REPORT OF THE BOARD OF TRUSTEES

B of T Report 4, June 2020

Subject:	Council on Legislation Sunset Review of 2008 and 2010 House Policies
Presented by:	Jesse M. Ehrenfeld, MD, MPH, Chair
Referred to:	Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, MD, Chair)

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

In this report, the Board of Trustees presents the Council on Legislation's recommendations on the disposition of the House policies that were assigned to it. The Council on Legislation's recommendations on policies are presented in Appendix 1 to this report.

RECOMMENDATION

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX 1 - RECOMMENDED ACTIONS ON 2008 & 2010 HOUSE POLICIES

Policy Number	Title	Text	Recommendation
D-120.957	Electronic Prescribing Incentive Program	Our AMA will continue to work with CMS to ensure that the Electronic Prescribing Incentive Program policies and reporting procedures provide the greatest flexibility to physicians who electronically prescribe and elect to participate in the program. Citation: Res. 223, I-08	Rescind – The Electronic Prescribing Incentive Program ended in 2013.
D-120.959	Elimination of Physician's "Appointment for Representative" Requirement in Medicare Prescription Drug Program Appeals	Our AMA urges the Centers for Medicare and Medicaid Services to immediately simplify the current Part D Prescription Drug Program Appeal Process by allowing physicians to submit an appeal without beneficiary approval. Citation: Res. 212, A-08	Retain – This policy remains relevant.
D-120.960	Internet Prescriptions	Our AMA will continue to advocate for its model federal legislation on Internet prescribing as the best means to effectively regulate the sale of prescription drugs, including controlled substances, over the Internet. Sub. Res. 506, A-08	Rescind – This policy has been accomplished. AMA evaluated federal Internet prescribing legislation and advocated AMA policy to members of Congress; H.R. 6353, the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, was enacted in October 2008 and provides for strong penalties for the inappropriate provision of prescription medication on the Internet.
D-120.961	Personal Medication Supply in Times of Disaster	Our AMA urges the appropriate federal agencies to convene a meeting of medical societies, health care organizations, and other stakeholders to: (a) develop a national plan to ensure timely distribution of and access to medications for chronic medical conditions in a disaster; (b) issue guidance to health professionals and the public on the appropriate stockpiling of medications for chronic medical conditions in a disaster or other serious emergency; and (c) deliberate the design, feasibility, and utility of a universal mechanism, which provides the essential health and medical information that can assist emergency medical responders and other health care personnel with the provision of medical care and assistance in a disaster or other serious emergency. Citation: BOT Rep. 15, A-08	Rescind – This policy has been accomplished. Relevant stakeholders were encouraged to: (1) develop a national plan regarding access to medications for chronic medical conditions in a disaster; (2) issue guidance on the appropriate stockpiling of medications for chronic conditions in a disaster; and (3) design a universal mechanism that provides essential health information.
D-130.991	Hospital Emergency Use	Our AMA Board of Trustees, to the fullest extent appropriate, will authorize continued support of federal legislation containing the same provisions as appear in H.R. 904, Access to Emergency Medical	Retain – This policy remains relevant but language should be added to provide additional

		Services Act of 1999, which would, among other things, ensure access to covered emergency medical services by group health plans and health insurance coverage without the need for any prior authorization determination and whether or not the physician furnishing such services is a participating physician. Citation: (Sub. Res. 706, I-00; Reaffirmed: BOT Rep. 6, A-10)	context on the purpose of the bill.
D-130.993	Confidentiality of Physician Peer Review "…"	(1) Our AMA will ~~study~~continue to assess the threat to the physician peer review process created by health care related federal regulation or statute, i.e. the Emergency Medical Treatment and Active Labor Act (EMTALA); and (2) If our AMA determines that Federal regulations or laws (including EMTALA) undermine state protections for the confidentiality of the peer review process, our AMA will take urgent action to establish protections for covering all Federal programs and related regulations for physician peer review. Citation: (Res. 219. I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain in part, with a modification: change "Our AMA will study the threat to the physician peer review process..." to read instead "Our AMA will continue to assess the threat to the physician peer review process…."
D-130.994	Limit Scope of EMTALA to Original Legislative Intent "…"	(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians; (b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients; (c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement. (2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare	Rescind – The report was submitted, and the general issues addressed in the directive are included in other policies/directives, such as The Future of Emergency and Trauma Care D-130.971; EMTALA -- Major Regulatory and Legislative Developments D-130.982; and Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950.

		conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose. (3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting. Citation: (Sub. Res. 217, I-00; Reaffirmed: BOT Rep. 6, A-10)	
D-160.988	Financial Impact of Immigration on American Health System	Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid. Citation: Res. 235, A-06; Reaffirmation I-10	Retain – This policy remains relevant.
D-165.943	Financial Assistance for Provision of Legally Mandated Health Care Services	Our AMA will request the continuation of funding for federally-mandated health care for non-residents. Citation: (Res. 229, A-10)	Retain – This policy remains relevant.
D-165.962	Health Savings Accounts for Older Americans	Our AMA will monitor pending regulations and take appropriate steps to ensure access to Health Savings Accounts by all Medicare eligible individuals. Citation: (Sub. Res. 702, A-04; Reaffirmation A-10)	Retain – This policy is still relevant.
D-165.971	Association Health Plans	Our AMA will work with federal legislators to ensure that any Association Health Plan program safeguard state and federal patient protection laws, including but not limited to those state regulations regarding fiscal soundness and prompt payment. Citation: (Sub. Res. 125, A-03; Reaffirmation A-10; Reaffirmed in lieu of Res. 105, A-10)	Retain – This policy is still relevant.
D-175.991	Action to Oppose The Office of Inspector General (OIG) "Draft Compliance Proposed Guidelines for Individual and Small Group Physician Practices"	Our AMA will: (1) condemn the OIG for its unwarranted punitive attitude and reject the final version of the "Office of the Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices" and discourage its members from voluntarily participating in the program the until such time that a program is developed which is not burdensome to medical practices and focuses on education rather than criminal punishment; (2) aggressively utilize all available means to have CMS and the OIG appropriately define true fraud and true abuse in fair legal terms and desist in the criminalization of the practice of medicine and focus on education rather	Rescind – Our AMA is actively engaging with the OIG on fraud and abuse policy reform as evident in our recent letters on the Stark/AKS proposed rules.

		than criminal punishment; and (3) pursue such relief through legislative and regulatory advocacy. Citation: (Sub. Res. 204, I-00; Reaffirmed: BOT Rep. 6, A-10)	
D-175.994	Misapplication of Fraud and Abuse Laws	Our AMA: (1) will collaborate with state and component medical societies to develop an educational program for physicians on how to be in compliance with current fraud and abuse laws; and (2) continues implementation of our new web-based fraud and abuse tutorial system, and after careful review upon release of final Physician Office Compliance Guidelines issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services, provide member physicians with information and advice consistent with those guidelines, and to advocate for physicians with the OIG regarding these guidelines, and to advocate for physicians with the OIG regarding these guidelines. Citation: (Sub. Res. 244, A-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – Our AMA is actively engaging with the OIG on fraud and abuse policy reform and continues to provide updated information on our AMA's Medicare waste, fraud & abuse webpage.
D-185.998	Litigation Regarding Patient Care Guidelines	Our AMA will: (1) continue to monitor Batas v. Prudential and provide such support as may be appropriate; and (2) aggressively seek other opportunities to challenge the misuse of M & R and similar patient care guidelines. Citation: (BOT Rep. 4, I-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – Reference to the Batas case is no longer relevant and Policies H-373.995 (Government Interference in Patient Counseling) and H-410.980 (Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level) address the use of clinical guidelines.
D-190.975	Coordination of Benefits	Our AMA will work with payers and other appropriate parties to streamline the coordination of benefits attestation process by requiring employers to convey the attestation obtained during an open enrollment period to the payer and require the payer to accept the attestations from the employer as the only attestation required to release payment for dependent care. Citation: (Res. 721, A-10)	Retain – This policy remains relevant.
D-275.962	Threat to Medical Licensure	Our AMA will develop model legislation to ensure that medical licensure is independent of participation in any health insurance program. Citation: (Res. 717, A-10; Reaffirmation I-10)	Rescind – Model legislation has been developed. "An Act to Prohibit Mandatory Physician Participation in Health Insurance Programs as a Condition of Physician Licensure."
D-285.966	Benefit Management Companies Conflicts of Interest	Our AMA will study possible conflicts of interest and anti-competitive behavior when the owners of a benefit management company include providers or others who have a financial interest in the provision of medical services in the same market in which that benefit management company is contracted to help	Retain – this policy remains relevant.

		manage care, and where non-owner providers who are in competition with the owners of the benefit management company may be affected by the company's decisions. Citation: (Res. 825, I-10)	
D-315.980	Encryption Standards for Storage and Transmission of Patient Data	Our AMA will work with the US Department of Health and Human Services to develop and disseminate to its membership, current information on privacy and security risk assessment tools, including tools addressing encryption, to help ensure physicians can meet the requirements of "safe harbor" provisions contained in regulations promulgated pursuant to the HITECH Act. Citation: (Sub. Res. 828, I-10)	Rescind – The AMA maintains up-to-date information regarding HIPAA security and privacy as well as materials related to Meaningful Use (Promoting Interoperability).
D-385.981	Increased Administrative Fees for Multivalent Vaccines	Our AMA: (1) advocate with the Centers for Medicare and Medicaid Services and ALL other payers to effect an increase in the administration fee for multivalent vaccines to reflect the true costs to the physician for the administration of such vaccines; and (2) work with the Centers for Medicare and Medicaid Services and appropriate specialty societies to develop pediatric specific immunization codes to accurately reflect the physician work in administering vaccines to the pediatric population. Citation: (Res. 731, I-02; Reaffirmation I-10)	Rescind – The AMA has heard from a number of specialties and submitted comments to CMS about the crosswalk problems for immunization administration and has met with the Administration about this issue. In the 2020 MPFS, CMS left the door open so AMA will continue working with the Administration and urging them to fix this problem. AMA will also be commenting about this in our cover letter to the RUC recommendations, as well, so they will hopefully propose a change in the 2021 NPRM. AMA also has other policy on vaccines, including D-440.981.
D-390.959	Supervision Requirements for Outpatient Therapeutic Services	Our AMA will work with key stakeholders to make general supervision, rather than direct supervision, the requirement for Medicare payment for most, but not all, outpatient therapeutic services. Citation: (BOT action in response to referred for decision Res. 218, A-10)	Retain – the policy is still relevant.
D-390.960	Assuring Patients' Continued Access to Physician Services	1. Our AMA will immediately formulate legislation for an additional payment option in Medicare fee for service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. This legislative language shall be available to our AMA members no later than September 30, 2010. 2. Our AMA is committed to a well funded and priority legislative and grassroots campaign to	Rescind – This directive has been implemented and superseded by more recent policy: D-390.957 (A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act); D-165.938 (Redefining AMA's Position on ACA

		ensure passage of legislation in the US Congress that will ensure Medicare patients can keep their benefits when they privately contract with any physician of their choice with the AMA's "Medicare Patient Empowerment Act" as the centerpiece legislation the AMA supports. 3. Our AMA will report back to the AMA House of Delegates on its progress in ensuring passage of the Medicare Patient Empowerment Act or similar legislation. Citation: Sub. Res. 204, A-10; Appended: Res. 202, I-10	and Healthcare Reform); D-380.997 (Private Contracting by Medicare Patients); and H-383.991 (Right to Privately Contract). See also Board Report 11-A-11 (Effective AMA Action to Preserve Medicare Benefits for Patients)
D-390.966	Inappropriate Changes to Physician Medicare Participation Status by the Centers for Medicare & Medicaid Services	1. Our AMA will work with the Centers for Medicare and Medicaid Services, when necessary, to: a. return physicians to their self-designated Medicare non-participation status in those cases where CMS changed physicians from "non-participating" to "participating" status without the physicians? request or permission; b. have the agency provide written documentation of the erroneous change in the physicians? Medicare participation status thereby allowing those affected physicians to prove that they had no part in the appearance of fraudulent activity resulting from the erroneous CMS action; and c. have the agency provide written documentation of the erroneous change in the physicians' Medicare participation status thereby allowing those affected physicians to prove their innocence to their patients and to all of the Medigap providers whose erroneous explanation of medical benefits forms now imply wrongdoing by these non-participating physicians. 2. Our AMA will educate physicians, through appropriate means, of the option of electing the Medicare "non-participating status," together with simple instructions for effecting such a change of status. Citation: (Res. 105, A-07; Appended: Res. 227, I-10)	Retain – This directive remains relevant.
D-390.970	Recovery Audit Contractor Appeals	1. Our AMA will: (a) educate state medical societies and AMA-member physicians about the available methods for administrative and judicial appeals of Recovery Audit Contractors overpayment recoveries; (b) define common appeal scenarios and methods of appeals, provide technical support on appeals, and seek to consolidate cases for appeal with assistance of state medical societies via the AMA Litigation Center; and (c) continue to oppose the Recovery Audit Contractors' pilot projects and reaffirm existing policy D-390.972. 2. Our AMA will inform state and specialty societies about available AMA resources to assist physicians with Recovery Audit Contractor audits	Rescind – The AMA has recently updated our RAC web information, including the appeals information. In addition, the RAC recoveries have steeply declined in recent years, a trend that seemed to coincide with Medicare's Targeted Probe and Educate Initiative.

		and prominently feature on our AMA website information about methods, resources, and technologies related to appeals of Recovery Audit Contractor overpayment recoveries as a members only benefit. Citation: Sub. Res. 603, I-06; Appended and Reaffirmed: Sub. Res. 603, I-10	
D-420.999	To Amend The Family Leave Act	Our AMA will work to simplify the Family Medical Leave Act form, reducing the physician work required for completion. Citation: (Sub. Res. 203, I-00; Modified: BOT Rep. 6, A-10)	Retain – this policy is still relevant.
D-450.980	Physician Time Spent with Patients and with Hospital Documentation	Our AMA will: (1) advocate for continued research into quality determinants--including time spent with patients--and lead the effort to develop and appropriately implement quality indicators, i.e., clinical performance measures; (2) continue to work with accrediting bodies and government agencies to substantially reduce hospital paperwork; and (3) continue to work with electronic health record (EHR) system developers to ensure that the perspectives of practicing physicians are adequately incorporated, to ensure the standardization and integration of clinical performance measures developed by physicians for physicians, and to ensure a seamless integration of the EHR into the day-to-day practice of medicine. Citation: (BOT Action in response to referred for decision Res. 511, A-03; Reaffirmation I-10)	Retain – This policy is still relevant.
D-478.998	HIPAA Requirements for E-Commerce in Health Care	Our AMA will: (1) intensify its on-going effort to inform practicing physicians about the consequences of implementation (including financial implications) of the Health Insurance Portability and Accountability Act (HIPAA) regulations for transmission of electronic information; and (2) study strategies on implementation of the HIPAA regulations, such as a limit on the frequency of modifications, which will lessen the financial impact on physicians, with a report back to the AMA House of Delegates when final regulations are promulgated. Citation: (Res. 802, A-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – The AMA has worked on educational efforts around HIPAA and produced the required BOT Report (BOT Report 34-A-01, HIPAA Update; It was an informational report and was adopted).
D-478.999	Guidelines for Patient-Physician Electronic Mail	The BOT revisit "Guidelines for Patient-Physician Electronic Mail" when the proposed HIPAA guidelines, encryption, and pertinent federal laws or regulations have been proposed or implemented. Citation: (BOT Rep. 2, A-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind - Regulations around electronic transmission of PHI, including encryption, have been around for many years now and there is guidance from OCR on use of email from 2008. AMA

			also has policy H-478.997 (Guidelines for Patient-Physician Electronic Mail and Text Messaging), which was reaffirmed at I-18, providing guidelines to physicians for use of email and text.
D-510.992	Restoring Veteran Administration Physicians' Use of Prescription Drug Monitoring Programs	Our AMA will work to address the statutory restrictions which impede the ability of VA physicians and pharmacists in participating state-run Drug Monitoring Programs in order to better treat their veteran patients. Citation: (Res. 705, A-10)	Rescind - The VA Prescription Data Accountability Act, signed into law in 2017, requires Veterans Health Administration (VHA) health professionals with the authority to dispense controlled substances to provide data to their state PDMPs.
H-100.958	Inappropriate Pharmacy Advertising	Our AMA supports legislation or regulation that prohibits pharmacies and pharmacy benefit managers from using patient-specific drug information to directly market to patients. Citation: (Res. 215, I-10)	Retain – This policy remains relevant.
H-130.957	Emergency Transfer Responsibilities	Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to: (1) require that the Office of the Inspector General (IG) request and receive the review of the ~~Peer Review Organization (PRO)~~ Quality Improvement Organization (QIO) prior to imposing sanctions; (2) make the ~~PRO~~QIO determination in alleged patient transfer violations binding upon the IG; (3) expand the scope of ~~PRO~~QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks; (4) restore the knowing standard of proof for physician violation; (5) recognize appropriate referral of patients from emergency departments to physician offices; (6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer; (7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient; (8) clarify the appropriate role of the on-call	Retain in part, with a modification to reflect the change from Peer Review Organization to Quality Improvement Organization (1) require that the Office of the Inspector General (IG) request and receive the review of the ~~Peer Review Organization (PRO)~~ Quality Improvement Organization (QIO) prior to imposing sanctions; (2) make the ~~PRO~~ QIO determination in alleged patient transfer violations binding upon the IG (3) expand the scope of ~~PRO~~ QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks.

		specialist, including situations where the on-call specialist may be treating other patients; and (9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act. Citation: (Sub. Res. 78, A-91; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)	
H-130.959	Repeal of COBRA Anti-Physician Provisions	It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility. Citation: (Sub. Res. 145, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-165.834	National Pain Care	Our AMA will, in consultation with all interested Federation organizations whose members treat pain disorders, become actively engaged in the implementation and enabling process of the Patient Protection and Affordable Care Act (HR 3590) as it relates to pain care in SEC. 4305 et seq. pertaining to "Institute Of Medicine Conference On Pain," "Pain Research" and "Program For Education And Training In Pain Care." Citation: (Res. 226, A-10)	Rescind – This policy has been accomplished through the passage of the Affordable Care Act, and subsequent AMA advocacy activities over the past decade on pain management and treating substance use disorder.
H-165.836	Government Health Care Czars' Accountability	Our AMA will pursue all regulatory or legislative action in proposed health system reform legislation and regulations to assure accountability, an appeal process and judicial review for decisions made by healthcare officials charged with the responsibility of decisions related to patients and providers of health care. Citation: (Res. 209, A-10)	Rescind – This policy has been accomplished by passage of the Affordable Care Act.
H-180.988	Federal Policy Favoring HMOs	Our AMA supports legislation amending the current federal law so that employers must offer multiple options for health care benefits to employees or to their union representatives, including the traditional fee-for-service coverage option, if a health care benefit is provided. Citation: (Sub. Res. 43, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-190.957	Free Electronic Claims Billing	Our AMA: (1) supports the ability of physicians to submit claims directly to payors, either electronically or by mailing paper claims; and (2) opposes clearinghouses that inappropriately charge physicians for claim submission, alter codes, or otherwise inappropriately reduce reimbursements. Citation: (Res. 702, A-10)	Retain in part, with the following modification: Our AMA: (1) supports the ability of physicians to submit claims directly to payors, either electronically or by mailing paper claims; and (2) opposes clearinghouses that inappropriately charge

			physicians for claim submission, alter codes, or otherwise inappropriately reduce reimbursements. Citation: (Res. 702, A-10)
H-190.963	Identity Fraud	Our AMA policy is to discourage the use of Social Security numbers to identify insureds, patients, and physicians, except in those situations where the use of these numbers is required by law and/or regulation. Citation: (Res. 805, A-01; Reaffirmed: Res. 804, A-02; Reaffirmation A-10)	Retain – This policy remains relevant.
H-220.929	Use of Ongoing Professional Practice Evaluation Data	Our AMA advocates that Ongoing Professional Practice Evaluation (OPPE) data be considered as peer review information and therefore be afforded protections under relevant state and federal law, and not be used for economic credentialing purposes. Citation: (Sub. Res. 821, I-10)	Retain – This policy remains relevant.
H-230.995	Medical Liability Insurance Coverage as Mandatory Requirement for Hospital Staff Appointment	1. Each hospital medical staff should determine for itself whether or not it will require professional liability insurance coverage as a condition for membership on the hospital medical staff. 2. Our AMA also believes that, if equity demands that voluntary staff members should have insurance coverage so that the burden of financial loss would not fall entirely upon the hospital, then salaried hospital physicians should likewise be covered by adequate insurance or protected financially through self-insurance mechanisms established by the hospital, so that the burden would not fall unfairly upon the members of the voluntary medical staff. 3. Our AMA will seek federal legislation that would amend the federal bankruptcy code such that medical liability premiums that are contractually paid by a hospital on behalf of physician employees shall be considered a priority claim in bankruptcy filings and paid immediately out of the proceeds of the bankrupt hospital's estate. Citation: (BOT Rep. T, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 11, A-03; Reaffirmation A-04; Appended: Res. 230, I-10)	Retain – This policy remains relevant.
H-270.975	Cost Effectiveness of Legislation Regulating Medicine	The AMA will seek legislation to require a cost effectiveness study, including evaluation of the effects on the delivery of high quality patient care services, before congressional passage of any future legislation regulating the medical profession. Citation: (Res. 235, I-92; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-270.980	Independent Health Policy Advisory Council	Our AMA believes that yet another national health advisory body would be redundant and that the AMA should not sponsor legislation at the national level that would provide for an independent health policy advisory council. Citation: (BOT Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – This policy is no longer relevant.

H-270.982	Truth in Advertising Standards for Managed Health Care Plans	It is the policy of the AMA to seek legislation which would provide that managed health care plans meet high standards of truth in advertising and legal safeguards to assure high quality medical care is not compromised by deceptive marketing activities, unsubstantiated claims, bogus quality assurance activities, disruptive referral requirements, and unreasonable precertification and concurrent review practices. Citation: (Res. 220, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-270.997	Legal Restrictions on Sexual Behavior Between Consenting Adults	Our AMA supports in principle repeal of laws which classify as criminal any form of noncommercial sexual conduct between consenting adults in private, saving only those portions of the law which protect minors, public decorum, or the mentally incompetent. Citation: (BOT Rep. I, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-275.963	Mandatory Medicare Assignment or Determination of Fee Levels	Our AMA supports federal legislation that would prohibit states from enacting legislation to require that acceptance of Medicare assignment or the Medicare allowance of reimbursement be a condition of medical licensure, or used in determinations of unprofessional conduct, or made effectively mandatory in any other fashion. Citation: (Sub Res. 75, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Reaffirmation I-10)	Retain – This policy remains relevant.
H-275.984	Legislative Action	The AMA (1) vigorously opposes legislation which mandates that, as a condition of licensure, physicians who treat Medicare beneficiaries must agree to charge or collect from Medicare beneficiaries no more than the Medicare allowed amount; (2) strongly affirms the policy that medical licensure should be determined by educational qualifications, professional competence, ethics and other appropriate factors necessary to assure professional character and fitness to practice; and (3) opposes any law that compels either acceptance of Medicare assignment or acceptance of the Medicare allowed amount as payment in full as a condition of state licensure. Citation: (Sub. Res. 117, I-85; Modified by CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 12, A-05; Reaffirmation I-10)	Retain – This policy remains relevant.
H-275.995	Physician Membership on State Boards of Medicine	Rather than developing a model Medical Practice Act, our AMA supports providing continued assistance in the drafting of Medical Practice Act provisions by working individually with each state medical association desiring such assistance. Citation: (BOT Rep. Q, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.

H-290.989	Access to Care by Medicaid Patients	Our AMA (1) requests CMS to improve Medicaid patients' access to care by considering physicians' costs in its determinations regarding the cost effectiveness of Medicaid third party liability requirement; and (2) will work with CMS and/or Congress to allow state Medicaid agencies to waive the requirement that physicians pursue third party payments prior to seeking payment from Medicaid. Citation: (Res. 225, I-92; Appended: Res. 201, A-00; Modified: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-320.951	AMA Opposition to "Procedure-Specific" Informed Consent	Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure. Citation: (Res. 226, A-99; Reaffirmed: Res. 703, A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-330.892	Medicare Participation Status	It is AMA policy to eliminate any restrictions, including timing, on physicians' ability to determine their Medicare participation status. Citation: (Res. 104, A-10)	Retain – This policy remains relevant.
H-330.910	Congressional Oversight Hearings and Legislative Reform of CMS	Our AMA will: (1) seek immediate and periodic Congressional oversight hearings of the CMS on issues related to the administration of the Medicare and Medicaid programs and additionally will seek legislation to reform CMS; and (2) undertake and support activities that would hold state and federal agencies, their contractors, and employees dealing with health care issues to the same level of accountability as are physicians. Citation: (Sub. Res. 207, A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-340.949	Repeal/Modification of OBRA 1989	It is the policy of the AMA to continue to seek repeal and/or modification of OBRA 1989 to (1) allow for transfer of women in labor when medically indicated, and (2) provide for regular PRO work-up prior to any referral to HHS Office of Inspector General. Citation: (Res. 214, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Rescind – This policy focuses on PROs, which were replaced by QIOs. AMA has policy superseding this one on QIOs, including Quality Improvement Organization Program Status H-340.901 and Quality Improvement Organization Status H-340.903.
H-345.991	Psychologists' Admitting Privileges	The AMA encourages state medical associations to oppose legislation or regulations granting hospital admitting privileges to psychologists. Citation: (Sub. Res. 205, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 23, A-09)	Retain – This policy remains relevant.
H-373.996	Exclusion of Medical Debt That Has Been Fully Paid or Settled	Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner. Citation: (Res. 226, I-10)	Retain – This policy remains relevant.

H-390.910	Repeal of Portions of Catastrophic Coverage Act of 1988	It is the policy of the AMA to continue to work to effect legislation to repeal those portions of any law or regulation that would require that CMS include information in every Explanation of Benefits form for unassigned claims on how Medicare assignment would have affected nonassigned claims. Citation: (Sub. Res. 63, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-390.994	Government Regulations	Our AMA vigorously opposes regulations and legislation which would: (1) interfere with and/or redefine the practice of medicine; (2) substitute hourly wages or annual salaries for present reimbursement mechanisms for physicians' services to patients; (3) base physician reimbursement on any system which does not give recognition to knowledge, skill, time and effort; or (4) otherwise impinge significantly upon the practice of medicine. Citation: (Sub. Res. 28, I-82; Amended: CLRPD Rep. A, I-92; Reaffirmed by Sub. Res. 203, A-98; Reaffirmation A-00; Reaffirmation I-01; Reaffirmed: Res. 704, A-10)	Retain – This policy remains relevant.
H-40.968	Health Care Coverage for Children of Military Families	Our AMA supports legislation that would provide coverage for military children under TRICARE, consistent with coverage afforded to children under non-grandfathered private health plans. Citation: (Res. 218, I-10)	Retain – This policy remains relevant.
H-40.981	Liability Insurance Costs Caused by Military Service	Our AMA supports petitioning Congress, the President, and other relevant authorities to seek appropriate amendments to the ~~Soldiers and Sailors Relief Act~~ Servicemembers Civil Relief Act in order to provide adequate professional liability protections for physicians called to active military duty. Citation: (Sub. Res. 133, I-90; Modified: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	Retain in part. This policy remains relevant but should be modified to reflect a change in the name of the statute cited in this policy.
H-40.996	Appointment of Assistant Secretary of Defense for Health Affairs	Our AMA believes that the U.S. President should nominate a physician experienced in military medicine for appointment as Assistant Secretary of Defense for Health Affairs. Citation: (Res. 123, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10)	Retain – This policy remains relevant.
H-40.998	~~Variable~~ Incentive Pay Programs for Physicians in Military Service	Our AMA, through letters to the President and appropriate members of the Congress and through such other means as are appropriate, strongly supports ~~timely re-enactment of the Variable I~~incentive ~~P~~pay ~~P~~programs for physicians in military service. Citation: (Res. 91, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CLRPD Rep. 1, A-10)	Retain in part. The term "Variable Incentive Pay Program" is outdated and should be updated to apply to incentive pay programs more generally.
H-420.957	Shackling of Pregnant Women in Labor	1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints	Retain – policy remains relevant.

		necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents: - An immediate and serious threat of harm to herself, staff or others; or - A substantial flight risk and cannot be reasonably contained by other means. If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used." 2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. Citation: Res. 203, A-10	
H-460.969	Biomedical Research Protection	Our AMA: (1) encourages state medical associations to support legislation which would amend current criminal codes to specifically state that the unauthorized removal of research animals and/or damage to research projects/facilities is a crime, and the minimum penalty for this offense shall be a felony; and (2) supports passage of the intent of the Federal Animal Research Facilities Protection Act of 1989 (S 727) as originally proposed by Senator Heflin (D-Alabama). Citation: (Res. 251, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – This policy remains relevant.
H-480.996	Medical Device Amendments of the FDA	(1) The AMA reiterates its concerns regarding the implementation of the Medical Device Amendments to the Food and Drug Administration (FDA) and urges that regulations be promulgated or interpreted so as to: (a) not interfere with the physician-patient relationship; (b) not impose regulatory burdens that may discourage creativity and innovation in advancing device technology; (c) not change the character and mandate of existing Institutional Review Boards to unnecessarily burden members of the IRB's and clinical investigators; (d) not raise the cost of medical care and new medical technology without any concomitant benefit or additional safeguards being provided the patients; and (e) not interfere with patient records' confidentiality. (2) The AMA urges that existing mechanisms to assure ethical conduct be used to minimize burdensome reporting requirements and keep enforcement costs to a minimum for patients, health care providers, industry and the government.	Retain – This policy remains relevant.

		Citation: (Res. 146, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)	
H-510.994	Ethics Reform Act of 1989 (PL 101194)	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)	Retain – This policy remains relevant.
H-65.971	Mental Illness and the Right to Vote	Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness. Citation: (Res. 202, A-10)	Retain – This policy remains relevant.

APPENDIX 2

AMA Policies Superseding Policies Recommended for Rescission

Policy D-130.994, "Limit Scope of EMTALA to Original Legislative Intent"
(1) The Board of Trustees within 30 days develop an action plan that implements AMA policy H-130.950 that seeks to return to the original congressional intent of Emergency Medical Treatment and Active Labor Act (EMTALA) and oppose the continued judicial and regulatory expansion of its scope. The action plan may include, but is not limited to: (a) Opposing regulations that expand the scope and reach of EMTALA, including the criminalization of hospitals and physicians; (b) Working with the Administration to include adequate Federal funding to pay hospitals and physicians for providing medical screening examinations, for stabilization, and for any indicated transfers of uninsured patients; (c) Establishing a work group that includes representatives of emergency medicine, other physician organizations, hospitals, health plans, business coalitions, and consumers groups to improve policies and regulations with regard to the application of EMTALA; and (d) Seeking Congressional action or, if necessary, initiating litigation to compel revision of the onerous EMTALA regulations and their enforcement. (2) Our AMA work with the American Hospital Association to: (a) rescind the regulations extending EMTALA to hospital outpatient departments; (b) modify the regulations requiring receiving hospitals to report to the Centers for Medicare & Medicaid Services (CMS) suspected inappropriate transfers; (c) have CMS incorporate appropriate standards, that prohibit the discharge or inappropriate transfer of unstable hospitalized patients, into the Medicare conditions of participation for hospitals in lieu of utilizing EMTALA for this purpose. (3) Significant actions undertaken with regard to EMTALA will be reported to the AMA House of Delegates at the 2001 Annual Meeting.
Sub. Res. 217, I-00 Reaffirmed: BOT Rep. 6, A-10

Policy H-130.950, "Emergency Medical Treatment and Active Labor Act" (EMTALA)
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA;
(2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations;
(3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and. (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements.
Sub. Res. 214, A-97 Reaffirmation I-98 Reaffirmation A-99 Appended: Sub. Res. 235 and Reaffirmation A-00 Reaffirmation A-07 Reaffirmed: BOT Rep. 22, A-17

Policy D-130.982, "EMTALA -- Major Regulatory and Legislative Developments"
Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.
BOT Rep. 17, I-02 Reaffirmation A-07 Modified: BOT Rep. 22, A-17

Policy D-130.971, "The Future of Emergency and Trauma Care"
Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care; (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties; (3) continue to advocate for the following: a. Insurer payment to physicians who have

delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care; (4) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation; (5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care; (6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and (7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort.
BOT Rep. 14, I-06 Reaffirmation A-07 Reaffirmation A-08 BOT action in response to referred for decision Res. 204, A-11 Appended: Res. 221, I-11 Modified: CCB/CLRPD Rep. 2, A-14

Policy D-185.998, "Litigation Regarding Patient Care Guidelines"
Our AMA will: (1) continue to monitor Batas v. Prudential and provide such support as may be appropriate; and (2) aggressively seek other opportunities to challenge the misuse of M & R and similar patient care guidelines.
BOT Rep. 4, I-00; Reaffirmed: BOT Rep. 6, A-10

Policy H-373.995, "Government Interference in Patient Counseling"
1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?

G. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.
Res. 201, A-11Reaffirmation: I-12Appended: Res. 717, A-13Reaffirmed in lieu of Res. 5, I-13Appended: Res. 234, A-15Reaffirmation: A-19

Policy H-410.980, "Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level"

Our AMA has adopted the following principles regarding the implementation of clinical practice guidelines at the local/state/regional level: (1) Relevant physician organizations and interested physicians shall have an opportunity for input/comment on all issues related to the local/state/regional implementation of clinical practice guidelines, including: issue identification; issue refinement, identification of relevant clinical practice guidelines, evaluation of clinical practice guidelines, selection and modification of clinical practice guidelines, implementation of clinical practice guidelines, evaluation of impact of implementation of clinical practice guidelines, periodic review of clinical practice guideline recommendations, and justifications for departure from clinical practice guidelines..
(2) Effective mechanisms shall be established to ensure opportunity for appropriate input by relevant physician organizations and interested physicians on all issues related to the local/state/regional implementation of clinical practice guidelines, including: effective physician notice prior to implementation, with adequate opportunity for comment; and an adequate phase-in period prior to implementation for educational purposes.
(3) clinical practice guidelines that are selected for implementation at the local/state/regional level shall be limited to practice parameters that conform to established principles, including relevant AMA policy on practice parameters.
(4) Prioritization of issues for local/state/regional implementation of clinical practice guidelines shall be based on various factors, including: availability of relevant and high quality practice parameter(s), significant variation in practice and/or outcomes, prevalence of disease/illness, quality considerations, resource consumption/cost issues, and professional liability considerations.
(5) clinical practice guidelines shall be used in a manner that is consistent with AMA policy and with their sponsors' explanations of the appropriate uses of their clinical practice guidelines, including their disclaimers to prevent inappropriate use.
(6) clinical practice guidelines shall be adapted at the local/state/regional level, as appropriate, to account for local/state/regional factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information.
(7) clinical practice guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical practice guidelines, when appropriate, in the care of individual patients.
(8) The AMA and other relevant physician organizations should develop principles to assist physicians in appropriate documentation of their adherence to, or appropriate departure from, clinical practice guidelines implemented at the local/state/regional level.
(9) clinical practice guidelines, with adequate explanation of their intended purpose(s) and uses other than patient care, shall be widely disseminated to physicians who will be impacted by the clinical practice guidelines.
(10) Information on the impact of clinical practice guidelines at the local/state/regional level shall be collected and reported by appropriate medical organizations.
CMS Rep. D, A-93Reaffirmed: CMS Rep. 10, A-03Reaffirmed: CMS Rep. 4, A-13

Policy D-385.981, "Increased Administrative Fees for Multivalent Vaccines"
Our AMA: (1) advocate with the Centers for Medicare and Medicaid Services and ALL other payers to effect an increase in the administration fee for multivalent vaccines to reflect the true costs to the physician for the administration of such vaccines; and (2) work with the Centers for Medicare and Medicaid Services and appropriate specialty societies to develop pediatric specific immunization codes to accurately reflect the physician work in administering vaccines to the pediatric population.

Res. 731, I-02 Reaffirmation I-10

Policy D-440.981, "Appropriate Reimbursements and Carve-outs for Vaccines"
Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for **vaccine** services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular **vaccine**; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on **vaccine** recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physicians office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.
BOT Rep. 20, A-03 Reaffirmation A-07 Res. 128, A-09 Reaffirmation I-10 Reaffirmed: Res. 807, I-11 Appended: Res. 217, A-19

Policy D-390.960, "Assuring Patients' Continued Access to Physician Services"
1. Our AMA will immediately formulate legislation for an additional payment option in Medicare fee for service that allows patients and physicians to freely contract, without penalty to either party, for a fee that differs from the Medicare payment schedule and in a manner that does not forfeit benefits otherwise available to the patient. This legislative language shall be available to our AMA members no later than September 30, 2010.
2. Our AMA is committed to a well funded and priority legislative and grassroots campaign to ensure passage of legislation in the US Congress that will ensure Medicare patients can keep their benefits when they privately contract with any physician of their choice with the AMA's "Medicare Patient Empowerment Act" as the centerpiece legislation the AMA supports.
3. Our AMA will report back to the AMA House of Delegates on its progress in ensuring passage of the Medicare Patient Empowerment Act or similar legislation.
Citation: Sub. Res. 204, A-10; Appended: Res. 202, I-10

Policy D-390.957, "A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act"
Our AMA will now initiate and sustain our well-funded grassroots campaign to secure the support of the American People for passage of the Medicare Patient Empowerment Act in Congress as directed by the 2010 Interim Meeting of the House of Delegates through AMA Policy D-390.960.
Res. 203, I-11

Policy D-165.938, "Redefining AMA's Position on ACA and Healthcare Reform"
1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:
A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines;
B. Repeal and appropriate replacement of the SGR;
C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines;
D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting");
E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations;
F. Repeal the non-physician provider non-discrimination provisions of the ACA.
2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.
3. There will be a report back at each meeting of the AMA HOD.
Res. 231, A-13Reaffirmed in lieu of Res. 215, A-15Reaffirmation: A-17

Policy D-380.997, "Private Contracting by Medicare Patients"
1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry.
2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.
3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare.
CMS Rep. 6, A-99Reaffirmation A-04Reaffirmation A-08Reaffirmation I-13Modified: CMS Rep. 1, A-15Reaffirmed: Res. 217, I-16

Policy H-383.991, "Right to Privately Contract"
Our AMA includes in its top advocacy priorities: (1) the enactment of federal legislation that ensures and protects the fundamental right of patients to privately contract with physicians, without penalties for doing so and regardless of payer within the framework of free market principles with the goal of accomplishing this by 2010; (2) the restoration of fairness to the current health care marketplace through changes in statutes and regulations so that physicians are able to negotiate (individually and as defined groups) fair contracts with private sector and public sector health plans.
Res. 203, A-09Reaffirmed: BOT Rep. 09, A-19

Also see: BOT Report 11-A-11 - Effective AMA Action to Preserve Medicare Benefits for Patients.

Policy D-478.999, "Guidelines for Patient-Physician Electronic Mail"
The BOT revisit "Guidelines for Patient-Physician Electronic Mail" when the proposed HIPAA guidelines, encryption, and pertinent federal laws or regulations have been proposed or implemented.
BOT Rep. 2, A-00 Reaffirmed: BOT Rep. 6, A-10

Policy H-478.997, "Guidelines for Patient-Physician Electronic Mail and Text Messaging"
New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.
(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.
Communication Guidelines:
(a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
(b) Inform patient about privacy issues.
(c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
(d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
(e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject

matter (HIV, mental health, etc.) permitted over e-mail.
(f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
(g) Request that patients put their name and patient identification number in the body of the message.
(h) Configure automatic reply to acknowledge receipt of messages.
(i) Send a new message to inform patient of completion of request.
(j) Request that patients use autoreply feature to acknowledge reading clinicians message.
(k) Develop archival and retrieval mechanisms.
(l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
(m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
(n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
(o) Explain to patients that their messages should be concise.
(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
(q) Remind patients when they do not adhere to the guidelines.
(r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.
Medicolegal and Administrative Guidelines:
(a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
(b)Terms in communication guidelines (stated above).
(c) Provide instructions for when and how to convert to phone calls and office visits.
(d) Describe security mechanisms in place.
(e) Hold harmless the health care institution for information loss due to technical failures.
(f) Waive encryption requirement, if any, at patient's insistence.
(g) Describe security mechanisms in place including:
(h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
(i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
(j) Never using patient's e-mail address in a marketing scheme.
(k) Not sharing professional e-mail accounts with family members.
(l) Not using unencrypted wireless communications with patient-identifiable information.
(m) Double-checking all “To” fields prior to sending messages.
(n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
(o) Commit policy decisions to writing and electronic form.
(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.
(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.
(4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate.
BOT Rep. 2, A-00 Modified: CMS Rep. 4, A-01 Modified: BOT Rep. 24, A-02 Reaffirmed: CMS Rep. 4, A-12 Modified: BOT Rep. 11, A-17 Reaffirmation: I-18

Policy H-340.949, “Repeal/Modification of OBRA 1989”
It is the policy of the AMA to continue to seek repeal and/or modification of OBRA 1989 to (1) allow for transfer of women in labor when medically indicated, and (2) provide for regular PRO work-up prior to any referral to HHS Office of Inspector General.
Res. 214, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: BOT Rep. 6, A-10

Policy H-340.901, “Quality Improvement Organization Program Status”
1. Our AMA strongly urges CMS to require that Medicare Quality Improvement Organizations (QIOs) adhere to the following principles: (a) physicians should be provided with the fundamental principles of fairness and

due process throughout QIO proceedings; (b) all appeal mechanisms available to physicians should be exhausted before QIOs disclose their decisions to beneficiaries; (c) the language used in QIO correspondence with beneficiaries should be properly worded to ensure that the patient/physician relationship is not jeopardized; and (d) QIOs should be required to receive affirmative physician consent before patients are notified of QIO review determinations.
2. Our AMA will advocate to: (a) change the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict; (b) require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise; and (c) require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed.
CMS Rep. 7, I-96 Reaffirmed: CMS Rep. 16, I-98 Reaffirmation A-01 Reaffirmed: CMS Rep. 7, I-01 Modified: CMS Rep. 7, A-11 Appended: Res. 224, I-18

Policy H-340.903, "Quality Improvement Organization Status"
The AMA urges CMS to carefully review the potential for conflict of interest when the same organization that contracts as a Medicare Quality Improvement Organization fulfills similar quality improvement contracts in the private sector.
CMS Rep. 9, I-95 Reaffirmed and Modified with change in title: CMS Rep. 7, A-05 Reaffirmed: CMS Rep. 1, A-15