REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-A-24

Subject:	Council on Legislation Sunset Review of 2014 House Policies
Presented by:	Willie Underwood, III, MD, MSc, MPH, 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 (HOD) adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain it. Any action of our AMA HOD 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 HOD 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; or (f) The Speakers shall determine the best way for the HOD to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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 HOD 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 HOD 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-105.996	Impact of Pharmaceutical Advertising on Women's Health	1. Our AMA urges the US Food and Drug Administration (FDA) to assure that all direct-to-consumer advertising of pharmaceuticals includes information regarding differing effects and risks between the sexes. 2. Our AMA urges the FDA to assure that advertising of pharmaceuticals to health care professionals includes specifics outlining whether testing of drugs prescribed to both sexes has included sufficient numbers of women to assure safe use in this population and whether such testing has identified needs to modify dosages based on sex. (Res. 509, A-14)	Retain – this policy remains relevant.
D-115.988	Medication Non-Adherence and Errors	Our AMA will recommend the Centers for Medicare & Medicaid Services conduct a cost/benefit analysis and an analysis of the ability of seniors and people with disabilities to use blister packs in order to determine the feasibility of expanding coverage for timed calendar blister packs for prescription medications beyond residents of long term care facilities. (BOT Rep. 11, A-14)	Sunset this policy. The recommendation was communicated to the Centers for Medicare & Medicaid Services.
D-120.944	Improvement of Electronic Prescription Software	Our AMA will~~: (1) advocate for changing the national standards for controlled substance prescriptions so that prescriptions for controlled substances can be transmitted electronically directly to the pharmacy in a secure manner; and (2)~~ work with pharmacies, vendors, and other appropriate entities to encourage the use of standards that would allow the transmission of short messages regarding	Retain this policy in part. Delete clause (1). Drug Enforcement Administration regulations allow the option of writing prescriptions for controlled substances electronically. The regulations also permit

Policy Number	Title	Text	Recommendation
		prescriptions so that both physicians and pharmacists could communicate directly with each other within the secure health records systems that they are already using. (Res. 209, A-14)	pharmacies to receive, dispense, and archive these electronic prescriptions.
D-120.980	Regulation of Media-Based Drug Sales Without Good Faith Medical Examination	Our AMA will develop and promote model federal legislation to eliminate the sale, without a legitimate prescription, of prescription drugs over the Internet, if such bills to establish national standards in this area are not forthcoming. (Sub. Res. 520, A-04; Reaffirmed: BOT Rep. 19, A-14)	Sunset this policy. This policy has been superseded by more recent AMA policy (H-120.956, Internet Prescribing).
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	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		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)	
D-130.976	Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule	Our AMA will: (1) ask the EMTALA Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations; (2) work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		emergency services be appropriately compensated for providing EMTALA mandated services; (3) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (4) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (5) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation. (CME Rep. 3, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 605, I-08; Modified: CCB/CLRPD Rep. 2, A-14)	
D-160.991	Licensure and Liability for Senior Physician Volunteers	Our AMA (1) and its Senior Physician Group will inform physicians about federal and state-based charitable immunity laws that protect physicians wishing to volunteer their services in free medical clinics and other venues; and (2) will work with organizations representing free clinics to promote opportunities for physicians who wish to volunteer. (BOT Rep. 17, A-04; Reaffirmed: CCB/CLRPD Rep. 1, A-14)	Retain – this policy remains relevant.
D-175.985	The CMS Electronic Medical Records Initiative Should Not Be Used To Detect Alleged Fraud by Physicians	~~1. Our AMA will (A) communicate its concerns about the plan recently announced by the Centers for Medicare and Medicaid Services (CMS), in which CMS is to use data from the electronic medical record incentive program in the pursuit of fraud, waste and abuse; and (B) seek active involvement in the drafting of all program directives for CMS's electronic medical record~~	Retain this policy in part. Delete clauses (1) - (4) and modify clause (7). Our AMA communicated these concerns to the Centers for Medicare & Medicaid Services.

Policy Number	Title	Text	Recommendation
		~~initiative, including all directives about potential data capture and subsequent audit processes.~~ ~~2. Our AMA will lead an effort in concert with the Centers for Medicare and Medicaid Services to establish specific guidance to be utilized by entities that audit documentation generated by an electronic health record.~~ ~~3. Such guidance will provide specific protocols used by Medicare and Medicaid auditors to allege a service is not reasonable and necessary based on the generation of an electronic health record.~~ ~~4. Our AMA will inform state and specialty societies about available AMA resources to assist physicians with audits of electronic health records and prominently feature on their website information about methods, resources, and technologies related to appeals of electronic health record audits and Medicare and Medicaid overpayment recoveries as a members-only benefit.~~ ~~5~~1. Our AMA believes that the use of time-saving features, such as cloning, templates, macros, "pull forward technology", auto-population and identical language in EMRs, by itself is not an indication of inaccurate documentation or incorrect coding. ~~6~~2. Our AMA believes that audit results that imply incorrect coding must specifically indicate which portion of the chart language either does not accurately reflect the office visit or reflects unnecessary care. ~~7~~3. Our AMA will: ~~(1) develop guidelines in conjunction with the Centers for Medicare & Medicaid Services to provide clear and direct guidance to physicians concerning the permissible use for coding and billing of electronic health record (EHR) clinical documentation tools, such as templates, macros, cutting and pasting, and cloning, and (2)~~ study the impact of EHR clinical documentation tools and shortcuts on	

Policy Number	Title	Text	Recommendation
		patient safety, quality of care and safe harbor laws. (Res. 212, A-10; Appended: Res. 206, I-11; Appended: Res. 715, A-13; Reaffirmed: BOT Rep. 20, A-14)	
D-215.995	Specialty Hospitals and Impact on Health Care	Our AMA will: (1) oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest; (2) support changes in the inpatient and outpatient Medicare prospective payment systems to eliminate the need for cross-subsidization by more accurately reflecting the relative costs of hospital care; (3) support federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients; (4) encourage physicians who contemplate formation of a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital; and (5) oppose the enactment of federal certificate of need (CON) legislation and support state medical associations in their advocacy efforts to repeal current CON statutes and to oppose the reinstatement of CON legislation or its expansion to physician-owned ambulatory health care facilities. (BOT Rep. 15, I-04; Reaffirmation A-09; Modified: CCB/CLRPD Rep. 2, A-14)	Retain – this policy remains relevant.
D-255.985	Conrad 30 - J-1 Visa Waivers	1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program. 2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program. 3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs. 4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses. 5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA	

Policy Number	Title	Text	Recommendation
		Litigation Center, if it meets the Litigation Center's established case selection criteria. (Res. 233, A-06; Appended: CME Rep. 10, A-11; Appended: Res. 303, A-11; Reaffirmation I-11; Modified: BOT Rep. 5, I-12; Appended: BOT Rep. 27, A-13; Reaffirmation A-14)	
D-255.993	J-1 Visas and Waivers	1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program. ~~2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.~~ ~~3~~2. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians~~?~~' service requirements through the J-1 waiver and Conrad-30 programs ~~with a report back at A-03~~. ~~4~~3. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B waiver visas ~~for their J-1 visa waiver~~, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area. ~~5~~4. Our AMA ~~will work with state medical societies to study and report back on the feasibility of having~~ support a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program. (BOT Rep. 11, I-02; Appended: Res. 324, A-11; Appended: Res. 904, I-11; Reaffirmation A-14)	Retain this policy in part. Delete clause (2) and modify clauses (3) – (5). In 2002 the USDA decided to discontinue its role as an IGA on behalf of foreign research scientists or physicians desiring a recommendation of a J-1Visa waiver. Moreover, HHS has already expanded its J-1 visa waiver program.

Policy Number	Title	Text	Recommendation
D-260.994	Point of Care Availability for Blood Glucose Testing	Our AMA will work with the Food and Drug Administration and the Centers for Medicare & Medicaid Services to maintain the Clinical Laboratory Improvement Act exempt status of point-of-care glucose testing. (Res. 727, A-14)	Sunset this policy. Our AMA communicated support to the U.S. Food and Drug Administration and the Centers for Medicare & Medicaid services for Clinical Laboratory Improvement Amendments exempt status of point of care blood glucose testing.
D-315.984	Ownership of Claims Data	Our AMA will: (1) encourage physicians to include language designed to buttress rights associated with claims data ownership and access when contracting with health plan payers and other third parties; (2) continue to educate physicians on providing public and private health plan payers the "minimum necessary," as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and regulations thereunder, protected health information necessary to achieve the purpose of a disclosure; (3) assist physicians wishing to register a complaint against health plan payers that have used claims data to form a database, or that have permitted access to or sale of the database or its contents without explicit patient and/or physician authorization, beyond the scope permitted by HIPAA with the Department of Health and Human Services Office of Civil Rights; (4) advocate to the Department of Health and Human Services, Office of the National Coordinator of Health Information Technology and/or other appropriate agencies for rules and regulations ensuring appropriate physician ownership and access rights to claims data, and appropriate protection of claims data held by various parties; and (5) continue to monitor federal and state activities impacting the exchange of physician-generated health information, including claims data.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(BOT Rep. 19, I-06; Modified: CCB/CLRPD Rep. 2, A-14)	
D-35.994	Scope of Practice Participants in Health Plans	Our AMA Advocacy Resource Center will work at the invitation of AMA component societies to oppose legislative mandates on health care plans that may lead to inappropriate scope of practice expansion of non-physician providers. (Res. 923, I-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
D-375.997	Peer Reviewer Immunity	Our AMA will: (1) recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process; and (3) continue to work to provide peer review protection under federal law. (BOT Rep.8, I-01; Reaffirmation A-05; Modified: CCB/CLRPD Rep. 2, A-14)	Retain – this policy remains relevant.
D-40.995	The Implications of Health Care Personnel Delivery System	Our AMA will continue to monitor the Health Care Personnel Delivery System (HCPDS) and initiate communication with the Selective Service System and other relevant governmental bodies to address questions and concerns related to the implementation of the HCPDS.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(CME Rep. 2, I-04; Reaffirmed: CMS Rep. 1, A-14)	
D-400.984	Transparency, Participation, and Accountability in CMS' Payment Determination Process	1. Our AMA will urgently advocate for the Centers for Medicare and Medicaid Services (CMS) to improve its rate-setting processes by first publishing modifications to Medicare physician fees that result from CMS' misvalued codes initiative in the Medicare Physician Fee Schedule proposed rule instead of the final rule to afford adequate time for providers, professional medical societies and other stakeholders to review and comment on such changes before they take effect. 2. Our AMA will demand that CMS be transparent in its processes and methodologies for establishing physician work values and allow adequate opportunity for public comment on its methodologies before changes in physician work values take effect. (Res. 220, A-14)	Retain – this policy remains relevant.
D-406.998	National Provider Identification	Our AMA will work closely in consultation with the Centers for Medicare and Medicaid Services to introduce safeguards and penalties surrounding the use of National Provider Identification to protect physicians' privacy, integrity, autonomy, and ability to care for patients. (Res. 717, I-04; Reaffirmed: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
D-435.978	Loss of Medical Staff Privileges for Lack of "Tail Coverage"	Our AMA will: (1) Advocate for better disclosures by professional medical liability insurance carriers to their policyholders about the continuing financial health of the carrier; and advocate that carriers create and maintain a listing of alternate professional liability insurance carriers in good financial health which can provide physicians replacement tail or other coverage if the carrier becomes insolvent; and (2) Support model medical staff bylaw language stating: "Where continuous professional liability	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		insurance coverage is a condition of medical staff membership, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of medical staff membership. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement." (BOT Action in response to referred for decision Res. 537, A-04; Modified: CMS Rep. 1, A-14)	
D-435.985	Use of Countersuits to Discourage Frivolous Lawsuits	Our AMA will advise members of the option for countersuits against plaintiffs and attorneys who have filed frivolous lawsuits against physicians. (Sub. Res. 914, I-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
D-440.933	VA ACES Travel Policy	Our AMA will send a letter to the Secretary of the Department of Veterans Affairs (VA) and any other appropriate entities noting that the Attendance and Cost Estimation System (ACES) system has become a barrier to VA physician attendance at medical and scientific meetings, and encourage the Secretary to adopt ACES system reforms that will allow VA employed physicians to attend medical and scientific conferences. (Res. 614, A-14)	Sunset this policy. Our AMA submitted a letter to the Department of Veterans Affairs advocating for ACES reforms to lower the barriers and make it easier for VA-employed physicians and researchers to attend medical and scientific conferences.
D-440.934	Onerous Restrictions on Travel of Government Scientists	Our AMA ~~will pursue legislative or regulatory action to achieve~~ supports easing ~~of~~ travel restrictions for federally-employed scientists who are attending academic or scientific conferences that are consistent with current HHS policies and procedures, to include a simplified approval process. (Res. 608, A-14)	Retain this policy in part. Our AMA has communicated to the federal government about easing and simplifying restrictions related to federally employed scientists attending academic and scientific conferences.
D-450.959	Improvements to the Value-Based Modifier	Our AMA will: (1) seek a delay in the Value-Based Modifier (VBM) penalty for smaller practices; and (2) continue to encourage selection of VBM quality	Sunset this policy. The Value-Based Modifier program was replaced by

Policy Number	Title	Text	Recommendation
		measures that are physician-defined, clinically meaningful, specialty-appropriate, realistic, and within reasonable control of the physician. (Sub. Res. 218, A-14)	the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program.
D-450.981	Protecting Patients Rights	Our AMA will: (1) continue to advocate for the repeal of the flawed sustainable growth rate formula without compromising our AMA's principles for pay-for-performance; and (2) develop a media campaign and public education materials to teach patients and other stakeholders about the potential risks and liabilities of pay-for-performance programs, especially those that are not consistent with AMA policies, principles, and guidelines. (Modified: CCB/CLRPD Rep. 2, A-14)	Sunset this policy. The sustainable growth rate was repealed by the Medicare Access and CHIP Reauthorization Act.
D-450.987	Support of Patient Safety Aspects of The Joint Commission	Our AMA will continue to work with The Joint Commission on the development of standards which improve patient safety; and our AMA and The Joint Commission will then present these changes to the Centers for Medicare & Medicaid Services to effect an update of good health care policy and to delete outdated wasteful health care policy. (Res. 530, A-04; Modified: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
D-480.973	President's Council on Science and Technology Report	Our AMA will analyze the President's Council on Science and Technology Report entitled "Better Health Care and Lower Costs: Accelerating Improvement through Systems Engineering" and respond as appropriate. (Res. 523, A-14)	Sunset this policy. Our AMA thoroughly analyzed the May 2014 President’s Council on Science and Technology Report (PCAST) and has taken steps to implement the recommendations through testimony to an Office the National Coordinator Federal Advisory Committee, public comment on ONC’s proposed 10-year health IT roadmap, and comment letters to the

Policy Number	Title	Text	Recommendation
			Administration in support of the health IT framework outlined in the November 2014 Report to the President: Better Health Care and Lower Costs: Accelerating Improvement Through Systems Engineering.
D-60.968	Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth	Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services. (Res. 8, I-14)	Retain – this policy remains relevant.
D-80.997	Identify Theft	~~1.~~ Our AMA will request that the Internal Revenue Service (IRS) adopt policies to ensure greater security protection for electronically filed federal income tax returns, including the universal use of PINs, or personal identification numbers. ~~2. Our AMA will request that the IRS and the Centers for Medicare & Medical Services promulgate regulations to prohibit the use of Social Security numbers (SSN) by insurers, health care vendors, state agencies other than the state taxing authority and non-financial businesses.~~ (Res. 613, A-14)	Retain this policy in part. Delete clause 2. In 2023, the Centers for Medicare & Medicaid Services removed SSN-based health insurance claim numbers from Medicare cards and is now using Medicare Beneficiary Identifiers (MBIs) for Medicare transactions like billing, eligibility status, and claim status.
H-110.998	Cost of New Prescription Drugs	Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs. (Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14)	Sunset this policy. This policy has been superseded by more recent AMA policy (H-110.987, Pharmaceutical Costs; H-110.988, Controlling the Skyrocketing Costs of Generic Prescription Drugs;

Policy Number	Title	Text	Recommendation
			H-110.997, Cost of Prescription Drugs; H-285.965, Managed Care Cost Containment Involving Prescription Drugs; H-110.997, Cost of Prescription Drugs).
H-120.937	Methadone Should Not Be Designated as the Sole Preferred Analgesic	Our AMA recommends that methadone should not be designated as the sole preferred analgesic by any insurance payer, whether public or private. (Res. 117, A-14)	Sunset this policy. This policy has been superseded by more recent policy (H-185.931, Workforce and Coverage for Pain Management; D-120.932, Inappropriate Use of CDC Guidelines for Prescribing Opioids).
H-120.948	Positive Verification of Contact Lens Prescriptions	Our AMA will support positive prescription verification for contact lenses and recommend that the federal government monitor the effects of the Fairness to Contact Lens Consumers Act (FCLCA) on the accuracy of prescriptions. (Res. 225, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-160.907	Hospital Inpatient Admission Order and Certification	Our AMA: (1) supports the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital as a condition for payment for inpatient services; and (2) believes that upon admission of any patient to a hospital for inpatient services, the admitting/attending physician should have access to appropriate information--for example the Geometric Mean Length of Stay (GMLOS)--to help the physician plan appropriately for the services that will be required to care for that particular patient~~; and (3) will inform the Centers for Medicare & Medicaid Services as soon as possible of the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital, and take appropriate action to enact this policy~~.	Retain this policy in part. Delete clause (3). Our AMA communicated to the Centers for Medicare & Medicaid Services the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital.

Policy Number	Title	Text	Recommendation
		(Res. 227, I-13; BOT action in response to referred for decision Res. 227, I-13; Reaffirmation A-14)	
H-175.984	Health Care Fraud and Abuse Update	AMA policy is that: (1) our AMA leadership intensify efforts to urge federal policy makers to apply traditional definitions of fraud and abuse which focus on intentional acts of misconduct and activities inconsistent with accepted medical practice; (2) our AMA continue to work with federal law enforcement officials to improve the ability to root out intentional schemes to defraud public programs; (3) our AMA work with federal policymakers to balance payment integrity objectives with reasonable documentation and other administrative requirements; (4) our AMA develop model compliance plans and educational materials to assist physicians in conforming to the latest laws and regulations; and (5) our AMA continue to work in a coalition of other health care organizations to lobby for restrictions on the use of the False Claims Act. (BOT Rep. 25, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 223, A-14)	Retain – this policy remains relevant.
H-185.949	Centers for Medicare and Medicaid Services Policy on Hospital Acquired Conditions - Present on Admission	1. Our AMA will: (a) continue its strong opposition to non-payment for conditions outlined in the Hospital Acquired Condition -- Present on Admission (HAC-POA) policy that are not reasonably preventable through the application of evidence-based guidelines developed by appropriate medical specialty organizations based on non-biased, well-designed, prospective, randomized studies; (b) ask CMS or other appropriate bodies to monitor and evaluate practice changes made as a result of HAC-POA law, and associated outcomes, and report back on best practices; (c) educate physicians about	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		the HAC-POA law and its implications for patient care, coding requirements and payment; (d) continue its education and advocacy of CMS, Members of Congress and the public about the unintended consequences of non-payment for hospital acquired conditions that may not in fact be preventable, and that adversely affect access to and quality of care; (e) oppose the use of payment and coverage decisions of governmental and commercial health insurance entities as determinative of the standard of care for medical practice and advocate that payment decisions by any third party payer not be considered in determining standards of care for medical practice; and (f) continue to study the effect of HAC-POA penalty programs on professional liability; potential institutional demands to control or micro-manage doctors' professional decision-making; and efforts to develop evidence-based information about which events may be truly preventable as opposed to those whose frequency can be reduced by appropriate intervention. 2. Our AMA will: (a) continue its efforts to advocate against expansion of the Hospital Acquired Conditions - Present on Admission policy to physicians; (b) communicate to the Administration how burdensome the HAC-POA policy is for physicians and the Medicare program; (c) work with federal agencies to further monitor the HAC-POA program evaluation, and offer constructive input on its content and design; and (d) maintain efforts with our hospital association colleagues, such as the American Hospital Association, to monitor HAC-POA policy and its impact. (BOT Rep. 17, A-08; Appended: BOT Rep. 2, I-10; Modified: CCB/CLRPD Rep. 2, A-14)	

Policy Number	Title	Text	Recommendation
H-185.951	Home Anti-Coagulation Monitoring	1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions. 2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy. 3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions. (Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07; Appended: Res. 709, A-14)	Retain – this policy remains relevant.
H-225.995	Duplication in Hospital Liability and Physicians' Professional Liability Insurance	Our AMA believes that (1) Each physician should be free to determine whether to carry liability coverage as well as the amount of such coverage. Likewise, it is the responsibility of the hospital governing board to determine the extent to which the hospital should protect its assets by purchasing liability insurance; and (2) Regardless of the type of insurance coverage or protection plan hospitals and physicians on the organized staff have, the AMA encourages medical staffs and hospitals to work toward the establishment of effective risk management programs. (Res. 60, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Modified: Res. 813, I-02; Reaffirmation A-04; Modified: CMS Rep. 1, A-14)	Retain – this policy remains relevant.
H-245.979	Opposition to Proposed Budget	The AMA opposes reductions in funding for WIC and Head Start and other	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Cuts in WIC and Head Start	programs that significantly impact child and infant health and education. (Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)	
H-250.987	Duty-Free Medical Equipment and Supplies Donated to Foreign Countries	Our AMA will seek, through the federal government, a process to allow for duty-free donations of medical equipment and supplies, which are intended to reach medically-underserved areas and not be used for profit, to foreign countries. (Res. 229, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-275.918	Pediatric Medical Orders Between States	1. Our AMA supports legislation or regulation that allows physicians currently licensed and registered to practice medicine in any of the United States to duly execute conventional medical orders for their patients who are moving out of their state and into another state for use in any of the United States, for a transitional period of no more than sixty days. This would allow a child with special health care needs to attend early child care, daycare, nursery, preschool, and school safely in their new location while the family secures a new medical home, health insurance, and, when indicated, subspecialty care. 2. Our AMA will work with interested states and specialties on legislation or regulations to allow temporary honoring of medical orders by an out-of-state physician, as long as the physician is registered and licensed to practice medicine in the United States. (BOT Rep. 16, A-14)	Retain – this policy remains relevant.
H-330.974	Modification or Repeal of the Federal False Claims Act and Other Similar Statutes	It is the policy of the AMA to expend those resources necessary to monitor situations where physicians are under investigation, to provide financial and legal assistance where it is determined these are necessary, and to lobby for modification or repeal of the Federal False Claims Act and similar federal statutes.	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(Res. 152, A-90; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed in lieu of Res. 223, A-14)	
H-335.980	Payment For Copying Medical Records	It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided. (Res. 161, I-90; Appended by Res. 819, A-98; Reaffirmation A-08; Reaffirmed in lieu of Res. 710, A-14)	Sunset this policy. This matter is covered under Code of Medical Ethics 3.3.1, Management of Medical Records, which allows for physicians to charge a reasonable fee for the cost of transferring a record.
H-35.968	Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws	~~1. Our AMA will: (A) work to repeal new Public Health Service Act Section 2706, so-called provider "Non-Discrimination in Health Care," as enacted in PPACA, through active direct and grassroots lobbying of and formal AMA written communications and/or comment letters to the Secretary of Health and Human Services and Congressional leaders and the chairs and ranking members of the House Ways and Means and Energy and Commerce and Senate Finance Committees; and (B) promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act's "Non-Discrimination in Health Care" language, including direct collaboration with other interested components of organized medicine. 2.~~ Our AMA ~~will: (A) create and actively pursue legislative and regulatory opportunities to~~ advocates for the repeal of the ~~so-called~~ "Non-discrimination in Health Care" clause in Public Health Service Act Section 2706, as enacted in the Patient Protection and Affordable Care Act~~; and (B) lead a specific lobbying effort and grassroots campaign in cooperation with members~~	Retain this policy in part. Delete part 1 and modify part 2. Our AMA has advocated for repeal of section 2706 of the Affordable Care Act and has successfully advocated to the Centers for Medicare & Medicaid Services to clarify, consistent with the statutory language in the ACA and with Medicare Advantage and Medicaid policies, that section 2706 does not go beyond existing Medicare or Medicaid rules regarding the scope of practice of particular types of non-physician practitioners, nor does it require health plans and issuers to contract with particular types of non-physician practitioners or cover all types of services.

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		~~of the federation of medicine and other interested components of organized medicine to repeal the provider portion of PPACA's "Non-Discrimination in Health Care" language~~. (Res. 220, A-10; Appended: Res. 241, A-12; Appended: BOT Rep. 8, I-12; Modified: CCB/CLRPD Rep. 2, A-14)	
H-350.962	Reauthorization of the Indian Health Care Improvement Act	Our AMA supports reauthorization of the Indian Health Care Improvement Act. (Res. 221, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	Sunset this policy. The Indian Health Care Improvement Act (IHCIA) was made permanent in 2010 as part of the Patient Protection and Affordable Care Act.
H-355.975	Opposition to the National Practitioner Data Bank	1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank. 2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank. 3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office. 4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f)	Retain – this policy remains relevant.

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		of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank. 5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report; 6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement. 7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least $30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure.	

Policy Number	Title	Text	Recommendation
		8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates. (CCB/CLRPD Rep. 3, A-14)	
H-365.980	OSHA Regulations Pertaining to Physicians' Offices and Hospitals	The AMA continues to review the data and rationale used to substantiate OSHA regulations pertaining to medical practice in physician offices and health care facilities. Where OSHA rules and regulations are found to be unnecessary or inappropriate, the AMA will work for their modification or repeal. (Sub. Res. 218, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-375.972	Lack of Federal Peer Review Confidentiality Protection	Our AMA will seek to vigorously pursue enactment of federal legislation to prohibit discovery of records, information, and documents obtained during the course of professional review proceedings. Our AMA will immediately work with the Administration and Congress to enact legislation that is consistent with Policy H-375.972. (Res. 221, I-96; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 8, I-01; Reaffirmed: CMS Rep. 6, I-02; Appended: Res. 925, I-03; Reaffirmation A-05; Reaffirmed: BOT Rep. 13, I-11; Modified: CCB/CLRPD Rep. 2, A-14)	Sunset this policy. This policy is superseded by more recent AMA policy (D-375.999, Confidentiality of Physician Peer Review; H-375.962, Legal Protections for Peer Review).
H-40.967	Physician Participation in Department of Defense Reserve Components	1. Our AMA endorses voluntary physician participation in the military reserve components' medical programs as a means of actively aiding national defense while preserving the right of the individual physician to practice his/her profession without interruption in peace time. 2. Our AMA supports the U.S. Department of Defense by publicizing its needs for physicians in active duty military service and in the reserve components and guard, and encourages the active support and participation of	Retain – this policy remains relevant.

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		physicians in active duty military service and in the reserves. 3. Our AMA will (a) continue to work with all appropriate parties in developing and proposing a multi-faceted approach toward rejuvenation and improvement in recruitment and retention in the military reserves; (b) work to assure that retired military medical personnel become eligible for reserve status; (c) support enactment of federal laws to assist physicians in the transition from medical practice to active military service; (d) promote use of existing laws for selective service and retirement credits as models for development of practical equitable criteria to be applied; and (e) support improvements in professional utilization of military medical personnel during both active duty periods and "weekend drill." 4. Our AMA supports the development of a statutory system of limitations on call-up, retention and recall of reservists in order to provide stability and predictability to reserve status and duty, with the basis for such a system to be defined statutorily using credits or "points" to prioritize options available to individual reservists as to call-up, retention, rotation and recall. (CCB/CLRPD Rep. 3, A-14)	
H-406.989	Work of the Task Force on the Release of Physician Data	1. Our AMA Council on Legislation will use the Release of Claims and Payment Data from Governmental Programs as a basis for draft model legislation. 2. Our AMA will create additional tools to assist physicians in dealing with the release of physician data. 3. Our AMA will continue to monitor the status of, and take appropriate action on, any legislative or regulatory opportunities regarding the appropriate release and use of physician data and its use in physician profiling programs. 4. Our AMA will monitor new and existing Web sites and programs that collect and use data on patient	Retain – this policy remains relevant.

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		satisfaction and take appropriate action when safeguards are not in place to ensure the validity of the results. 5. Our AMA will continue and intensify its extensive efforts to educate employers, healthcare coalitions and the public about the potential risks and liabilities of pay-for-performance and public reporting programs that are not consistent with AMA policies, principles, and guidelines. 6. Our AMA: A) opposes the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL; and B) supports the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care, unless specifically approved by the physician. (BOT Rep. 18, A-09; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 808, I-10; Appended: Res. 327, A-11; Modified: CCB/CLRPD Rep. 2, A-14)	
H-415.998	Preferred Provider Organizations	The AMA: (1) opposes federal legislation that would preempt state regulation of PPOs; and (2) encourages state medical associations to support legislation that: (a) insures proper state regulation of PPOs, with particular attention to such practices as arbitrary determinations of medical necessity by carriers, "hold harmless" clauses, and predatory pricing concepts; and (b) requires independent, physician-directed peer review of the services provided by PPOs. (Sub. Res. 16, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-435.957	Uniform and Consistent Tort Reform	Our AMA will not pursue federal medical liability reform legislation that would divide or diminish the voice of the House of Medicine. (Sub. Res. 910, I-03; Reaffirmed in lieu of Res. 216, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-435.963	Professional Liability Claims Reporting	The AMA opposes the need for reporting on medical staff and other non-licensing board applications, including insurance company credentialing applications, (excepting professional liability insurance applications) any threatened, pending, or closed professional liability claims where the claim did not result in payment on behalf of that physician. (Sub. Res. 818, A-95; Modified: BOT Rep. 18, A-03; Reaffirmed: Res. 806, I-03; Reaffirmation A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-435.968	Enterprise Liability	The AMA: (1) affirms its position that effective medical liability reform based on California's MICRA model is integral to health system reform, and must be included in any comprehensive health system reform proposal that hopes to be effective in containing costs, providing access to health care services and promoting the quality and safety of health care services; (2) opposes any proposal that would mandate or impose enterprise liability concepts. Federal funding to evaluate the comparative advantages and disadvantages of enterprise liability may be best spent studying the operation, effect on liability costs and patient safety/injury prevention results of liability channeling systems that already exist and function as close analogs to the enterprise liability model (BOT Rep. I-93-53); and (3) supports strong patient safety initiatives and the investigation of alternative dispute resolution models, appropriate uses of practice parameters in medical liability litigation and other reform ideas that have the potential to decrease defensive	Retain – this policy remains relevant.

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		medicine costs and more fairly and cost-effectively compensate persons injured in the course of receiving health care services. (BOT Rep. III, A-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmation A-04; Reaffirmed: BOT Rep. 19, A-14)	
H-435.991	Professional Liability Countersuits	Our AMA supports the principle that the "special injury" element required to win a malicious prosecution countersuit in some jurisdictions should be eliminated. (Res. 44, I-84; Reaffirmed: Sunset Report, I-98; Reaffirmed: Sub. Res. 914, I-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-440.876	Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients	1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA ~~will work with local and state medical societies to immediately, actively and publicly~~ oppose<u>s</u> any legislative proposals that would criminalize the provision of health care to undocumented residents. (Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	Retain this policy in part. Modify Part 2 by broadening the language and making it more consistent with Part 1.
H-45.975	Proposed Change in Medical Requirements for 3rd Class Pilots' Licenses	Our AMA will: (1) oppose efforts to substitute the third class medical certificate with a driver's license; and (2) write a letter encouraging the Federal Aviation Administration to retain the third class medical certification process. (Res. 228, A-14)	Sunset this policy. Legislation was enacted in 2016 (Public Law 114-190, the FAA Extension, Safety, and Security Act of 2016) that statutorily allows pilots of small, non-commercial planes to forgo the medical

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			certification process if the pilot and aircraft meet certain prescribed conditions under an FAA program called "BasicMed." A 2020 FAA study found no difference in accident risk between flights conducted by pilots operating under BasicMed and flights conducted by pilots holding third-class medical certificates.
H-478.987	Compliance with Meaningful Use Requirements as a Condition of Medical Licensure	1. Our AMA stands on record as opposing any requirement that medical licensure be conditioned upon compliance with "Meaningful Use" requirements. 2. Our AMA, working with state and specialty medical societies, will make efforts at all appropriate levels of government to secure the reversal of any requirements that medical licensure be conditioned upon compliance with meaningful use requirements. (Res. 232, A-14)	Sunset this policy. The Centers for Medicare & Medicaid Services renamed this EHR Incentive Program to the Medicare and Medicaid Promoting Interoperability Programs in April 2018. This policy has been superseded by more recent AMA policy (H-478.993, Implementing Electronic Medical Records).
H-478.991	Federal EMR and Electronic Prescribing Incentive Program	Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with	Retain – this policy remains relevant.

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		meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required. (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13; Reaffirmed in lieu of Res. 214, I-13; Reaffirmed in lieu of Res. 221, I-13; Reaffirmed in lieu of Res. 222, I-13; Reaffirmed in lieu of Res. 223, I-14)	
H-55.991	Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain	Our AMA remains opposed to legislation or any other action that would reschedule heroin from Schedule 1 to Schedule 2 of the Controlled Substances Act. (BOT Rep. TT, A-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Modified: CCB/CLRPD Rep. 2, A-14)	Retain - this policy remains relevant.
H-60.940	Partner Co-Adoption	Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child. (Res. 204, A-04) (Res. 204, A-04; Modified: CSAPH Rep. 1, A-14)	Retain – this policy remains relevant.
H-75.998	Opposition to HHS Regulations on Contraceptive Services for Minors	(1) Our AMA continues to oppose regulations that require parental notification when prescription contraceptives are provided to minors through federally funded programs, since they create a breach of confidentiality in the physician-patient relationship. (2) The Association encourages physicians to provide comparable services on a confidential basis where legally permissible. (Sub. Res. 65, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28,	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		A-03; Reaffirmed: Res. 825, I-04; Reaffirmed: CMS Rep. 1, A-14)	
H-95.941	Restricting Prescriptions to Medicare Beneficiaries	1. Our AMA will work with the Centers for Medicare & Medicaid Services and state medical societies as needed to preserve access to care and eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs. 2. Our AMA supports federal legislation to eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs. (BOT Rep. 22, A-14)	Retain – this policy remains relevant.