subject: QPP and the Immediate Availability of Results in CEHRTs

Referred to: Reference Committee B

Whereas, The Centers for Medicare and Medicaid Services (CMS), through the Promoting Interoperability Program for hospitals and MIPS eligible clinicians, currently requires health care providers to share patient health data (including laboratory and pathology data) through an application programming interface (API) within four days of its availability; and

Whereas, CMS recently issued an Advanced Notice of Proposed Rulemaking (ANPRM) that seeks comment on whether Merit-based Incentive Payment System (MIPS) eligible clinicians should be required to make patient health information available immediately through an API no later than one day after it is available to the clinicians in the certified electronic health record technology (CEHRT); and

Whereas, This, if implemented, would be part of the Quality Payment Program's (QPP) Promoting Interoperability (PI) performance category and therefore directly impacts MIPS participants and their reimbursement; and

Whereas, Generally, feasibility of information exchange is driven by improvements in technology and the health information technology (HIT) infrastructure is led by vendors and developers, not physicians; and

Whereas, EHR prompts do not give physicians the ability to publish notes into just the practice-facing chart then separately into the patient-facing portal; and

Whereas, Patient access to their protected health information (PHI) should be supported, there are concerns relating to immediate availability of certain laboratory and pathology test results because patients would have access to pathology reports prior to a consultation with their physician to aid in the understanding of the results; and

Whereas, This situation could cause significant patient and family distress so it is important to equip patients with the necessary contextual information and clinical expertise provided by their physicians when reviewing test results; therefore be it

RESOLVED, That our American Medical Association urge the Centers for Medicare & Medicaid Services to create guardrails around the "immediate" availability of laboratory, pathology, and radiology results, factoring in an allowance for physician judgement and discretion regarding the timing of release of certain results (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage vendors to implement prompts that give physicians the ability to either approve notes to just the chart or approve and publish them in both the chart and patient portal. (Directive to Take Action)

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

Received: 10/17/19

RELEVANT AMA POLICY

Information Technology Standards and Costs D-478.996
1. Our AMA will:(a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;(b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;(c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems;(d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and(e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2.Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.
Citation: Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed in lieu of Res. 724, A-13; Reaffirmation I-13; Reaffirmation A-14; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 204, I-17; Reaffirmation: I-17; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19