REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-JUN-21

Subject: Council on Legislation Sunset Review of 2011 House Policies

Presented by: Russ Kridel, MD, Chair

Referred to: Reference Committee B

Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA's policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates (House) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the House or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA councils and the House should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

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

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-100.972	Generic vs Brand Medications	Our AMA will advocate to the US Food and Drug Administration against removal of generic medications from the market in favor of more expensive brand name products based solely on a lack of studies of the efficacy of the generic drug. Citation: Res. 220, I-11;	Retain – this policy remains relevant.
D-100.973	Stricter Oversight of Homeopathic Products by the Food and Drug Administration	Our AMA will urge the US Food and Drug Administration to review the existing regulatory framework for the approval and marketing of homeopathic drug products, including the Compliance Policy Guide, to determine if the current system is sufficient to reasonably ensure the safety and effectiveness of such products. Citation: (BOT action in response to referred for decision Res. 521, A-10; Reaffirmation A-11)	Rescind. FDA issued new draft guidance on Homeopathic products in 2019.
D-130.989	Coverage of Emergency Services	Our AMA: (1) will promote legislation, regulation, or both to require all health payers to utilize the AMA's definition of "emergency medical condition;" (2) will promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy; and (3) in conjunction with interested national medical specialty societies, continue to work expeditiously toward a comprehensive legislative solution to the continued expansion of EMTALA and problems under its current rules. Citation: (Res. 229, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-160.993	Limitation of Scope of Practice of Certified Registered Nurse Anesthetists	Our AMA, in conjunction with the state medical societies, will vigorously inform all state Governors and appropriate state regulatory agencies of AMA's policy position which requires physician supervision for certified registered nurse anesthetists for anesthesia services in Medicare participating hospitals, ambulatory surgery centers, and critical access hospitals.	Retain – this policy remains relevant.

		Citation: (Res. 220, I-01; Reaffirmed: CMS Rep. 7, A-11)	
D-190.978	HIPAA Privacy Regulations	The AMA will: 1. Not support repeal of the final privacy rule under the Congressional Review Act because the time for Congress to act under that Act has passed. 2. Continue its current strong advocacy efforts to improve and strengthen the final privacy rule while decreasing the administrative burdens it places upon physicians and other health care providers. 3. Partner actively with other relevant groups, such as state and national specialty medical societies, to look for other options for improvement and change and forward these to Department of Health and Human Services Secretary Thompson. 4. Communicate frequently with all interested parties about the progress of this process. Citation: (BOT Action in response to referred for decision Res. 240, A-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. This policy is no longer relevant. There is already a final HIPAA privacy rule.
D-250.988	Support Progress of Science by Addressing Travel Visa Problems	Our AMA will send a letter to the US Department of State explaining the negative impact current visa practices are having on medical and scientific progress and urging policy changes that remove unnecessary barriers in the business and travel visa process that prevent international physicians and scientists seeking to attend US-based medical and scientific conferences. Citation: (Res. 214, I-11)	Retain – this policy remains relevant.
D-265.999	The Right to Know Your Accuser	Our AMA will institute all possible measures on a national level to allow physicians who are subjected to investigations by federal agencies to know their accusers. Citation: (Resolution 220, A-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. This policy has been accomplished. Our AMA wrote a letter to CMS commenting on the new suspension of payment standards. CMS has defined a credible allegation of fraud as: A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following: (1) Fraud hotline

			complaints. (2) Claims data mining. (3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency (SMA) has reviewed all allegations, facts, and evidence carefully; and acts judiciously on a case-by-case basis. An allegation is now considered credible if the SMA finds that the allegation has evidence of reliability after carefully reviewing all allegations, facts, and evidence. In making credibility determinations, the SMA must act judiciously on a case-by-case basis. CMS has commented that the amount of evidence necessary to support a finding of credibility under the current standard will vary depending on the facts and circumstances surrounding each allegation.
D-270.988	AMA Improve its Transparency, Accountability and Communication	Our AMA will proactively improve its transparency, accountability, and communication by providing rationale for positions to constituent societies and members regarding its actions pertaining to all health care legislation. Citation: (Res. 210, A-11)	Retain – this policy remains relevant.
D-275.964	Principles of Due Process for Medical License Complaints	1. Our AMA will explore ways to establish principles of due process that must be used by a state licensing board prior to the restriction or revocation of a physician's medical license, including strong protections for physicians' rights.	Retain – this policy remains relevant.

		2. Our AMA takes the position that: A) when a state medical board conducts an investigation or inquiry of a licensee applicant's quality of care, that the standard of care be determined by physician(s) from the same specialty as the licensee applicant, and B) when a state medical board conducts an investigation or inquiry regarding quality of care by a medical licensee or licensee applicant, that the physician be given: (i) a minimum of 30 days to respond to inquiries or requests from a state medical board, (ii) prompt board decisions on all pending matters, (iii) sworn expert review by a physician of the same specialty, (iv) a list of witnesses providing expert review, and (v) exculpatory expert reports, should they exist. Citation: (Res. 238, A-08; Appended: Res. 301, A-11)	
D-315.981	National Master Patient Identifier	Our AMA, along with other stakeholders, will work with the Office of the National Coordinator for Health Information Technology to develop a strategy for patient identification system at the national level. Citation: (BOT Rep. 23, A-10)	Retain – this policy remains relevant.
D-315.992	Police, Payer and Government Access to Patient Health Information	Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act "privacy" rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician's concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians. Citation: (Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-330.922	Competitive Bidding for Purchase of Medical Equipment by Centers for Medicare and Medicaid Services	Our AMA will: (1) lobby in favor of modification of current Centers for Medicare & Medicaid Services policy to ensure that payments for medical technologies are comparable to market rates; and (2) lobby in favor of moving ahead with the Centers for Medicare & Medicaid Services' plans for a competitive bidding process for home medical equipment and encourage CMS to take into	Rescind. This policy has been accomplished. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the DMEPOS CBP was to be

		consideration quality and patient convenience, in addition to cost. Citation: (Res. 814, I-08; Reaffirmed in lieu of Res. 201, I-11)	phased-in so that competition under the program would first occur in 10 MSAs in 2007. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes. In accordance with MIPPA, CMS successfully implemented the Round 1 Rebid in 2011 in select markets and expanded in 2013 for a total of 130 CBAs. After recompeting DMEPOS CBP contracts in these markets, CMS announced plans for Round 2019 in all 130 CBAs. In February 2017, CMS announced that Round 2019 was delayed to allow for reforms to the DMEPOS CBP. Round 2021 of the DMEPOS Competitive Bidding Program began on January 1, 2021 and extends through December 31, 2023. Round 2021 consolidates the CBAs that were included in Round 1 2017 and Round 2 Recompete. Round 2021 includes 130 CBAs. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid
D-330.969	Opposition to Mandatory Hospitalization Prior to Nursing Home Placement	Our AMA shall inform the Centers for Medicare & Medicaid Services that the regulation concerning mandatory hospitalization prior to skilled nursing home placement for Medicare beneficiaries is	Rescind. Our AMA has completed this directive and has more recent and broad policy, including

		obsolete, wasteful of valuable resources and should be abolished. Citation: (Res. 139, A-02; Reaffirmed: Res. 234, A-09; Reaffirmation A-11)	H-280.947, Three Day Stay Rule; H-280.950, Medicare's Three-Day Hospital Stay Requirement.
D-330.979	Medicare Reimbursement for Vitamin D Therapy for Dialysis Patients	Our AMA will petition the Centers for Medicare & Medicaid Services and/or lobby Congress to defeat the "Vitamin D Analogs Draft Local Medical Review Policy" and to prevent its implementation in Florida or any other state. Citation: (Res. 134, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-335.994	Medical Necessity Determinations under Medicare	Our AMA will urge the Centers for Medicare & Medicaid Services and Congress that medical necessity denials within the Medicare program be reviewed by a physician of the same specialty and licensed in the same state. Citation: (Sub. Res. 713, A-01; Reaffirmed: CMS Rep. 7, A-11)	Rescind. This policy has been accomplished. Multiple letters were written to relevant stakeholders (letter 1; letter 2; letter 3) encouraging physician review of medical necessity denials.
D-35.983	Addressing Safety and Regulation in Medical Spas	Our AMA will: (1) advocate for state regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as "medically necessary" procedures, including those which require appropriate training, supervision and oversight; (2) advocate that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be considered the practice of medicine; (3) take steps to increase the public awareness about the dangers of those medical spas which do not adhere to patient safety standards by encouraging the creation of formal complaint procedures and accountability measures in order to increase transparency; and (4) continue to evaluate the evolving issues related to medical spas, in conjunction with interested state and medical specialty societies. Res. 209, I-11	Retain – this policy remains relevant.
D-35.986	Encouraging the AMA to Ask the Robert Wood Johnson Foundation to Substantiate Report Findings	Our AMA will request that the Robert Wood Johnson Foundation: 1) reevaluate the role of advanced practice nurses in the context of a physician-led, patient-centered medical home model; 2) consider the current demographic distribution of advanced practice nurses in independent practice states as an indicator that	Rescind. Our AMA continues to support physician-led teams; created the GEOMAPS (2008, 2014, 2018, 2020) and Health Workforce Mapper to show

	Regarding Nurse Practitioners	there are no true market barriers to competition in health care, rather there are other factors that influence where advanced practices nurses and doctors practice; and 3) require the accuracy of scientific control measures when comparing outcomes of two different care groups, nurse practitioners and physicians. Citation: (Res. 232, A-11)	distribution of non-physicians compared to physicians; continues to urge lawmakers to rely on fact-based data when considering scope expansions.
D-350.988	American Indian/ Alaska Native Adolescent Suicide	Our AMA will: 1) provide active testimony in Congress for suicide prevention and intervention resources to be directed towards American Indian/Alaska Native communities; 2) encourage significant funding to be allocated to research the causes, prevention, and intervention regarding American Indian/Alaska Native adolescent suicide and make these findings widely available; and 3) lobby the Senate Committee on Indian Affairs on the important issue of American Indian/Alaska Native adolescent suicide. Citation: (Sub Res. 404, A-11)	Retain – this policy remains relevant.
D-373.996	Possible HIPAA Violations by Law Firms	Our AMA will encourage the Office for Civil Rights of the Department of Health and Human Services to investigate the activities of entities, including Consumer Injury Alert, with regard to possible Health Insurance Portability and Accountability Act (HIPAA) violations and solicitations of lawsuits, and to take whatever action may be legally permissible and fiscally affordable to stop such possible violations and solicitations. Citation: (Res. 217, I-11)	Retain – this policy remains relevant.
D-375.988	Local Peer-Review and Physician Sponsorship Requirements from Medicare QIO Work	Our AMA supports efforts in Congress to reverse the Medicare QIO program structure changes in HR 2832 related to physician involvement in state level QIO work, maintain the statewide scope of QIO contracts, assure the continuation of the beneficiary complaint process and quality improvement efforts at the state level, and maintain the essential local relationships that QIOs must have with physicians and other providers. Citation: (Res. 832, I-11)	Retain – this policy remains relevant.
D-375.991	IOM Report on QIO Program	Our AMA will advocate that: (a) the medical review duties currently included in the Medicare Quality Improvement Organization (QIO) scope of work continue to remain the responsibility of the federally designated QIO in each state through the	Retain – this policy remains relevant.

		end of the current Eighth Scope of Work on into the Ninth Scope of Work and beyond; and (2) medical review of physicians continue to be performed by physicians taking into account both cultural competency and local conditions. Citation: (Res. 726, A-06; Reaffirmed: Res. 832, I-11)	
D-375.998	Peer Review Protection for Physicians Covered by the Federal Tort Claims Act	Our AMA will work with the Indian Health Service headquarters, Public Health Service, and the Department of Health and Human Services Office of the General Counsel to enact federal legislation protecting the confidentiality of peer review/clinical quality assurance information done by physicians and organizations covered by the Federal Tort Claims Act. Citation: (Res. 230, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-375.999	Confidentiality of Physician Peer Review	Our AMA will draft and advocate for legislation amending, as appropriate: (1) the Freedom of Information Act to exempt confidential peer review information from disclosure under the Act; and (2) the Health Care Quality Improvement Act to prohibit discovery of information obtained in the course of peer review proceedings. Citation: (BOT Rep. 22, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
D-385.962	AMA Statement to FTC, CMS and OIG DHHS Supporting the Ability of ACOs to Negotiate with Insurers on an Exclusive Basis	Our AMA will clarify its support of antitrust relief for physician-led accountable care organizations (ACOs), as stated in its September 27, 2010 statement to the Federal Trade Commission, the Centers for Medicare & Medicaid Services, and the Office of Inspector General of the US Department of Health and Human Services, as being limited to physician-led ACOs and not to ACOs owned and controlled by non-physicians, including hospitals, insurance companies, or others. Citation: (Res. 830, I-10; Reaffirmed: Res. 215, A-11)	Rescind. This policy has been accomplished. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Faco-antitrust-reform-proposal-comment-letter.pdf
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. Citation: (Res. 203, I-11)	Retain – this policy remains relevant.

D-435.970	Expert Witness Certification	1. Our AMA will immediately assist all interested state medical associations in initiating similar legislation as recently passed in Florida to require physicians licensed in another state to obtain an expert witness certificate before being able to provide expert witness testimony in medical liability actions, and that state physician licensing boards be empowered to discipline any expert witness, both those licensed in that state and those with an expert witness certificate, who provide deceptive or fraudulent expert witness testimony. 2. Our AMA will continue to provide updates on our AMA Web site regarding the progress that has occurred in the implementation of expert witness legislation in states throughout the United States. Citation: (Res. 203, A-11)	Retain – this policy remains relevant.
D-440.939	National Diabetes Clinical Care Commission	Our AMA will actively work to secure congressional enactment of a National Diabetes Clinical Care Commission. Citation: (Res. 223, I-11)	Rescind. This policy has been accomplished. The National Clinical Care Commission Act (Pub. L. 115–80) required the HHS Secretary to establish the National Clinical Care Commission, which has conducted activities since 2018.
D-450.966	American Health Care Access, Innovation, Satisfaction and Quality	Our AMA will begin an international comparative study on health care quality that is a comprehensive and balanced study including comparisons of patient satisfaction, cancer outcomes, outcomes among more severe illnesses and injuries, rapidity of access and patient satisfaction as end points, and present their findings to the AMA House of Delegates at the 2012 Annual Meeting. Citation: (Res. 104, A-11)	Rescind. Aspects of this policy continue to be addressed in articles published in JAMA, Health Affairs, Kaiser Family Foundation, World Health Organization, and several other sources.
D-460.972	Creation of a National Registry for Healthy Subjects in Phase I Clinical Trials	Our AMA encourages the development and implementation of a national registry, with minimally identifiable information, for healthy subjects in Phase 1 trials by the US Food and Drug Administration or other appropriate organizations to promote subject safety, research quality, and to document previous trial participation. Citation: (Res. 913, I-11)	Retain – this policy remains relevant.

D-460.973	Comparative Effectiveness Research	Our AMA will solicit from our members and others articles or postings about current clinical topics where comparative effectiveness research should be conducted and will periodically invite AMA members to recommend topics where the need for comparative effectiveness research is most pressing, and the results will be forwarded to the Patient-Centered Outcomes Research Institute (PCORI) once it is established, or to another relevant federal agency. Citation: (Res. 221, A-11)	Retain – this policy remains relevant.
D-478.979	Promoting Internet-Based Electronic Health Records and Personal Health Records	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)	Rescind. Most people are not using PHRs in the way envisioned when this policy was first adopted. The movement now is for smartphone apps to essentially function as PHRs. In that sense, our AMA continues to work with multiple agencies to minimize risks, educate about implementation barriers, and promote best practices, etc., more focused on apps rather than other types of PHRs.

G-615.070	COL Activities	AMA policy on the activities of the Council on Legislation include the following: (1) All medical legislative issues should be cleared through the COL before action is taken by any other AMA council or committee, and the Board shall take whatever action is appropriate to achieve this objective; (2) The Council shall continue to refer issues to other committees and councils for advice and recommendations, when said issues properly fall within their sphere of knowledge and activities; (3) The Board shall be advised of the Council's desire to maintain constant surveillance of legislative matters; (4) The Council shall have authority to recommend to the Board the initiation of specific legislation or legislative policy to meet current problems confronting physicians or our AMA; and (5) The Board shall be advised of the Council's willingness and ability to testify before congressional committees or to accompany the principal witnesses who may testify on behalf of the Association. Citation: (COL/BOT Rec., I-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11)	Retain – this policy remains relevant.
H-120.951	Mandatory Acceptance of the Currently Utilized Physician Prescription Form by Pharmacy Benefit Plan Administration	Our AMA seeks legislation or regulation that would: (1) require that pharmacy benefits plans accept the currently utilized physician prescription forms for all initial prescriptions and renewals; and (2) ensure that a written, oral or electronically transmitted prescription that complies with state and federal law constitutes the entirety of the physician's responsibility in providing patient prescriptions. Citation: (Res. 516, A-02; Reaffirmed: BOT Rep. 8, A-11)	Retain – this policy remains relevant.
H-120.999	Refilling of Prescriptions	The AMA supports pursuing through the proper state or federal enforcement agencies full compliance with the laws, and if no law applies, supports legislation to carry out the following criteria: (1) any prescription not labeled as to number of refills may not be refilled; and (2) any prescription labeled PRN or ad lib may not be refilled.	Retain – this policy remains relevant.

		Citation: (Res. 46, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 8, A-11)	
H-150.998	Food Additives	Our AMA supports the passage of legislation that would amend the Food Additive Act to require evidence based upon scientifically reproducible studies of the association of food additives with an increased incidence of cancer in animals or humans at dosage levels related to the amounts calculated as normal daily consumption for humans before removal of an additive from the market. Citation: (Sub. Res. 4, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: BOT Rep. 6, A-10)	Retain – this policy remains relevant.
H-160.929	Anesthesiology is the Practice of Medicine	It is the policy of the AMA that anesthesiology is the practice of medicine. Our AMA seeks legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy, or dentistry. Citation: (Sub. Res. 216, I-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-175.973	Medicare Investigation Search and Seizure Process	(1) It is the policy of our AMA that: (1) no duly authorized law enforcement or legal agency conduct any unannounced search of physicians' offices or seizure of records without observance of appropriate legal procedures; (2) should unannounced search and seizure procedures be warranted in emergency situations based on clear and immediate threats to the lives or physical well-being of patients or the general public, such searches/seizures be conducted within the following parameters: (a) the search and/or seizure shall be conducted in a non-threatening and thoroughly professional manner; (b) the search and/or seizure shall not disrupt patient care; (c) the search and/or seizure shall be conducted in a manner to avoid publicity injurious to a physician's practice and professional reputation until all facts are known and culpability, if any, can be proven; (3) When an episode occurs whereby a governmental agency disrupts the daily activities of a physician's office in the process of investigating alleged fraud and abuse activities, that such	Retain – this policy remains relevant. Update Clause 3 so reports are directed to the AMA Advocacy unit since there is no longer a separate Division of Private Sector Advocacy.

		episodes be reported to the ~~Division of Private Sector~~ AMA Advocacy unit for tracking purposes and to assist the involved/affected physician(s); and. (4) If abusive practices of the investigative agency are noted, the AMA will inform the Department of Justice of those tactics. Citation: (Res. 205, I-01; Reaffirmed: BOT Rep. 22, A-11)	
H-175.977	Disruptive Visits to Medical Offices by Government Investigators and Agents	Our AMA: (1) supports legislation and/or other appropriate means to ensure that State and Federal investigators, and/or agents, give a physician written notice prior to a visit to a medical office, so that such visit may be scheduled upon mutual agreement at a time when patients are not present in the medical office; (2) in any circumstances which lawfully permit a visit to a medical office without notice, such as a search warrant, arrest warrant or subpoena, investigators and/or agents should be required to initially identify themselves to appropriate medical staff in a quiet and confidential way that allows the physician an opportunity to comply in a manner that is least disruptive and threatening to the patients in the medical office; and (3) encourages physicians to report incidents of inappropriate intrusions into their medical offices to the AMA's Office of the General Counsel and consider development of a hotline for implementation. Citation: (Res. 211, A-99; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-175.979	Medicare "Fraud and Abuse" Update	Our AMA seeks congressional intervention to halt abusive practices by the federal government and refocus enforcement activities on traditional definitions of fraud rather than inadvertent billing errors. Citation: (BOT Rep. 34, I-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-175.981	Fraud and Abuse Within the Medicare System	(1) Our AMA stands firmly committed to eradicate true fraud and abuse from within the Medicare system. Furthermore, the AMA calls upon the DOJ, OIG, and CMS to establish truly effective working relationships where the AMA can effectively assist in identifying, policing, and deterring true fraud and abuse.	Retain – this policy remains relevant.

		(2) Physicians must be protected from allegations of fraud and abuse and criminal and civil penalties and/or sanctions due to differences in interpretation and or inadvertent errors in coding of the E&M documentation guidelines by public or private payers or law enforcement agencies. (3) The burden of proof for proving fraud and abuse should rest with the government at all times. (4) Congressional action should be sought to enact a "knowing and willful" standard in the law for civil fraud and abuse penalties as it already applies to criminal fraud and abuse penalties with regard to coding and billing errors and insufficient documentation. (5) Physicians must be accorded the same due process protections under the Medicare audit system or Department of Justice investigations, that are afforded all US citizens. Citation: (Sub. Res. 801, A-98; Reaffirmed: Res. 804, I-98; Reaffirmed: BOT Rep. 6, A-00; Reaffirmation I-01; Modified: CMS Rep. 7, A-11)	
H-175.987	All-Payer Health Care Fraud and Abuse Enforcement Program	Our AMA: (1) opposes an All-Payer Health Care Fraud and Abuse Enforcement Program described in the Health Security Act of 1993 as it specifically applies to the seizure of property as a punitive measure in health care fraud cases; (2) supports efforts to clearly define health care fraud and establish an intergovernmental commission to investigate the nature, magnitude and costs involved in health care fraud and abuse; and (3) will pursue enactment of laws that ensure the equal application of due process rights to physicians in health care fraud prosecution. Citation: (Res. 215, A-94; Reaffirmation A-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. The Health Security Act of 1993, S. 491, was introduced but never passed. However, Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a comprehensive program to combat fraud committed against all health plans, both public and private. The legislation required the establishment of a national Health Care Fraud and Abuse Control Program (HCFAC), under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS)

			acting through the Department's Inspector General (HHS/OIG). The HCFAC program is designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse.
H-180.955	Deductibles Should Be Prorated to Make Them Equitable for Enrollees	Our AMA seeks legislation, regulation or other appropriate relief to require insurers to prorate annual deductibles to the date of contract enrollment. Citation: (Res. 235, A-01; Reaffirmed: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-190.961	Repeal of Federally Mandated Uniform Medical Identifiers	Our AMA: (1) actively supports legislation that would repeal the unique patient medical health identifier mandated by the Health Insurance Portability and Accountability Act of 1996; and (2) urges all state medical societies to ask each of their congressional delegations to declare themselves publicly on this matter. Citation: (Res. 207, I-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. Policy D-315.981, National Master Patient Identifier, is recommended to be retained (see above) and more broadly calls for our AMA to develop a strategy for a patient identification system at the national level.
H-215.962	Maintain CMS Inpatient Rehabilitation Classification Criteria at 60%	Our AMA: (1) reaffirms existing AMA policy and supports continuation of the compliance threshold for inpatient rehabilitation hospitals at its current level of 60 percent; and (2) strongly opposes any increase in the compliance threshold for inpatient rehabilitation hospitals. Citation: (Res. 212, I-11)	Retain – this policy remains relevant.
H-240.960	Opposition to Equalization of Payment Rates for Inpatient Rehabilitation Facilities and Skilled Nursing Facilities	Our AMA will oppose legislative or regulatory efforts to equalize payments for more medically complex rehabilitation patients with greater functional deficits, who require more intensive rehabilitation in an Inpatient Rehabilitation Facility, compared to less medically complex rehabilitation patients with fewer functional deficits, who require less intensive rehabilitation at a Skilled-Nursing Facility, regardless of their specific medical diagnosis. Citation: (Res. 213, I-11)	Retain – this policy remains relevant.
H-270.956	Evidence-Based Standard Requirement for	Our AMA supports federal mandates that all federal health care regulatory agencies (e.g., the FDA, the DEA, and the CMS) must demonstrate	Retain – this policy remains relevant.

	Governmental Regulation	the benefit of existing regulations and new regulations within three years of implementation; and that the demonstration of benefit must employ evidence-based standards of care; and that any regulations that do not show measurable improved patient outcomes must be revised or rescinded. Citation: (BOT Rep. 7, A-11)	
H-270.964	Fraud Compliance and Compliance Plans	Our AMA express its strong objections to the OIG for its unwarranted punitive attitude and the financial and administrative burden to physician practices and seeks modification to the final version of the "Office of Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices" so that it is not burdensome nor costly to medical practices (with respect to physician, staff, administrative, and financial resources) and focuses on education rather than criminal punishment. Citation: (BOT Rep. 29, A-01; Reaffirmed: BOT Rep. 22, A-11)	Rescind. Our AMA is, and will continue to, engage with the OIG to oppose policies that negatively impact individual and small group physician practices. The Office of Inspector General's Compliance Program Guidance for Individual and Small Group Physician Practices" is no longer on the OIG website, and has been replaced by a "Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud Abuse." Although the guidance document does provide information on penalties, the tone is more focused on education.
H-270.999	Legislation Making the Federal Register Give Fairer and More Reasonable Notice of the Promulgation of Regulations Which Will Have the Force of Law	Our AMA (1) is concerned over the lack of opportunity to develop and submit appropriate comments on proposed regulations, especially in the Federal Register, without adequate notice; and (2) supports (a) taking appropriate action to obtain greater advance notice and opportunity to comment on proposed regulations; (b) consideration of appropriate means to make available for the profession information concerning significant proposals of the various federal agencies on health matters; and (c) development of mechanisms to provide for more effective relief from the implementation of regulations harmful to sound medical practice should comments adverse to such regulations be ignored. Citation: (Sub. Res. 152, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report,	Retain – this policy remains relevant.

		A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	
H-285.939	Managed Care Medical Director Liability	AMA policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. (1) Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions; (2) that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and (3) that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability. Citation: (Sub. Res. 202, A-98; Appended: Res. 201, I-98; Reaffirmation A-99; Reaffirmed: BOT Rep. 18, I-00; Reaffirmation A-07; Reaffirmed in lieu of Res. 235, A-11: BOT action in response to referred for decision Res. 235, A-11)	Retain – this policy remains relevant.
H-290.977	Medicaid Sterilization Services Without Time Constraints	Our AMA will pursue an action to amend federal Medicaid law and regulations to remove the time restrictions on informed consent, and thereby allow all patients, over the age of 21 and legally competent, to choose sterilization services. Citation: (Res. 226, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-295.947	Legislative Threats to the Voluntary Accreditation Process	It is the policy of the AMA to strongly oppose legislation which would: (1) dismantle national accrediting agencies and which would substitute state standards for a uniform level of national standards in medical education; and (2) limit professional participation in the setting and evaluation of quality standards in medical education. Citation: (Res. 225, I-91; Modified: Sunset Report, I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.

H-305.962	Taxation of Federal Student Aid	Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). Citation: (Res. 210, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)	Retain – this policy remains relevant.
H-305.997	Income Tax Exemption for Medical Student Loans and Scholarships	The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. Citation: (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01; Reaffirmed: CME Rep. 2, A-11)	Rescind. This issue is addressed in H-305.962, Taxation of Federal Student Aid.
H-330.918	Violation of Medicare Act	Our AMA will take all measures to oppose any provision in the Medicare law and regulations that permits inappropriate federal involvement in medical treatment decisions or control over the practice of medicine as prohibited by Section 1801 of the Social Security Act. Citation: (BOT Rep. 37, I-98; Reaffirmation A-99; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-330.943	Physicians' Rights	Our AMA: (1) in conjunction with CMS, will seek to develop a simple, straightforward statement of a health care professional's or a provider's rights when initially under investigation for alleged fraud or abuse; and (2) urges that, where records or other information are requested from hospitals or other sources by a Medicare carrier fraud and abuse unit and where the investigation does not yield a potential case referable to the Office of the Inspector General, those sources from which information was sought and the involved physicians and others should be notified of their absolution after such an investigation. Citation: (Substitute Res. 212, I-94; Reaffirmation A-99; Reaffirmation I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-330.948	Three Day Prior Hospital Stay Requirement	Our AMA will recommend that the Secretary of the U.S. Department of Health and Human Services, in consultation with health care professionals and skilled care providers, define a subset of patients (or DRGs) for whom the elimination of the three-day prior hospital stay requirement for eligibility of the Medicare Skilled Nursing Facility benefit would avert hospitalization and generate overall cost savings.	Rescind. This policy is not relevant as our AMA has advocated more broadly to eliminate the three-day hospital stay requirement for SNFs.

		Citation: (Res. 805, I-93; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-04; Reaffirmed: Res. 234, A-09; Reaffirmation A-11)	
H-330.964	Federal Budgetary Process Reform as It Affects Medicare	Our AMA seeks legislative reform of the federal budgetary process to remove last-minute changes in Medicare funding in the reconciliation budget process and to insure appropriate and timely public input. Citation: (Res. 177, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-330.988	Free Choice by Patient and Physician Guaranteed	Our AMA reaffirms the original intent of Title XVIII, Section 1802 of the Social Security Act, which guarantees free choice by patient and physician. Citation: (Res. 115, I-87; Reaffirmed: Res. 731, A-95; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-335.962	Recovery Audit Contractors Should Confirm Problem Has Not Already Been Resolved Before Undertaking an Audit	Our AMA advocates that Federal Recovery Audit Contractors (RACs), prior to instituting an audit of a physician practice, make a good faith effort to ascertain whether the practice has already self-identified any billing irregularities that may have resulted in overpayments (including any such overpayment that may have been reported to the RAC), and has satisfactorily cured the irregularities by returning the overpayments and making any needed changes in their billing procedures, and where such self-identification and rectification has already occurred, that the audit not be initiated. Citation: (Res. 214, A-11)	Retain – this policy remains relevant.
H-335.984	Medicare Regulatory Relief Legislation	It is the policy of the AMA to initiate modifications to the Regulatory Relief Amendments or introduce additional legislation to address further areas where unwieldy or inequitable federal regulations or legislation place unrealistic or unfair demands on physicians and their office staff to: (1) abolish the A/B Data Link in which physician services provided during inpatient treatment, where payment to the hospital has been denied, are reviewed and can be denied as medically unnecessary years after the treatment has been provided; (2) abolish the practice of downcoding claims where Medicare carriers arbitrarily alter physician claims so that physicians are paid for a lower level of service than the one actually provided;	Retain – this policy remains relevant.

		(3) further clarify Section 6109 of OBRA 1989 that nullified the recoupment of funds from Texas physicians and patients so that the original intent of the legislation would be realized through repayment of funds to those physicians and beneficiaries who had already repaid funds to the government; (4) include provisions that relieve patients and physicians of responsibility for implementation of the Medicare as a Secondary Payer provisions and that the Medicare carrier be charged with responsibility for obtaining payment from the proper insurer rather than from physicians or beneficiaries for any errors that may be made in the determination of a beneficiary's insurance status; and (5) include provisions that would nullify Section 6102(g)(4) of OBRA 1989 that all Medicare claims be filed by physicians so that physicians who have large numbers of claims for small amounts would not be burdened with the transaction costs of meeting the mandatory claims filing provision, particularly since the OBRA 1989 provisions explicitly forbid physicians from requesting or receiving any additional payment for this costly and time-consuming service. Citation: (Res. 213, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 7, A-11)	
H-340.900	Quality Improvement Organization Program Status	Our AMA urges implementation of a Medicare beneficiary complaint process under the Medicare Quality Improvement Organization Program that meets the information needs of patients, offers appropriate due process for physicians, and maintains confidentiality of review findings. Citation: (CMS Rep. 1, A-97; Reaffirmation A-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-340.917	Publication in Federal Register of Proposed Changes in QIO Review Process or Procedures	Our AMA strongly urges CMS to publish in the Federal Register for review and comment any significant proposed changes in the quality improvement organization (QIO) process or procedures which would affect physician practice patterns and/or the delivery of medical care. Citation: (Sub. Res. 710, I-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.

H-340.930	~~Peer Review~~ Quality Improvement Organization Sanctions	Our AMA supports vigorously pursuing with appropriate ~~peer review~~quality improvement organizations (1) the careful definition of an adverse event, (2) the identification of whether the event is avoidable or unavoidable and whether it is a recognized complication of diagnosis or treatment, and (3) whether the event establishes a pattern or trend pointing to inappropriate physician or institutional behavior. Citation: (Res. 185, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)	Retain part of the policy. The Medicare Peer Review Organization program was renamed the Quality Improvement Organization program. Modify the title and policy by replacing "peer review" with "quality improvement."
H-340.931	Unannounced Enforcement of Regulation	Our AMA petitions CMS to preclude application of a law, rule or regulation prior to its effective date and urges CMS to announce the date on which the enforcement of a law, rule or regulation applicable to the Medicare program will begin. Citation: (Res. 199, A-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-340.932	Time Restrictions Placed on QIOs to Implement Changes in Review Procedures	Our AMA supports working with CMS to assure that quality improvement organizations are given adequate time for proper implementation of mandated changes to review processes and procedures. Citation: (Res. 95, A-91; Reaffirmed: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-340.933	QIO Data Dissemination	Our AMA discourages the use of any QIO data by any hospital, medical staff or other body for credentialing purposes. Citation: (Res. 249, A-91; Modified: Sunset Report, I-01; Modified: CMS Rep. 7, A-11)	Retain – this policy remains relevant.
H-340.972	Office of the Inspector General Involvement in ~~Peer Review~~ Quality Improvement	The AMA supports (1) careful review of the involvement of the Office of Inspector General in ~~peer review~~quality improvement organization and other sanction activity against physicians based on the quality of care provided; and (2) taking all appropriate steps, including legislative action if necessary, to establish a fair review mechanism designed to ensure that quality of care determinations are medically correct. Citation: (Res. 67, I-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 7, A-11)	Retain part of the policy. The Medicare Peer Review Organization program was renamed the Quality Improvement Organization program. Modify the title and policy by replacing "peer review" with "quality improvement."

H-35.970	Doctor of Nursing Practice	1. Our American Medical Association opposes participation of the National Board of Medical Examiners in any examination for Doctors of Nursing Practice (DrNP) and refrain from producing test questions to certify DrNP candidates. 2. AMA policy is that Doctors of Nursing Practice must practice as part of a medical team under the supervision of a licensed physician who has final authority and responsibility for the patient. Citation: (Res. 214, A-08; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-35.973	Scopes of Practice of Physician Extenders	Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care. Citation: (Res. 213, A-02; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-35.974	Prescribing by Allied Health Practitioners	Our AMA will work with national specialty societies to monitor the status of any initiatives to introduce legislation that would permit prescribing by psychologists and other allied health practitioners, and develop in concert with state medical associations specific strategies aimed at successfully opposing the passage of any such future legislation. Citation: (Sub. Res. 203, A-02; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-35.982	Direct Access to Physical Therapy	Our AMA (1) affirms that the ordering of medical services for patients constitutes the practice of medicine and that legislation to authorize non-physicians to prescribe physical therapy and other medical care services should be opposed; and (2) encourages physicians who prescribe physical therapy to closely monitor their prescriptions to ensure that treatment is appropriate. Citation: (Res. 203, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: Res. 224, A-11)	Retain – this policy remains relevant.

H-35.993	Opposition to Direct Medicare Payments for Physician Extenders	Our AMA reaffirms its opposition to any legislation or program which would provide for Medicare payments directly to physician extenders, or payment for physician extender services not provided under the supervision and direction of a physician. Citation: (CMS Rep. N, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11)	Retain – this policy remains relevant.
H-355.979	National Practitioner Data Bank	It is policy of the AMA to improve patient access to reliable information and as an alternative to a federally operated national data repository, our AMA strongly supports and actively encourages the provision of accurate and relevant physician-specific information through a system developed and operated by state licensing boards or other appropriate state agencies Our AMA: (1) supports requiring felony convictions of physicians to be reported to state licensing boards; (2) supports federal block grants that provide states with sufficient financial resources to develop and implement officially recognized, Internet accessible, physician-specific information systems that will assist patients in choosing physicians; and (3) believes that serious problems exist in correlating lawsuits with physician competence or negligence and some studies indicate lawsuits seldom correlate with findings of incompetence. Only a state licensing board should determine when lawsuit settlements and judgments should result in a disciplinary action, and public disclosure of lawsuit settlements and judgments should only occur in connection with a negative state medical board licensing action. Citation: (BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01; Reaffirmed: CME Rep. 2, A-11)	Retain – this policy remains relevant.
H-365.986	US Efforts to Address Health Problems Related to Agricultural Activities	Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities. Citation: (Res. 212, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain – this policy remains relevant.
H-385.918	Urging CMS to Direct Carriers	Our AMA will: (1) urge the Centers for Medicare & Medicaid Services to direct its carriers to effect	Rescind. This policy has been accomplished. Our

	to Effect Mass Retroactive Claims Adjustments	mass retrospective claims adjustments at the rates issued by Congress in the Patient Protection and Affordable Care Act, the Health Care and Education Reconciliation Act, and the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010; and (2) urge Medicare contractors to ensure corrected payments are issued to physicians going forward so that physicians receive the full benefit of the increased reimbursement rates as soon as possible. Citation: (Res. 231, I-10; Reaffirmed: Res. 216, A-11)	AMA repeatedly urged CMS to proceed with the retroactive processing of claims as instructed by the Affordable Care Act. As a result of AMA advocacy, CMS finally moved forward with the processing of the claims.
H-385.950	Managed Care Secondary Payers	Our AMA: (1) will seek regulatory changes that require all payers of secondary Medicare insurance to reimburse the co-insurance and applicable deductible obligations of Medicare beneficiaries; (2) will require that these co-insurance and deductible obligations cannot be waived contractually; ~~(3) will develop model state legislation that would mandate that all secondary insurers to Medicare either pay their contracted physicians full Medicare deductible and coinsurance amounts regardless of whether their fee schedules are lower than Medicare, or allow physicians to bill Medicare beneficiaries directly for the full Medicare deductible and coinsurance amounts;~~ (4<u>3</u>) will consider the development of draft federal legislation to require Medicare to recognize the total coinsurance and deductible amounts facing Medicare beneficiaries in instances where Medicare provides secondary insurance coverage; (~~5~~<u>4</u>) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan (not a Medigap policy) as their secondary carrier should be entitled to receive payment in full from their secondary carriers for all Medicare patient deductible and copayments without regard to the amount of the Medicare payment for the service; (~~6~~<u>5</u>) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan as secondary should be entitled to receive payment in full from their secondary plans for all Medicare patient	Retain part of the policy. Delete Clause (3) and renumber Clauses 4-7 accordingly. Our AMA has developed model legislation called for in Clause (3).

		deductibles and copayments without regard to any requirement that there be prior authorization by the secondary plan for medical care and treatment that is medically necessary under Medicare, by imposing limits on the amount, type or frequency of services covered, and by thereby seeking to "manage" the Medicare benefit, as if the secondary carrier were the primary carrier; and (~~7~~6) in its advocacy efforts, will address and seek to solve (by negotiation, regulation, or legislation) the problem wherein a secondary insurance company does not reimburse the patient for, nor pay the physician for, the remainder/balance of the allowable amount on the original claim filed with the patient's primary insurance carrier, regardless of the maximum allowed by the secondary insurance payer. Citation: (BOT Rep. 33, A-96; Appended: Res. 122, A-98; Reaffirmed: Res. 105, A-00; Sub. Res. 104, A-01; Reaffirmation I-01; Appended: Res. 105 and 106, A-03; Appended: Res. 821, I-11)	
H-390.971	Hospitals Limited to Participating Physicians	Our AMA (1) advises its members that the decision of whether or not to be a "participating" physician in Medicare is a personal choice; (2) supports use of all appropriate means to rescind those recently enacted regulations and statutes which unfairly discriminate against health care providers and which jeopardize the quality, availability and affordability of health care for the aged and the infirm; (3) urges a return to the original intent of the Medicare Law (Title XVIII) as expressed in Sections 1801 and 1802 enacted in 1965 which read as follows: "Section 1801 [42 U.S.C. 1895] Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." "Section 1802 [42 U.S.C. 1895a] Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to	Retain – this policy remains relevant.

		participate under this title if such institution, agency, or person undertakes to provide him such services;" (4) supports rescinding the "incentive" in OBRA 1986 regarding hospital referral of Medicare patients to participating physicians; (5) supports amendment of the Medicare law to eliminate any financial incentives to Medicare carriers for signing up large numbers of physician providers; and (6) supports rescinding OBRA 1986 provision that requires a nonparticipating physician who performed an elective surgical procedure on an unassigned basis for a Medicare beneficiary to provide the beneficiary in writing the estimated approved charge under Medicare, the excess of the physician's actual charge over the approved amount, and the coinsurance applicable to the procedure. Citation: (Res. 31, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 217, A-01; Reaffirmed: BOT Rep. 22, A-11)	
H-420.978	Access to Prenatal Care	(1) The AMA supports development of legislation or other appropriate means to provide for access to prenatal care for all women, with alternative methods of funding, including private payment, third party coverage, and/or governmental funding, depending on the individual's economic circumstances. (2) In developing such legislation, the AMA urges that the effect of medical liability in restricting access to prenatal and natal care be taken into account. Citation: (Res. 33, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmation A-07; Reaffirmed: Res. 227, A-11)	Retain – this policy remains relevant.
H-425.973	CMS Should Provide Date Eligibility Information to Beneficiaries	Our AMA encourages the Centers for Medicare & Medicaid Services to establish user-friendly mechanisms, such as an automated phone-in system or a web portal, much as is currently provided by banks, including of course appropriate measures to ensure security and confidentiality, via which any Medicare beneficiary can easily and quickly verify the dates of eligibility for all preventative services to which the person is entitled.	Retain – this policy remains relevant.

		Citation: (Res. 213, A-11)	
H-425.978	Stroke Prevention and Care Legislation	Our AMA supports comprehensive stroke legislation such as S.1274, the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act) as introduced, and work with Congress to enact legislation that will help improve our nation's system of stroke prevention and care. Citation: (Res. 215, I-01; Reaffirmed: BOT Rep. 22, A-11)	Retain – this policy remains relevant.
H-435.945	Binding Arbitration	Our AMA supports the utilization of pre-dispute binding arbitration that is agreed to by a patient and a physician prior to non-emergent treatment as an effective method of doctor-patient conflict resolution. Citation: (Res. 229, A-11)	Retain – this policy remains relevant.
H-435.962	Tort Reform and Managed Care	AMA policy states that medical liability reform be construed in the context of managed care and be consistent with these objectives: that (1) all managed care organizations (MCOs) are held responsible for assuring quality healthcare, and are held liable for any negligence on the part of the health plan resulting in patient injury; (2) physicians know and are able to carry out their professional obligations to patients despite cost constraints and contractual obligations to MCOs; and (3) coordinated patient safety systems tailored to managed care arrangements are in place. Citation: (BOT Rep. 18, I-96; Reaffirmation I-98; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed in lieu of Res. 224, A-09; Reaffirmed in lieu of Res. 235, A-11: BOT action in response to referred for decision Res. 235, A-11)	Retain – this policy remains relevant.
H-435.972	Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability	The AMA will continue to address the need for effective nationwide tort reform through the AMA's coalition-building activities and efforts on behalf of state and federal tort reform. Citation: (BOT Rep. M, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed in lieu of Res. 205, I-11)	Retain – this policy remains relevant.
H-435.974	Support of Campaigns Against Lawsuit Abuse	Our AMA supports expanding its tort reform activities by assisting state and county medical societies and interested civic groups in developing and implementing anti-lawsuit abuse campaigns and by encouraging members to involve themselves in these campaigns.	Retain – this policy remains relevant.

		Citation: (Res. 223, I-91; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 22, A-11)	
H-450.934	Timely Access to Health Insurance Plan Claims Data	Our AMA will: 1) advocate for appropriate policies, legislation, and/or regulatory action that would require third-party payers engaged in risk or incentive contracts with physician practice entities (including IPAs, PHOs, ACOs, healthcare networks, and healthcare systems) to provide physicians with timely access to reports of initial claims for service for patients served by those risk or incentive contracts; 2) advocate that third-party payers be required to make available electronically to physician practice entities reports of initial claims for service for patients served by risk or incentive contracts immediately upon such claims being received by the payer; and 3) advocate that third-party payers be required to make immediately available to physicians any relevant data on their patients collected in furtherance of risk profiling or incentive contracts that affect the safety or quality of patient care, in a form that permits efficient searching and retrieval. Citation: (Res. 220, A-11)	Retain – this policy remains relevant.
H-450.971	Quality Improvement of Health Care Services	Our AMA will continue to encourage the development and provision of educational and training opportunities for physicians and others to improve the quality of medical care. Citation: (BOT Rep. I, I-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)	Retain – this policy remains relevant.
H-460.931	Genetics Testing Legislation	The AMA opposes legislative initiatives on genetic testing that would unduly restrict the ability to use stored tissue for medical research; and will continue to support existing federal and private accreditation and quality assurance programs designed to ensure the accuracy and reliability of tests, but oppose legislation that could establish redundant or duplicative federal programs of quality assurance in genetic testing. Citation: (Sub. Res. 219, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CEJA Rep. 6, A-11)	Retain – this policy remains relevant.
H-460.953	Biomedical Research and Animal Activism	Our AMA: (1) supports working through Congress to oppose legislation which inappropriately restricts the choice of scientific animal models used in research and will work with Congress and the USDA to	Retain – this policy remains relevant.

		ensure that needs and views of patients and the scientific community are heard during any further consideration of USDA's role in laboratory animal oversight; and (2) supports laws which make it a federal crime, and similar legislation at state levels to make it a felony, to trespass and/or destroy laboratory areas where biomedical research is conducted. Citation: (Res. 238, A-91; Appended: Res. 513, I-00; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11)	
H-460.975	Support for NIH Research Facilities	Our AMA urges: (1) the enactment of federal legislation which would grant to the National Institutes of Health (NIH) funding authority to expand, remodel, and renovate existing biomedical research facilities and to construct new research facilities; (2) that the authority be granted to the NIH Director and not fragmented at the categorical institute level; and (3) that institutions be required to match federal funding for this program in a systematic way. Citation: (BOT Rep. S, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)	Retain – this policy remains relevant.