

**REPORTS OF REFERENCE COMMITTEES OF THE AMERICAN MEDICAL ASSOCIATION
HOUSE OF DELEGATES 2013 ANNUAL MEETING**

REPORT OF REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION AND BYLAWS

- (1) BOARD OF TRUSTEES REPORT 3 - PHYSICIAN INSURERS
ASSOCIATION OF AMERICA: OFFICIAL OBSERVER STATUS IN THE
HOUSE OF DELEGATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 3 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 3 adopted and the remainder of the report filed.

Board of Trustees Report 3 asks that the Physician Insurers Association of America be granted official observer status in our AMA House of Delegates.

Limited testimony favored adoption of this report. The Physician Insurers Association of America has met all of the requirements in our Bylaws to obtain official observer status and our Board of Trustees believes the PIAA would bring a welcome perspective to House of Delegates deliberations. In the capacity as official observer, they can speak and debate on the floor of the House of Delegates if invited by the Speaker, but cannot introduce business or amendments, make motions, or vote. Therefore, your Reference Committee recommends that Board of Trustees Report 3 be adopted.

- (2) BOARD OF TRUSTEES REPORT 6 - NEW SPECIALTY ORGANIZATION
REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 6 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 6 adopted and the remainder of the report filed.

Board of Trustees Report 6 asks that the American Society of Echocardiography and the Gay and Lesbian Medical Association be granted representation in our AMA House of Delegates.

Limited testimony supported granting representation to both societies, highlighting the value of diversity in the House of Delegates' democratic process. Your Reference Committee, in reviewing the report, thought it important to clarify that the two groups are being recommended for representation under different policies. Specifically, the American Society of Echocardiography is being recommended under American Medical Association Policy G-600.020 for national medical specialty organizations, while the Gay and Lesbian Medical Association is being recommended under American Medical Association Policy G- 600.022 for professional interest medical associations. The Board of Trustees believes that each group has met the respective criteria for representation. Therefore, your Reference Committee recommends that Board of Trustees Report 6 be adopted.

(3) BOARD OF TRUSTEES REPORT 15 - EQUAL ACCESS TO ORGAN TRANSPLANTATION FOR MEDICAID BENEFICIARIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 15 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 15 adopted as amended and the remainder of the report filed.

That our AMA supports federal funding financing of organ transplants for Medicaid patients by Congress.

Board of Trustees Report 15 recommends that Resolution 1-I-11, calling for our AMA to urge the Centers for Medicare & Medicaid Services (CMS) to designate organ transplantation as a mandatory and essential benefit under Medicaid, not be adopted in the interest of current AMA policy and advocacy efforts that promote state flexibility surrounding health benefits.

Limited testimony in the virtual reference committee supported adoption of the report and underscored the importance of state variability in responding to fiscal challenges related to Medicaid and health benefits. Concerns were heard in the live hearing that the cost of dying from end stage organ failure and other alternative cost issues may not have been considered by the Board of Trustees in developing their recommendations. However, this concern was heard when the resolution was introduced at I-11, thus your Reference Committee believes that the Board of Trustees has considered this in their analysis. The issues of disparities of care for Medicaid beneficiaries may remain unchanged, but your Reference Committee agrees with the decision of the Board of Trustees, as well as other testimony, which recognized that CMS does not have clear authority to mandate organ transplantation as an essential benefit. Your Reference Committee believes that the myriad of complex issues have been sufficiently considered by the Board of Trustees in their analysis, report and recommendation. Therefore, your Reference Committee recommends that Board of Trustees Report 15 be adopted.

(4) BOARD OF TRUSTEES REPORT 29 - EMPLOYMENT STATUS AND ELIGIBILITY FOR ELECTION OR APPOINTMENT TO MEDICAL STAFF LEADERSHIP POSITIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 29 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 29 adopted and the remainder of the report filed.

Board of Trustees Report 29 responds to Resolution 1-I-12 which asked our AMA to provide draft guidance on medical staff governance, election and appointment of medical staff leaders and relevant conflict of interest policies. The report recommends amending American Medical Association Policy H-235.970 to provide for a more balanced management of potential conflicts of interest among medical staff in leadership positions. It also recommends drafting model medical staff bylaws that encourage disclosure of financial and personal affiliations by potential leaders and refers to *AMA's Physician's Guide to Medical Staff Organization Bylaws* and the *AMA Conflict of Interest Guidelines for Organized Medical Staff* as additional resources.

Some virtual testimony questioned the necessity of the amendment to American Medical Association Policy H-235.970 which establishes a process for disqualification from voting any leader who fails to disclose an interest. Other testimony felt it was necessary to give the policy some remedy when the policy is violated. Testimony heard during the live session supported adoption of the report, recognizing that the increasing rate of employed physicians

necessitates guidance in this area. Your Reference Committee agrees with the proposed changes suggested by the Board of Trustees and, moreover, agrees that a policy about disqualification is needed to enforce American Medical Association Policy H-235.970. Therefore, your Reference Committee recommends that Board of Trustees Report 29 be adopted.

- (5) BOARD OF TRUSTEES REPORT 33 - SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES- FIVE YEAR REVIEW

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 33 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 33 adopted and the remainder of the report filed.

Board of Trustees Report 33 summarizes the annual five-year review of specialty society representation in the House of Delegates. The report recommends that the Aerospace Medical Association, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgery, Inc., American Academy of Family Physicians, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American College of Medical Quality, American Society of Addiction Medicine, American Society of Ophthalmic Plastic and Reconstructive Surgery, The Endocrine Society and the International Spinal Intervention Society retain representation in the American Medical Association House of Delegates. It also recommends that the American Academy of Hospice and Palliative Medicine be given a grace period of one year to meet the membership requirements to retain their position in the American Medical Association House of Delegates.

The Board of Trustees introduced this report and there was no further testimony. Your Reference Committee recommends that Board of Trustees Report 33 be adopted.

- (6) COUNCIL ON CONSTITUTION AND BYLAWS REPORT 2 - AMA SENIOR PHYSICIANS SECTION, ADDITIONAL BYLAWS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws Report 2 be adopted and that the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws Report 2 adopted and the remainder of the report filed.

Council on Constitution & Bylaws Report 2 asks that our AMA amend its bylaws related to elections to the American Medical Associations' Senior Physicians Section's Governing Council. The modification would add provisions to Bylaw 7.90, to stipulate that all members of the Senior Physician Section are eligible to vote in elections of Governing Council members, and that the Governing Council shall elect the Section Chair-Elect from among the Governing Council members.

Virtual testimony was mixed but overall favored adoption of this report. Testimony highlighted the importance of a Senior Physician Section generally. Though some question was raised about the rationale for the Section's voting methods, your Reference Committee notes that the precedent has always been for individual sections to determine their own internal operating procedures and elections, unless the method would violate our AMA's Constitution and Bylaws. Testimony on behalf of the Senior Physician Section thanked the Council on Constitution and Bylaws for their assistance in crafting the bylaws, and your Reference Committee notes that the Board of Trustees has approved

the Senior Physician Section's internal operating procedures. For these reasons, your Reference Committee recommends that Council on Constitution and Bylaws Report 2 be adopted.

(7) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 3 - AMENDMENT TO E-5.055 "CONFIDENTIAL CARE FOR MINORS"

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 3 be adopted and that the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 3 adopted and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 03 responds to Resolution 1-A-12, "HPV Vaccination for Minors", which asked our AMA to develop and support policy allowing unemancipated minors to consent to the human papillomavirus vaccine. This report recommends that Opinion E-5.055, "Confidential Care for Minors", be amended to clarify that minors' ability to consent to treatment for sexually transmitted disease also includes the ability to consent to measures to prevent sexually transmitted disease.

Testimony mainly supported adoption of this report. Testimony supported a need for physicians to encourage teens to share information with their parents, while recognizing that the primary concern is to treat the patient. Testimony also emphasized a need to protect confidentiality to ensure teens seek necessary medical care. While there was discussion about how this report raises the wider issue of unemancipated minor consent to certain types of medical care, concerns of this nature address the already-existing policy rather than the proposed amendment. Further, the amendment brings Ethics policy in line with existing House policy. Therefore, your Reference Committee recommends that the Council on Ethical and Judicial Affairs Report 3 be adopted.

(8) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 4 - CEJA SUNSET REVIEW OF 2003 HOUSE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 4 be adopted and that the remainder of the report be filed.

HOD ACTION: Council on Ethical and Judicial Affairs Report 4 adopted and the remainder of the report filed.

Council on Ethical and Judicial Affairs Report 4 recommends that the House of Delegates policies that are listed in the Appendix to Council on Ethical and Judicial Affairs Report 4 be acted upon in the manner indicated and the remainder of the report be filed.

Some testimony in the virtual reference committee questioned the rationale for sunseting certain policies. The following provides greater specificity of the rationale for each policy:

American Medical Association Policy D-140.979 is recommended for rescinding because the directive was implemented by AMA staff in 2003.

American Medical Association Policy H-100.967 is recommended for rescinding because it is replaced by more recent Opinion E-5.5091 which more broadly addresses outside observers and the clinical encounter.

American Medical Association Policy H-210.984 is recommended for rescinding because it has been replaced with more recent policies, American Medical Association Policies H-210.981 and H-210.994. The change has been confirmed with Council on Science and Public Health staff.

American Medical Association Policy H-245.984 is being retained because the relevant law was reaffirmed in 2010 and it maintains its relevance, according to staff in American Medical Association's Advocacy Department.

American Medical Association Policy H-275.952 is being recommended for rescinding. Council on Medical Education staff has confirmed that the current policy is outdated and can adequately be replaced with American Medical Association Policies H-275.940, H-275.998, H-375.962 and Opinion E-9.031.

American Medical Association Policy H-515.983 is recommended for rescinding because, as acknowledged by Council on Science and Public Health staff, its essence is covered by more recent policies, American Medical Association Policy H-515.965 and Opinion E-2.02.

Upon examining the relevant policies, your Reference Committee feels that the sunset recommendations are appropriate and properly capture the spirit of the rescinded policies. No testimony was heard other than the introduction of the report. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 4 be adopted.

(9) BOARD OF TRUSTEES REPORT 20 - PHYSICIANS RESPONSE TO VICTIMS OF HUMAN TRAFFICKING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 20 be amended by addition and deletion on page 3, lines 14-20 to read as follows:

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, ~~many of them children~~ the majority of whom are women and/or children.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 20 be adopted as amended.

HOD ACTION: Board of Trustees Report 20 adopted as amended and the remainder of the report filed.

Board of Trustees Report 20, which responds to Resolution 4-A-12, "Educating Medical Providers as First-Line Responders to Stop Human Trafficking" and Resolution 8-A-12, "The Recognition and Protection of Human Trafficking Victims", recommends that our AMA encourage its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about relevant resources, in lieu of adopting the resolutions.

Testimony supported adoption of this report. Testimony recognized the important roles that physicians play in identifying human trafficking victims. Some testimony suggested an addition to the recommendation to include legal protections for physicians who, in good faith, report human trafficking incidents. Your Reference Committee did not feel that it had enough information or context to include specific language on the scope of this legal protection. Written testimony requested an amendment to note that 80% of the victims are female and 50% are children where the recommendation states "many of them children." Your Reference Committee agrees that including women as a significantly affected demographic is important, but is refraining from citing the actual percentage rate, which may

change over time. Therefore, your Reference Committee recommends that Board of Trustees Report 20 be adopted as amended.

(10) RESOLUTION 1 - DISCRIMINATION AGAINST PATIENTS BY MEDICAL STUDENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 1 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association oppose the refusal by medical students to participate in the care of ~~treat~~ patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 1 be adopted as amended.

HOD ACTION: Resolution 1 adopted as amended.

Resolution 1 asks for our American Medical Association to oppose the refusal by medical students to treat patients on basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.

Testimony regarding the intent of this resolution was favorable and supported adoption. There was consensus that medical students, like physicians, should not discriminate against patients when providing care. However, testimony also favored amending the language of the resolve to replace the term "treat", as medical students do not independently treat patients. Medical students, however, are part of the medical team which provides care, and thus are considered participants in the care of the patient. Your Reference Committee believes that the change addresses the concerns raised in testimony while maintaining the meaning of the resolution, and recommends that the Resolution 1 be adopted as amended.

(11) RESOLUTION 3 - ORGAN DONATION EDUCATION IN DRIVER TRAINING PROGRAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy H-370.984 be amended by addition to read as follows:

H-370.984 Organ Donation Education

Our AMA encourages all states and local organ procurement organizations to provide educational materials to driver education and safety classes. (Res. 504, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policy H-370.984 be adopted as amended in lieu of Resolution 3.

HOD ACTION: Policy H-370.984 adopted as amended in lieu of Resolution 3.

Resolution 3 asks our American Medical Association to encourage all states to include organ and tissue donation education in pre-licensing and driver training programs.

The majority of testimony supported the concept of education about organ and tissue donation. Limited concern was heard regarding parental consent where minors are not able to consent to organ donation themselves, but testimony in response noted that the educational programs could provide an educational foundation for when the minor becomes able to consent. Such education will also serve to correct misconceptions about who is able to consent to donate organs as well as what issues are important to consider when making that decision.

Current AMA policy supports providing educational materials to driver education and safety classes but currently only specifically notes that local organ procurement organizations provide these materials. However, the resolution asks that our AMA encourage states themselves to include organ and tissue education in pre-licensing and driver training programs. Thus, your Reference Committee believes that amending the language in current American Medical Association Policy H-370.984 to include all states in addition to local organ procurement organizations sufficiently captures the intent of the resolution and recommends adopting amended American Medical Association Policy H-370.984 in lieu of Resolution 3.

(12) RESOLUTION 4 - CONFORMING BIRTH CERTIFICATE POLICIES TO CURRENT MEDICAL STANDARDS FOR TRANSGENDER PATIENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 4 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by ~~a health care provider~~ a physician (MD or DO) that the individual has undergone transition according to applicable medical standards of care. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 4 be adopted as amended.

HOD ACTION: Resolution 4 adopted as amended.

Resolution 4 asks that our American Medical Association support policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a health care provider that the individual has undergone gender transition according to applicable medical standards of care.

Testimony largely favored the adoption of this resolution, emphasizing AMA's ongoing leadership in the area of civil rights and transgender healthcare. Testimony highlighted the distress caused by gender incongruence and the social barriers, discrimination and psychological harm facing this vulnerable population. Testimony also recognized that the birth certificate determines the provision of passports, drivers' licenses, and other documents of identification, and that changing the sex on a birth certificate is an important decision for transgender individuals who wish to have formal identification accurately depict their gender. It was emphasized that the resolution does not address the larger legal question about whether sex should be changed on birth certificates, which can and is being addressed by the States. Instead, the resolution promotes *physicians* as the decision-maker where sex change on birth certificate is possible, rather than bureaucrats. Such guidance is in line with those organizations that are expert in transgender health. However, there was emphasis placed on ensuring that those individuals who are assessing a transgender individual's sex should be properly trained to do so and your Reference Committee has amended the resolution to clarify this point. Therefore, your Reference Committee recommends that Resolution 4 be adopted as amended.

- (13) RESOLUTION 8 - PHYSICIANS AND PHYSICIANS-IN-TRAINING AS EXAMPLES FOR THEIR PATIENTS TO PROMOTE WELLNESS AND HEALTHY LIFESTYLES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first Resolve of Resolution 8 be amended by addition and deletion to read as follows:

That our American Medical Association establish a program that recognizes recognition program for physicians and physicians-in-training who model ~~exemplify~~ wellness and healthy lifestyles in their practice and communities or establish programs that contribute to the wellness of their patients and/or community, particularly in minority communities (Directive to Take Action);

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 8 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA accept wellness and healthy lifestyle activities for continuing medical education credit hours towards the AMA Physician Recognition Award (PRA). (Directive to Take Action)~~

RESOLVED, That our AMA aid in the development of a health and wellness component in conjunction with the Doctors Back to School Program.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 8 be adopted as amended.

HOD ACTION: Resolution 8 adopted as amended.

Resolution 8 asks that our American Medical Association establish a recognition program for physicians and physicians-in-training who exemplify wellness and healthy lifestyles in their practice and communities.

Testimony largely favored adoption of the first resolve of this resolution, noting the importance of physician health and wellness as a key component to improving patient health. The majority of testimony stated opposition to the resolve addressing CME credit; however, the authors of the resolution suggested removing the CME resolve and proposing a new resolve to combine health and wellness efforts with the Doctors Back to School Program. Testimony favored the amendments to this resolution. For these reasons, your Reference Committee recommends that Resolution 8 be adopted as amended.

- (14) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 1 - PHYSICIAN EXERCISE OF CONSCIENCE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 1 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 1 referred.

Council on Ethical and Judicial Affairs Report 1 examines the implications for patients, physicians, and the medical profession when tensions arise between a physician's professional commitments and his or her deeply held personal moral beliefs. It offers guidance on when a physician's professional commitments should outweigh personal beliefs

as well as when physicians should have freedom to act according to the dictates of conscience while still protecting patients' interests.

Testimony on this report was mixed. Virtual testimony largely favored adoption of this report and acknowledged the importance of conscience and moral issues as part of the core ethics of the profession of medicine. Some testimony suggested amending the report to address physicians' role in providing "treatment" or "therapy" rather than "care." This issue was raised again in the live hearing. Other testimony heard in the live hearing supported referral based on the belief that the recommendations could be much more succinct and less complex, and that perhaps there is sufficient language in existing AMA policies. Further testimony supported referral because the scope of the language is too broad and could have unintended consequences. Your Reference Committee believes that this is an important topic, but that CEJA should review the report and recommendations again in light of the testimony heard. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 1 be referred.

(15) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 2 -
AMENDMENT TO E-8.061 "GIFTS TO PHYSICIANS FROM INDUSTRY"

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

HOD ACTION: Council on Ethical and Judicial Affairs Report 2 referred.

Council on Ethical and Judicial Affairs Report 2 updates ethics policy on gifts to physicians from industry to reflect best thinking in the area and to respond to growing empirical evidence about the influence of industry relationships on physician practice.

Testimony predominantly supported referral of this report. Supportive testimony found the report timely, well-balanced in recognizing the importance of continued collaboration between industry and physicians, and necessary in the face of greater knowledge about the ramifications of gifts from industry in physician practice. Opposing testimony found the report too restrictive of physician autonomy, mainly focusing on recommendations (d) and (e). Recommendation (d), promoting a central distribution system for free samples, was critiqued for being too burdensome on small and rural practices and for hampering indigent care. Recommendation (e), which addresses physician provision of free samples to patients, was challenged for being too restrictive. Noted examples arguing for greater leeway included: providing free samples to patients for use in determining efficacy and any intolerances before purchasing or for permitting samples for those drugs that may not be immediately available in a pharmacy. There was some concern that recommendation (c), which limits gifts to a nominal value, might inadvertently preclude patient access to some expensive samples. The importance of widely distributing such a policy to ensure physician awareness of these ethical responsibilities was noted. Therefore, your Reference Committee recommends that Council on Ethical and Judicial Affairs Report 2 be referred.

(16) RESOLUTION 5 - CONFORMING BIRTH CERTIFICATE POLICIES TO
CURRENT MEDICAL STANDARDS FOR TRANSGENDER PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 5 be referred.

HOD ACTION: Resolution 5 referred.

Resolution 5 asks that our American Medical Association support policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by physician that the individual has undergone the gender transition according to applicable standards of care. The resolution also asks that our AMA support eliminating any government requirement that an individual has undergone surgery in order to change the sex

designation on birth certificates. Lastly, the resolution asks that our AMA support that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventative care.

Resolution 5 addressed similar issues to Resolution 4 but raised additional considerations about implications for transgender care as well as medical vs. surgical requirements for change in sex designation. While it was largely acknowledged that this was an important area for our AMA to study, testimony to these points mainly supported referral due the scientific, legal, and other complexities which these resolves raise.

Testimony was concerned about the possible long-term and unintended consequences of changing the sex on one's birth certificate prior to surgery, ramifications for insurance coverage of reproductive care, and disagreement in the medical community over what constitutes a medical change in sex. While your Reference Committee acknowledges the importance of formal gender identification, we believe the science, public health, reimbursement, legal, and other implications deserve greater analysis and study, considering the interests of long-term concern for transgender patients. Your Reference Committee therefore recommends that Resolution 5 be referred.

(17) RESOLUTION 9 - RESTRICTIVE COVENANTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be referred.

HOD ACTION: Resolution 9 referred.

Resolution 9 asks that our American Medical Association conduct an in depth evaluation of and update existing AMA policy on restrictive covenants in physician contracts, which is contained in the American Medical Association Opinion 9.02 of the American Medical Association's *Code of Medical Ethics*.

Testimony favored referral for an evaluation of the ethical and legal considerations. Changes in the way medicine is practiced, particularly a growth in large health care systems, employed physicians and hospital-owned practices, all call for renewed attention to the American Medical Association's *Code of Medical Ethics Opinion*, which has not been updated since 1998. Your Reference Committee notes that the Council on Ethical and Judicial Affairs is currently undertaking a review of all *Code of Medical Ethics* Opinions. Your Reference Committee suggests referral to consider all testimony on this resolution in connection with the review, and work with appropriate AMA entities on legal considerations as well as implications for employed physicians. Therefore, your Reference Committee recommends that Resolution 9 be referred.

(18) RESOLUTION 2 - INVESTIGATING THE POSSIBILITY OF A UNIFIED LIVING DONOR KIDNEY REGISTRY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 2 be referred for decision.

HOD ACTION: Resolution 2 referred for decision.

Resolution 2 asks for our American Medical Association to support the study of developing a unified, nationwide living kidney donor registry and to advocate for public and private funding of such studies to reach the long term goal of establishing a unified registry.

Testimony regarding this resolution was limited but favorable. Testimony recognized the importance of efforts to study and improve the renal transplant process on a national level. However, significant testimony explained that other entities, both public and private, as well as groups within the transplant community, are already studying this issue. The resolution asks that our AMA support these endeavors, but it is unclear both what kind of support would be appropriate for our AMA to provide, and what types of programs or studies our AMA should support. Therefore, your Reference Committee recommends that Resolution 2 be referred for decision.

(19) RESOLUTION 6 - MAINTAINING PUBLIC SAFETY AND TRUST IN MEDICINE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-175.992 be reaffirmed in lieu of Resolution 6.

HOD ACTION: Policy H-175.992 reaffirmed in lieu of Resolution 6.

Resolution 6 asks that our American Medical Association address the physician-presented misinformation about medical topics through the public media.

Testimony in the virtual reference committee was mixed. Several individuals recommended referring the item for study regarding the legal implications of this resolution, while others recommended reaffirming current HOD policy, particularly American Medical Association Policy H-175.992. American Medical Association Policy H-175.992 Deceptive Health Care Advertising encourages and assists all physicians and medical societies to monitor and report to the appropriate state and federal agencies any health care advertising for which there is a reasonable, good-faith basis for believing that said advertising is false and/or deceptive. Testimony in the live hearing was minimal and agreed that current policy adequately addresses the concerns in Resolution 6. Your Reference Committee therefore recommends that American Medical Association Policy H-175.992 be reaffirmed in lieu of Resolution 6.

(20) RESOLUTION 7 - RESIDENTS' RIGHTS TO MAKE POTENTIALLY UNSAFE CHOICES IN LONG-TERM CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Opinion E-8.08 be reaffirmed in lieu of Resolution 7.

HOD ACTION: Opinion E-8.08 reaffirmed in lieu of Resolution 7.

Resolution 7 asks that our American Medical Association support the freedom of occupants of long-term care facilities to choose potentially unsafe treatment options after signing informed consent and waiver of liability.

Testimony regarding this resolution was varied. Some individuals opposed this resolution wholly, while others emphasized the importance of respecting patient autonomy while promoting patient safety. In considering the testimony and background information on this resolution, your Reference Committee concluded that American Medical Association Opinion E-8.08, "Informed Consent" adequately addresses the fundamental issues underlying Resolution 7. American Medical Association Opinion E-8.08, "Informed Consent" states that the patient's right to self-determination can be effectively exercised only when the patient possesses enough information to enable an informed choice. Testimony favored this reaffirmation. Your Reference Committee therefore recommends that American Medical Association Opinion E-8.08 be reaffirmed in lieu of Resolution 7.

(21) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OPINION 1 - AMENDMENT TO E-9.011 "CONTINUING MEDICAL EDUCATION"

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the opinion be filed.

HOD ACTION: CEJA Opinion 1 Amendment to E-9.011 filed.

Council on Ethical and Judicial Affairs Opinion 1 provides ethical guidance for physicians to reflect evolving standards for CME providers, as reflected by the Accreditation Council on Continuing Medical Education changes. It speaks directly to the attendees of CME activities.

There was a concern raised that “commercial entity” in recommendation (d) might be broadly construed to not permit physicians to attend CME events paid for by their professional societies or some employers. However, the Council on Ethical and Judicial Affairs responded that the definition of “commercial entity” as per ACCME does not include these entities. Additionally, this language was approved by the Council on Medical Education and this report was adopted by the House of Delegates. Therefore, your Reference Committee agrees with the filing of this opinion.

REPORT OF REFERENCE COMMITTEE A

- (1) RESOLUTION 103 – MANAGED CARE CONTRACT PAYMENT SHOULD BE ABOVE MEDICARE FEES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 103 be adopted.

HOD ACTION: Resolution 103 adopted.

Resolution 103 asks that our AMA seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.

A preponderance of the testimony heard on Resolution 103 was supportive. The resolution's sponsor acknowledged the similarity of their request with existing AMA policy (Policy D-400.990), which asks the AMA to use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate payment level. Your Reference Committee points to the AMA's strategic focus area on payment and care delivery, which builds upon ongoing legislative activities to shape payment and delivery models that improve physician satisfaction.

The sponsor underscored the continued downward spiral of physician payment levels and the trend among managed care companies to link physician payment to Medicare rates plus or minus certain percentages. Multiple speakers also described insurers who have uncoupled their fees from Medicare conversion factors in ways that negatively affect physician payments. Because testimony on Resolution 103 was largely supportive, your Reference Committee recommends that it be adopted.

- (2) RESOLUTION 109 - COMPREHENSIVE DENTAL COVERAGE (INCLUDING DENTAL IMPLANTS) FOR CHILDREN WITH OROFACIAL CLEFTING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 109 be adopted.

HOD ACTION: Resolution 109 adopted.

Resolution 109 asks that our AMA advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting.

There was limited, yet unanimous positive testimony heard on Resolution 109. Speakers urged the AMA to support comprehensive dental coverage to assist children with orofacial clefting as this condition can be a tremendous burden for the children afflicted by this disorder. Your Reference Committee notes that existing AMA Policy H-185.967[1] supports insurance coverage for the treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease. Given supportive testimony and consistency with existing AMA policy, your Reference Committee recommends that Resolution 109 be adopted.

- (3) RESOLUTION 114 - ONCOFERTILITY AND FERTILITY PRESERVATION TREATMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 114 be adopted.

HOD ACTION: Resolution 114 adopted.

Resolution 114 asks that our AMA support payment for and lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary oncologic treatments as determined by a licensed physician.

Your Reference Committee heard extensive, impassioned testimony on Resolution 114. Many speakers supported the adoption of Resolution 114 as written stating that providing fertility preservation treatment is the standard of care although patients are often not able to obtain this care because health insurers are not covering such treatment. One speaker highlighted a series of adverse health conditions that have resulted from oncology care, which are all covered by health insurers. Therefore, it was urged that oncofertility and fertility preservation treatment should be covered as well. Given supportive testimony, your Reference Committee recommends that Resolution 114 be adopted.

- (4) RESOLUTION 121 - NEED TO DEACTIVATE NEW CODING EDITS THAT BUNDLE EVALUATION AND MANAGEMENT CODES AND CODES FOR IMMUNIZATION SERVICES, RESULTING IN DECREASED IMMUNIZATION RATES FOR CHILDREN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 121 be adopted.

HOD ACTION: Resolution 121 adopted.

Resolution 121 asks that AMA Policy H-60.969, Childhood Immunizations, be reaffirmed and that our AMA work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage CMS to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.

The sponsors of Resolution 121 expressed concern about the Center for Medicare and Medicaid Services' National Correct Coding Initiative, which has resulted in the bundling of all evaluation and management services with immunization codes. The unintended consequence of this bundling of services has resulted in making it more difficult for physicians caring for children to provide preventive medicine, specifically immunizations. Several speakers expressed strong concerns about barriers that make it difficult to administer immunizations. Given supportive testimony, your Reference Committee recommends that Resolution 121 be adopted.

- (5) BOARD OF TRUSTEES REPORT 14 - DIRECT-TO-CONSUMER ADVERTISING OF DURABLE MEDICAL EQUIPMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2b in Board of Trustees Report 14 be amended by addition and deletion to read as follows:

(b) ~~whenever feasible~~ list the actual criteria (or a summary thereof) from the appropriate source, such as the applicable Certificate of Medical Necessity, DME Information Form (DIF), "Dear Physician Letter" from DME Contractor Medical Directors, Local Coverage Determination or associated policy article; and

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 in Board of Trustees Report 14 be amended by addition and deletion to read as follows:

That our AMA recommend that DME companies stop coercive acts which ~~push~~ inappropriately influence physicians to sign these prescriptions for their patients.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 14 be adopted as amended and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 14 adopted as amended and the remainder of the report filed.

Board of Trustees Report 14 recommends that policies H-330.945 Durable Medical Equipment Requirements, H-330.955 Prescription of Durable Medical Equipment and H-330.960 Cost of Medically Related Services and Supplies be reaffirmed.

Board of Trustees Report 14 also recommends that Resolution 505-A-12 be amended by deletion to read as follows and adopted: That our AMA pursue legislation or regulation as appropriate to require that direct-to-consumer advertising and any other media for durable medical equipment and other medical supplies: (a) include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria; (b) whenever feasible list the actual criteria (or a summary thereof) from the appropriate Certificate of Medical Necessity; ~~(e) note that patients who knowingly obtain DME or other supplies without meeting the eligibility criteria and the physicians who inappropriately certify such patients may be subject to civil and/or criminal penalties for fraud;~~ and, ~~(d)~~ (c) refrain from statements to the effect that only a physician order or signature is required to obtain the desired items. In addition, the report suggests that our AMA recommend that DME companies stop coercive acts which push physicians to sign these prescriptions for their patients.

Your Reference Committee commends the Board on its examination of durable medical equipment (DME) and supplies sales, direct-to-consumer advertising of these products and federal oversight activities of medical devices. Testimony on this report was generally supportive. Your Reference Committee believes that the report's recommendations address the adverse effects of direct-to-consumer advertising of DME and supplies. Moreover, the report includes compelling information in support of the recommendations. Suggested edits to the body of the report, but not to the report's recommendations, were submitted by the U.S. Food and Drug Administration. An amendment to Recommendation 2b accounting for a range of sources of criteria was well-received and is recommended by your Reference Committee. Your Reference Committee also concurs with a minor amendment to Recommendation 3 that was suggested in online testimony. Accordingly, your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended.

(6) COUNCIL ON MEDICAL SERVICE REPORT 3 – PAYMENT VARIATIONS
ACROSS OUTPATIENT SITES OF SERVICE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 of Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

1. That our AMA work with states to advocate that third party payers be required to:

- a. Assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility);
- b. Publish and routinely update pertinent information related to patient cost-sharing; and
- c. Allow their plan's participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Original Council on Medical Service Report 3 adopted.

Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-330.925, H-240.993 and D-330.997, which support equitable Medicare payments across outpatient settings, and reaffirm Policy H-165.846, which supports mechanisms to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing, out-of-pocket limits and lifetime benefit caps, and excluded services. Council on Medical Service Report 3 also recommends that our AMA work with states to advocate that third party payers be required to: (a) assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility); (b) publish and routinely update pertinent information related to patient cost-sharing; and (c) allow their plan's participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient.

Your Reference Committee heard testimony that was supportive of Council on Medical Service Report 3. Testimony noted that a variety of factors may justify higher payments to hospital outpatient departments, such as hospital requirements to meet Joint Commission accreditation standards and Medicare Conditions of Participation. Alternatively, physician offices are not required to meet these standards. An additional comment suggested that our AMA explore whether higher payments in certain settings are justified by patient safety concerns. Your Reference Committee discussed possible reasons for higher payments to hospital outpatient departments, including hospitals' 24-hour access and the proximity of outpatient departments to hospital emergency departments. Your Reference Committee concludes that data are not yet available to substantiate whether pay disparities for services performed across outpatient settings are in fact justifiable. Furthermore, there is no comprehensive evidence base to help patients determine the optimal location to have a particular outpatient procedure performed.

Testimony also acknowledged the importance of cost transparency to help patients understand that the amount of their cost-sharing may differ, depending on the site of service. Your Reference Committee clarified that transparency regarding costs is important but does not inform patients about actual quality of care. Additional testimony noted that the payment disparities discussed in the Council's report have led many cardiologists to migrate to the hospital setting, thereby increasing costs of certain outpatient cardiac procedures. Speakers also expressed concern that physician payments across sites of service will be equalized at the lowest possible level.

Substitute language for Recommendation 3a was offered out of concern that the recommendation as written does not sufficiently hold patients accountable to make quality and cost-effective choices. Testimony was supportive of this language, and your Reference Committee therefore recommends incorporating the substitute language into Recommendation 3a and adopting Council on Medical Service Report 3 as amended.

(7) COUNCIL ON MEDICAL SERVICE REPORT 5 - DELIVERY OF CARE AND FINANCING REFORM FOR MEDICARE AND MEDICAID DUALY ELIGIBLE BENEFICIARIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1a of Council on Medical Service Report 5 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) adopt the following principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible beneficiaries:
 - a. Various approaches to integrated delivery of care should be promoted under demonstrations such as ~~primary care~~ physician-led patient-centered medical homes with adequate payment to physicians, provision of care management and mental health resources.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 5 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 5 recommends that our AMA adopt the following principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible beneficiaries: a. Various approaches to integrated delivery of care should be promoted under demonstrations such as primary care medical homes with adequate payment to physicians, provision of care management and mental health resources; b. Customized benefits and services from health plans are necessary according to each beneficiary's specific medical needs; c. Care coordination demonstrations should not interfere with the established patient-physician relationships in this vulnerable population; d. Delivery and payment reform for dually eligible beneficiaries should involve actively practicing physicians and take into consideration the diverse patient population and local area resource; e. States with approved financial alignment demonstration models should provide education and counseling to beneficiaries on options for receiving Medicare and Medicaid benefits; f. Conflicting payment rules between the Medicare and Medicaid programs should be eliminated; g. Medicare and Medicaid benefit plans and the delivery of benefits should be coordinated and h. Care plans for beneficiaries should be streamlined among all clinical providers and social service agencies.

Council on Medical Service Report 5 also recommends that our AMA reaffirm Policy D-290.978, which calls for the Centers for Medicare & Medicaid Services to require all states to develop forms and related processes to facilitate "opting out" of managed care programs by dually eligible individuals, and that those forms and directives be available no less than 120 days before the implementation date of a state's dually eligible managed care program.

Your Reference Committee heard supportive testimony on Council on Medical Service Report 5. A speaker acknowledged that the report provides a good summary of some of the issues and solutions for providing health care services for Medicare and Medicaid dually eligible beneficiaries.

Amendments were proposed for consideration. Testimony provided information that there are National Committee for Quality Assurance standards for specialty medical homes as well as primary care medical homes. Therefore, it was suggested that Recommendation 1a be amended to read "patient-centered medical homes" rather than "primary care medical homes." In addition, an amendment was suggested to include "physician-led" at the beginning of

“patient-centered medical homes,” which was supported by the Council on Medical Service. Your Reference Committee concurs with these amendments.

In addition, testimony suggested that recommendation 1f be more explicit so that the administration of the dually eligible population takes into consideration physician payments, medical office administration and patient empowerment. A speaker suggested amending the recommendation to read “Conflicting payment rules between the Medicare and Medicaid programs should be eliminated in a manner that benefits the physician-patient team.” Your Reference Committee considered this amendment, but felt that the suggested new language was too vague and questioned what examples of benefiting the physician-patient team would apply in this situation.

A concern was raised that this report may allow for any willing provider provisions. A member of the Council on Medical Service testified that the report does not advocate for any willing provider provisions since it is focused on not disrupting continuity of care of dually eligible patients when possible. It is not designed to allow any willing provider to care for any patient, but rather to support the long term patient-physician relationships that have already been established in this vulnerable population. As such, your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended.

(8) RESOLUTION 102 - PATIENT SATISFACTION SURVEYS AND QUALITY PARAMETERS AS CRITERIA FOR PHYSICIAN REIMBURSEMENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 102 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician ~~reimbursement~~ payment (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 102 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with CMS and non-government payers to ensure that ~~reimbursement-physician payment~~ physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 102 be adopted as amended.

HOD ACTION: Resolution 102 adopted as amended with a change in title.

New title: Patient Satisfaction Surveys and Quality Parameters for Physician Payment

Resolution 102 asks that our AMA work with CMS and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician reimbursement and that reimbursement determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician.

Testimony on Resolution 102 was mixed. Several amendments were proposed, such as replacing the term “reimbursement” with “payment” in both resolves. Your Reference Committee concurs with this suggested language change. In addition, your Reference Committee notes that existing AMA policy is consistent with the requests in Resolution 102. Policy H-406.991[5] advocates that physician-profiling programs may rank individual physician members of a medical group but should not use those individual rankings for placement in a network or for payment purposes. Policy H-450.966 advocates that regarding the development and evaluation of quality and performance standards, standards and measures should recognize and adjust for factors that are not within the direct control of those being measured. Given the minor amendments and consistency with AMA policy, your Reference Committee recommends that Resolution 102 be adopted as amended.

(9) RESOLUTION 104 - COST-SAVING PUBLIC COVERAGE FOR RENAL TRANSPLANT PATIENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 104 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support private and public mechanisms that would extend insurance coverage for ~~the full spectrum~~ evidence-based treatment of renal transplant care for the life of the transplanted organ (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 104 be amended by addition to read as follows:

RESOLVED, That our AMA continue to offer technical assistance to individual state and specialty societies when those societies lobby state or federal legislative or executive bodies to implement evidence-based cost-saving policies within public health insurance programs. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 104 be adopted as amended.

HOD ACTION: Resolution 104 adopted as amended.

Resolution 104 asks that our AMA support private and public mechanisms that would extend insurance coverage for the full spectrum of renal transplant care for the life of the transplanted organ and offer technical assistance to individual state and specialty societies when those societies lobby state or federal legislative or executive bodies to implement evidence-based cost-saving policies within public health insurance programs.

Mixed, yet mostly supportive testimony was heard on Resolution 104. Speakers in favor of Resolution 104 identified the cost savings that would occur by covering a lifelong immunosuppressive regimen in order to prevent failure of a kidney transplant. Furthermore, it was cautioned that discontinuing this treatment in the midst of care would result in poor health outcomes. Opposing testimony highlighted that our AMA does not support life-long public support for other health care conditions and urged consistency with existing policy.

The first resolve requests AMA support for extending coverage for the “full spectrum” of renal transplant care. Your Reference Committee is concerned that this language is too broad and could include any type of treatments. Therefore, your Reference Committee recommends replacing “full spectrum” with “evidence-based treatment.” In addition, the second resolve asks our AMA to offer technical assistance to state and specialty societies when these entities lobby to implement evidence-based cost-saving policies within public health insurance programs. Your Reference Committee is aware that our AMA is available to provide this service and therefore suggests additional language supporting our AMA to continue this service. As such, your Reference Committee recommends that Resolution 104 be adopted as amended.

(10) RESOLUTION 106 - SURPRISE FEE IN PATIENT PROTECTION AND AFFORDABLE CARE ACT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 106 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate that any proposed assessment on ‘issuers of insurance’ (scheduled to commence in 2014 for a 3-year period), intended to fund a ‘risk adjustment program’ to cushion insurers against any actual uncertainties surrounding the health status of the uninsured, ~~not be passed along to consumers~~ be taken from administrative and medical management costs. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 106 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 106 be changed to read as follows:

TRANSITIONAL REINSURANCE FEES UNDER THE AFFORDABLE CARE ACT

HOD ACTION: Resolution 106 adopted as amended with a change in title.

Resolution 106 asks that our AMA advocate that any proposed assessment on ‘issuers of insurance’ (scheduled to commence in 2014 for a 3-year period), intended to fund a ‘risk adjustment program’ to cushion insurers against any actual uncertainties surrounding the health status of the uninsured, not be passed along to consumers.

Testimony received on Resolution 106 was mixed. Your Reference Committee acknowledges the sponsors’ concern that transitional reinsurance fees enacted under the ACA will be passed along to consumers. These fees, which will be imposed on insurers beginning in 2014, are intended to fund reinsurance payments that cover high-risk people in the individual market. Your Reference Committee heard testimony on the appropriateness of insulating patients from the costs of covering risk adjustment pools. Concerns regarding Resolution 106 largely focused on the potential that physicians will ultimately bear the burden of these fees. In an effort to prevent the reinsurance fees from being passed on to consumers or to physicians via payment reductions, your Reference Committee recommends adding a clause at the end of the resolve specifying that the transitional reinsurance fees “be taken from administrative and medical management costs,” as suggested by one of the speakers. To clarify the fee program addressed in the resolution, your Reference Committee also recommends that the title of Resolution 106 be changed to Transitional Reinsurance Fees under the Affordable Care Act.

(11) RESOLUTION 107 - MEDICARE'S NON-EXISTENT RELATIONSHIP TO USUAL AND CUSTOMARY (U&C) FEES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 107 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association take the position that there is no relationship between the Medicare fee schedule and Usual, & Customary and Reasonable Fees. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 107 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 7 be changed to read as follows:

MEDICARE'S NON-EXISTENT RELATIONSHIP TO USUAL, CUSTOMARY AND REASONABLE (UCR) FEES

HOD ACTION: Resolution 107 be adopted as amended with a change in title.

Resolution 107 asks that our AMA take the position that there is no relationship between the Medicare fee schedule and usual and customary fees. Testimony on Resolution 107 was supportive. It was suggested in the online testimony that "usual and customary" be defined for those less familiar with these terms. Under Policy H-385.923, "usual" means a fee that the physician usually charges to his/her private patients. "Customary" means the charge is within the range of usual fees currently charged by physicians of similar training and experience for the same service within the same limited geographic area. "Reasonable" is defined as a charge that is usual and customary, and is justifiable considering the special circumstances of the case in question, without regard to payments that have been discounted under governmental or non-governmental health insurance plans or policies.

Our AMA has been consistent in its position that Medicare payment rates are significantly lower than the cost to provide medical services. Your Reference Committee concurs that there is no relationship between the Medicare physician fee schedule and usual, customary and reasonable (UCR) fees. Testimony regarding this position was supportive. Your Reference Committee heard testimony offering an amendment to replace "fee schedule" with "payment schedule" but notes that the correct terminology is "Medicare fee schedule." To be consistent with existing AMA policy, your Reference Committee also suggests adding the word "reasonable" to the resolution and its title, and recommends that Resolution 107 be adopted with these minor amendments.

(12) RESOLUTION 108 - VACCINES FOR CHILDREN PROGRAM AND THE NEW CPT CODES FOR IMMUNIZATION ADMINISTRATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 108 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association work with the American Academy of Pediatrics and other groups to convince the Centers for Medicare & Medicaid Services to allow state Medicaid agencies to pay physicians for using the new immunization administration codes (90460, 90461) to ~~compassionately~~

immunize eligible patients and to be paid fairly for their participation in the Vaccines for Children Program. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 108 be adopted as amended.

HOD ACTION: Resolution 108 adopted as amended.

Resolution 108 asks that our AMA work with the American Academy of Pediatrics and other groups to convince CMS to allow state Medicaid agencies to pay physicians for using the new immunization administration codes (90460, 90461) to compassionately immunize eligible patients and to be paid fairly for their participation in the Vaccines for Children Program.

Unanimous positive testimony was heard on Resolution 108. Your Reference Committee notes that Resolution 108 is consistent with AMA policy D-440.956, which advocates for improved financing mechanisms for vaccines, including the expansion of the Vaccines for Children Program. Your Reference Committee agrees that this is an important issue for our AMA to support. However, an amendment is suggested to strike the term “compassionately” since it appears unnecessary given that the services provided by physicians are naturally compassionate.

(13) **RESOLUTION 116 - EXTENDING MEDICAID PAYMENT INCREASES TO PRIMARY CARE PHYSICIANS TO INCLUDE OBSTETRICIAN/GYNECOLOGISTS**

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends adoption of the following Substitute Resolution 116:

RESOLVED, That our AMA advocate for the extension of Medicaid payment increases to primary care physicians to include all physicians who furnish a substantial portion (60%) of their Medicare or Medicaid billings (allowable charges) for designated primary care services.

RESOLVED, That our AMA advocate for the continuation of the Affordable Care Act primary care rate increases after the expiration of such provision on December 31, 2014.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 116 be changed to read as follows:

EXTENDING MEDICAID PAYMENT INCREASES

HOD ACTION: Resolution 116 referred.

Resolution 116 asks that our AMA advocate for the extension of Medicaid reimbursement rate increases to primary care physicians to include obstetrician/gynecologists.

Extensive mixed testimony was heard on Resolution 116. One speaker stated that extending the increase in Medicaid reimbursement rates for primary care physicians to include obstetricians/ gynecologists would improve access to care for Medicaid-insured women. Concern was voiced about inadequate payment for all other physicians. Several speakers requested that other specialties, such as neurology, psychiatry and emergency medicine be included in the increased payment rates. Several amendments were suggested. Your Reference Committee considered these amendments and drafted a substitute resolution in response.

Your Reference Committee notes that Medicare uses a fee schedule to pay physicians for the services they furnish to beneficiaries. The ACA provides a 10 percent bonus payment on top of the fee schedule payment for select primary care services furnished by primary care physicians in calendar years 2011-2015. To qualify for the bonus, a physician must be self-designated in a primary care specialty (general internal medicine, family practice, pediatrics, and geriatrics) and a substantial portion (60 percent) of their Medicare billings, or allowable charges, must be for the designated primary care services (mainly, office-and other outpatient visits) on which a bonus payment is made. CMS will assess eligibility for the bonus by (1) checking a physician's specialty self-designation to ensure that they are in general internal medicine or in another primary care specialty and (2) looking back on the percentage of designated primary care services furnished by the physician during an earlier time period.

Given supportive testimony and the fact that existing AMA policy supports a sufficient supply of primary care physicians, including obstetricians/gynecologists, your Reference Committee recommends that Substitute Resolution 116 be adopted.

- (14) RESOLUTION 111 – MEDICARE LONG-TERM CARE PRIOR HOSPITALIZATION REQUIREMENT
RESOLUTION 117 - OBSERVATION STATUS AND MEDICARE PART A QUALIFICATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 117 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for Medicare Part A coverage for a patient's direct admission to a skilled facility if directed by their physician and if the patient's condition meets skilled nursing criteria. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 117 be adopted as amended in lieu of Resolution 111.

HOD ACTION: Resolution 117 adopted as amended in lieu of Resolution 111.

Resolution 111 asks that our AMA work to eliminate the “three day” requirement for inpatient hospital admission prior to skilled nursing facility admission as a prerequisite for Medicare coverage and substitute other appropriate criteria that would allow for timely and appropriate skilled nursing facility placement of Medicare patients.

Resolution 117 asks that our AMA seek and/or support a requirement that a 72-hour hospital stay, either under inpatient status or under observation status, will qualify a patient for Medicare Part A coverage for skilled services after discharge.

Testimony heard on Resolution 111 supported reaffirmation of existing policy; however, some testimony favored adoption of this resolution out of concern that reaffirmation would not help eliminate the three-day inpatient hospital requirement for Medicare coverage of skilled nursing facility services. Testimony heard on Resolution 117 was very supportive. Multiple speakers emphasized that current federal observation care policy is archaic and problematic. Others spoke about the costs associated with hospitalizing patients for 72 hours for non-acute treatments to qualify for post-hospital skilled nursing facility care. It was repeatedly suggested that legislative and/or regulatory relief is very much needed, and that our AMA has had policies in place to eliminate the three-day stay for several years. There was discussion of requiring no hospital stay; however, your Reference Committee believes the resolution as amended captures the spirit and intent of Resolution 117.

Your Reference Committee points out that our AMA is actively working with Congress and the Centers for Medicare & Medicaid Services (CMS) on solutions to coverage problems associated with hospital observation stays and subsequent skilled nursing facility care. Our AMA is working in support of federal legislation (S 569; HR 1179)

that would count observation care toward the three-day stay requirement. Our AMA has also repeatedly requested that CMS review its policy on the three-day stay requirement. Your Reference Committee recognizes similarities in intent between Resolutions 111 and 117 and existing AMA policy on the three-day hospital stay requirement. After hearing discussion of several amendments suggested during testimony, your Reference Committee recommends asking our AMA to continue to advocate that hospital stays of any duration, under either inpatient or observation status, will qualify a patient for Medicare Part A coverage of skilled nursing facility services after discharge. Your Reference Committee recommends that Resolution 117 be adopted as amended in lieu of Resolution 111.

(15) RESOLUTION 120 - PATIENT ACCESS TO ANTI-TUBERCULOSIS MEDICATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 120 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support state and federal policy to cover TB testing for individuals deemed to have a high risk for contracting TB infection and to provide anti-tuberculosis medications to patients with both active and latent TB free of charge or insurance co-pays or deductibles in order to prevent the transmission of this airborne infectious disease. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 120 be adopted as amended.

HOD ACTION: Resolution 120 adopted as amended.

Resolution 120 asks that our AMA support state and federal policy to provide anti-tuberculosis medications to patients with both active and latent TB free of charge or insurance co-pays or deductibles in order to prevent the transmission of this airborne infectious disease.

Your Reference Committee heard mostly supportive testimony on Resolution 120. While support was voiced for adopting this resolution, several concerns were raised. One speaker questioned if there were widespread issues with anti-tuberculosis medications not being covered for free. Another speaker felt that the resolution did not take into account the continuing emergence of drug resistance to common TB regimens, the challenge of drug shortages or the fact that TB is a global problem. In addition, it was cautioned that offering free medication for any condition should be carefully considered.

Your Reference Committee considered the issues raised in testimony, but notes that while most states provide free TB medications for both active and latent TB, there are a few states where this is the responsibility of the local health departments. In addition, your Reference Committee is aware that there has been a shortage of TB medications, which has caused some states to either decrease the dosage to make it last longer or have temporarily restricted free TB medications to only high priority patients. Given the shortage of TB medications in addition to drug resistant TB, this is a growing problem that your Reference Committee believes needs to be further addressed. Your Reference Committee recommends additional language to include the coverage of testing for individuals deemed to have a high risk for contracting TB infection in order to increase the efforts to eliminate this disease.

(16) RESOLUTION 112 - UNFAIR MEDICARE PAYMENT PRACTICE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 112 be referred.

HOD ACTION: Resolution 112 referred.

Resolution 112 asks that our AMA seek legislation to fairly compensate procedures across all service sites (physician office, ambulatory surgical centers, and hospital outpatient departments) to include a single formula for reimbursement that recognizes the different average resource costs to provide each procedure and a single update formula (such as the Consumer Price Index for all Urban Consumers) for all sites with an appropriate conversion factor that recognizes different average resource costs for the different sites.

Testimony on Resolution 112 was mixed, and included suggestions for referral. A member of the Council on Medical Service noted that Council on Medical Service Report 3-A-13 addresses payment variations across outpatient sites of service, and asked what additional information would be expected from referral. A concern was expressed that adopting the resolution as written will not increase payments for physicians in solo practice or those in rural or at-risk areas. Alternatively, the sponsors noted that hospital-based care is more expensive but may not produce better outcomes than outpatient facilities owned and operated by independent physicians. Your Reference Committee discussed the complexity associated with transitioning existing payment update formulas into a single update formula, as requested by the resolution. Your Reference Committee concurs that this is a complex issue worthy of further study and therefore recommends referral.

(17) RESOLUTION 118 - PAP TESTING GUIDELINES: HEDIS VERSUS USPSTF

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 118 be referred.

HOD ACTION: Resolution 118 referred.

Resolution 118 asks that our AMA urge third party payers not to withhold payment to physicians for preventive health services that fall under accepted guidelines, even if they differ from the payer's own guidelines.

While testimony was supportive of the topic in general, concern was raised that physicians should practice according to the specific needs of each individual patient rather than according to guidelines created by other entities. In addition several speakers felt that this was a complicated issue that deserved more consideration and therefore urged referral.

In addition, your Reference Committee had several concerns. First, the reference to "acceptable guidelines" is not defined in the resolve, which is preferable if adopting policy so that our AMA's position is clear. In addition, the resolve is much broader than the subject of the resolution. Your Reference Committee suggests that the terminology "pap smear testing" should be in the resolve so that it reflects the resolution's subject matter. Finally, referencing "guidelines" in the resolve is of concern as the guidelines could change and our AMA may not remain supportive. For these reasons, your Reference Committee recommends that Resolution 118 be referred.

(18) RESOLUTION 119 - PLACE OF SERVICE CODE FOR OBSERVATION SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 119 be referred.

HOD ACTION: Resolution 119 referred.

Resolution 119 asks that our AMA conduct a study of the impact on patient cost-sharing, physician payment, physician administrative cost, and the quality of care if a specific place-of-service code is created for observation services, consult with the AHA and other stakeholders in this study on place of service code for observation services and that based on the findings of the study our AMA and other interested stakeholders petition CMS to recognize a new place-of-service code for observation services.

Testimony on Resolution 119 was limited to one comment in support of adoption. Your Reference Committee interprets this resolution as a call for a high-level AMA study on a complex issue (new place of service codes for observation services). As stated previously in this report, our AMA is working with Congress and CMS to advocate for solutions to Medicare coverage problems associated with hospital observation status. Your Reference Committee believes that our AMA should look into the use of new place-of-service codes for observation services before committing to the study called for in Resolution 119, and therefore recommends referral.

(19) RESOLUTION 122 - HEALTH INSURER CODE OF CONDUCT PRINCIPLES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 122 be referred.

HOD ACTION: Resolution 122 referred.

Resolution 122 asks that our AMA update the AMA Health Insurer Code of Conduct Principles and report back at the 2014 Annual Meeting.

Your Reference Committee heard limited, yet supportive testimony on Resolution 122. The sponsor highlighted the fact that the AMA Health Insurer Code of Conduct Principles were developed before health system reform legislation was adopted and therefore certain sections may no longer be relevant. The sponsor and a member of the Board of Trustees suggested that Resolution 122 be referred for additional consideration of appropriate updates. Therefore your Reference Committee recommends that Resolution 122 be referred.

(20) RESOLUTION 115 - MEDICATION NON-ADHERENCE AND ERRORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 115 be referred.

HOD ACTION: Resolution 115 referred.

Resolution 115 asks that our AMA work with the Centers for Medicare & Medicaid Services or seek federal legislation to require Medicare to provide the option of prescribing, according to patient need, timed calendar blister packs to be filled locally with pharmacist counseling with no or minimal extra cost to the patient.

Testimony on Resolution 115 was mixed, and included comments on the costs of providing timed calendar blister packs as well as the potential cost savings from the use of blister packs if they prevent emergency room visits and hospitalizations. The sponsor spoke of senior citizens who, lacking blister packs and/or pharmacist counseling, may take medications incorrectly and end up in the hospital. The sponsor also testified that blister packs have been shown to increase medication adherence and save money on hospitalizations.

Your Reference Committee discussed the considerable expenses associated with having timed calendar blister packs filled locally with pharmacist counseling. Your Reference Committee is aware that current regulations require Medicare Part D plans to cover unit dose packaged drugs in the long-term care setting and believes further study is

warranted before asking our AMA to advocate for broader Medicare coverage. Accordingly, your Reference Committee recommends that Resolution 115 be referred.

(21) RESOLUTION 101 - AFFORDABLE ACCESS FOR LOW INCOME INDIVIDUALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-165.855, D-165.955 and H-165.848 be reaffirmed in lieu of Resolution 101.

HOD ACTION: Policies H-165.855, D-165.955 and H-165.848 be reaffirmed in lieu of Resolution 101.

Resolution 101 asks that our AMA adopt policy that all individuals under 400% FPL should be eligible for refundable tax credits to provide premium assistance for coverage of a qualified health plan and that the refundable tax credit for all individuals with incomes below 100% FPL should be based on the exchange plan that covers the highest percentage of benefit costs and has the lowest out of pocket limits, and have a taxpayer's applicable percentage (out of pocket limit) of 0%.

Your Reference Committee heard mostly supportive testimony on Resolution 101. However, one speaker acknowledged that AMA policy already addresses the issues asked for in this resolution. Concerns were raised that the ACA did not foresee the fact that some states would not expand Medicaid services. It was questioned what would happen to the individuals who live below 100 percent of the federal poverty level and may not have access to health insurance in the states that are not expanding Medicaid. Current AMA policies support this population having health insurance. A member of the Council on Medical Service testified in favor of reaffirmation and cautioned that the impact of the ACA will be realized in the future, but it is too early now to determine the outcome.

Policy H-165.855[1] advocates that states be allowed the option to provide health care coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with premium tax credits that are refundable, advanceable, inversely related to income and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. This policy also advocates that children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations.

Policy D-165.955[2] advocates for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all Americans. Furthermore, Policy H-165.848[2] supports refundable advanceable tax credits in the form of a voucher to be provided on a sliding scale basis for the purchase of health care insurance for individuals living below 500% of the federal poverty level.

Given that existing AMA policy is broader in scope and more generous in suggested benefits, your Reference Committee was concerned that Resolution 101 would weaken existing policy. Therefore, your Reference Committee recommends that Policies H-165.855, D-165.955 and H-165.848 be reaffirmed in lieu of Resolution 101.

H-165.855 Medical Care for Patients with Low Incomes

It is the policy of our AMA that: (1) states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations. (2) in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans. (3) to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the

time at which an eligible person seeks medical care. (4) tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment. (5) state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se. (6) as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage. (7) our AMA encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy) (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation I-07; Modified: CMS Rep. 1, A-12)

D-165.955 Status Report on Expanding Health Care Coverage to all Individuals, with an Emphasis on the Uninsured

1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all. 2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region. (CMS Rep. 1, I-05)

H-165.848 Individual Responsibility To Obtain Health Insurance

1. Our AMA will support a requirement that individuals and families earning greater than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. 2. Upon implementation of a system of refundable, advanceable tax credits inversely related to income or other subsidies to obtain health care coverage, our AMA will support a requirement that individuals and families earning less than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (CMS Rep. 3, A-06; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11)

(22) RESOLUTION 105 - REDUCING THE COST OF PRESCRIPTION DRUGS TO LOW INCOME SENIORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-110.990 and H-330.902 be reaffirmed in lieu of Resolution 105.

HOD ACTION: Policies H-110.990 and H-330.902 reaffirmed in lieu of Resolution 105.

Resolution 105 asks that our AMA engage in a dialogue with appropriate stakeholders (i.e., state medical associations, national specialty societies, consumer organizations, patient advocacy groups, etc.), in support of the concepts in the “Senior Protection Plan,” that would reduce the excessive costs of prescription drugs incurred by low income seniors.

Mixed testimony was heard on Resolution 105. Supportive testimony agreed with conceptual support by our AMA for strategies to make medication more affordable. Opposing testimony raised a concern that the resolution could unintentionally shift costs to our country’s younger generations who are already paying for the seniors’ Medicare program. In addition, there was concern about what the “Senior Protection Plan” contains and if it would be appropriate for our AMA to support Resolution 105 without first reviewing this document.

Your Reference Committee agrees with being cautious about supporting a resolution containing a lengthy document before first reviewing its contents. Given that our AMA has policy supporting the consideration of personal income and means testing when determining cost-sharing and the subsidization of prescription drugs, your Reference Committee recommends that Policies H-110.990 and H-330.902 be reaffirmed in lieu of Resolution 105.

H-110.990 Cost Sharing Arrangements for Prescription Drugs

Our AMA: 1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients; 2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and 3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition. (CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12)

H-330.902 Subsidizing Prescription Drugs for Elderly Patients

Our AMA strongly supports subsidization of prescription drugs for Medicare patients based on means testing. (Res. 122, A-03)

(23) RESOLUTION 110 - LANGUAGE AND HEARING IMPAIRED INTERPRETER SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-385.978, H-285.985 and H-160.924 be reaffirmed in lieu of Resolution 110.

HOD ACTION: Policies D-385.978, H-285.985 and H-160.924 reaffirmed in lieu of Resolution 110.

Resolution 110 asks that our AMA work with CMS and other public and private entities to require the payment of interpreter services by all public and private payers.

Testimony was supportive of payment for interpreter services, but also acknowledged that our AMA has policy that sufficiently addresses this issue. A member of the Council on Medical Service (CMS) stated that AMA Policies D-385.978, H-285.985 and H-160.924 in addition to CMS Report 5-I-11, Interpreter Services and Payment Responsibilities, adequately address the requests in Resolution 110. The identified policies and report address the need for language interpretive services to be a covered benefit by all health plans, that physicians practicing in an office setting should not incur the costs for qualified interpreters and that physicians should not be required to participate in payment arrangements for interpreter services.

Regarding the requests for AMA advocacy, our AMA has been and continues to be active on this issue. Our AMA has long been involved in efforts to promote patient-centered communication and collaborate with multiple stakeholders to address critical issues in providing medical care to patients with limited English proficiency (LEP).

In 2010, the US Government Accountability Office released a report on LEP and interpreter services. Our AMA was interviewed for this report and made the case that LEP requirements are unfunded mandates. Importantly, as required by AMA policy, the AMA continues to monitor and weigh in on federal and congressional activity around LEP and interpreter services. Specifically, our AMA highlights the financial constraints as a factor that must be addressed in providing interpretation services for LEP patients. Our AMA has also participated in the development of the Ethical Force program, which is being actively promoted and includes a toolkit that organizations can use to assess their communication climate, including health literacy and language services.

Given that existing policy adequately addresses this issue and our AMA is actively advocating that LEP requirements are unfunded mandates for physicians, your Reference Committee recommends that Policies D-385.978, H-285.985 and H-160.924 be reaffirmed in lieu of Resolution 110.

D-385.978 Language Interpreters

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense. (Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep. 5, A-11)

H-285.985 Discrimination Against Physicians by Health Care Plans

Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans; (2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans; (3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need; (4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and (5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate. (BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10)

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H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship

AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these

translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. (BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 5, A-11)

(24) RESOLUTION 113 - MAKING MEDICARE PRICE STANDARDIZATION ACCURATE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-450.964, H-400.984, H-400.988 and H-400.966 be reaffirmed in lieu of Resolution 113.

HOD ACTION: Policies D-450.964, H-400.984, H-400.988 and H-400.966 reaffirmed in lieu of Resolution 113.

Resolution 113 asks that our AMA advocate with the Centers for Medicare & Medicaid Services, MedPAC, and Congress to ban the use of proxies of non-physician incomes that have been used to adjust prices (spending) for the Quality and Resource Use Reports (QRUR) and Value-Based Payment Modifier (VBPM), and that no price adjustment/ standardization of physician spending shall be performed, as the actual amount paid to physicians is the most accurate data for QRUR and VBPM.

Testimony on Resolution 113 was limited. The sponsor spoke against reaffirmation and in favor of an amendment asking our AMA to testify before Congress and in comments to CMS and MedPAC on inaccurate price adjustment or price standardization methodology. A member of the Council on Medical Service pointed to Policy D-450.964 as an appropriate policy to reaffirm in lieu of Resolution 113.

Your Reference Committee acknowledges the concerns expressed by some states regarding the data sources and methodologies used to calculate the Geographic Practice Cost Index (GPCI). Your Reference Committee also recognizes the significant challenges involved in developing consensus on the use of GPCIs or potential improvements to them. Furthermore, your Reference Committee points to our AMA's recent work on GCPI-related issues as exemplified in Council on Medical Service Reports 4-A-11 and Council on Medical Service Report 1-I-11. Numerous policies guide AMA advocacy on geographic variation, including Policies H-400.984, H-400.988 and H-400.966. Policy D-450.964 directs our AMA to continue to work with the Centers for Medicare & Medicaid Services to improve the design, content and performance indicators included in the QRURs for physicians, so that the reports reflect the quality and cost data associated with these physicians in calculating VBPMs. Therefore, your Reference Committee recommends that these policies be reaffirmed in lieu of Resolution 113.

D-450.964 Medicare Quality and Resource Use Reports

Our AMA will: (1) continue to work with the Centers for Medicare & Medicaid Services to improve the design, content, and performance indicators included in the Quality and Resource Use Reports (QRURs) for physicians, so that the reports reflect the quality and cost data associated with these physicians in calculating Value-Based Payment Modifiers (VBM); and (2) continue to advocate, educate and seek to delay implementation of the VBM program. (Res. 810, I-12)

H-400.984 Geographic Practice Costs

1. Our AMA will work to ensure that the most current, valid and reliable data are collected and applied in calculating accurate geographic practice cost indices (GPCIs) and in determining geographic payment areas for use in the new Medicare physician payment system. 2. Our AMA supports the use of physician office rent data, along with other practice expense data, to measure geographic variation in rent costs and to determine the proportion of overall costs that relate to rental expense. These data should be obtained through new or existing data sources that are accurate, standardized, verifiable and include per unit costs in physician offices. (Sub. Res. 25, A-90; Modified: Sunset Report, I-00; Reaffirmation A-09; Modified: CMS Rep. 4, A-11; Reaffirmed and Appended: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Reaffirmation: I-12)

H-400.988 Medicare Reimbursement, Geographical Differences

The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas. (Sub. Res. 82, A-89; Reaffirmed: BOT Rep. DD, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Modified: CMS Rep. 4, A-11; Reaffirmed: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 122, A-12)

H-400.966 Medicare Payment Schedule Conversion Factor

(1) The AMA will aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) The AMA will work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index. (CMS Rep. B, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 6, I-08; Reaffirmed: CMS Rep. 1, I-11; Reaffirmation: I-12)

REPORT OF REFERENCE COMMITTEE B**(1) BOARD OF TRUSTEES REPORT 5 – PHYSICIAN PRACTICE DRIFT****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendations of Board Trustees Report 5 be adopted, and that the remainder of the report be filed.

HOD ACTION: Board Trustees Report 5 adopted, and the remainder of the report filed.

The Board of Trustees recommends: 1. That our American Medical Association Policies E-5.02 and E-9.132 be reaffirmed. (Reaffirm 10 House Policy); 2. That our AMA continue to work with interested state and national medical specialty societies to advance truth in advertising legislation. (Directive to Take Action); 3. That our AMA continue to monitor legislative and regulatory activity related to physician practice drift. (Directive to Take Action); and (4) That Policy H-410.952 be rescinded. (Directive to Take Action)

All testimony received by your Reference Committee supported Board of Trustees Report 5. Your Reference Committee, therefore, recommends adoption of Board of Trustees Report 5.

(2) BOARD OF TRUSTEES REPORT 12 – SEPARATE PALLIATIVE DEATHS FROM THE MORTALITY STATISTICS**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 12 be adopted in lieu of Resolution 225 A-12, and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 12 adopted in lieu of Resolution 225 A-12, and the remainder of the report filed.

The Board of Trustees Report recommends 1) That our American Medical Association continue to monitor the development and performance on the CMS 30-day mortality measures, and enrollments in the Medicare hospice program and the VA hospice programs. (Directive to Take Action); 2) That our AMA support efforts to clarify coding guidance or development of codes to capture “comfort care,” “end-of-life care,” and “hospice care.” (Directive to Take Action); 3) That our AMA continue to work to have CMS exclude palliative patients from mortality measures. (Directive to Take Action)

All testimony received by your Reference Committee supported Board of Trustees Report 12. Your Reference Committee recommends adoption of Board of Trustees Report 12 in lieu of Resolution 225 A-12.

(3) BOARD OF TRUSTEES REPORT 27 – WORK-RELATED ABUSES OF IMG PHYSICIANS WORKING UNDER THE CONRAD-30 PROGRAMS**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 27 be adopted in lieu of Resolution 222 A-12, and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 27 adopted in lieu of Resolution 222 A-12, and the remainder of the report filed.

The Board of Trustees Report 27 recommends 1) That our American Medical Association continue to monitor legislations and provide support for improvements to the J-1 Visa Waiver program (Directive to Take Action); 2) That our AMA continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs (Directive to Take Action); 3) That as a benefit of membership, our AMA 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 (Directive to Take Action); and 4) That our AMA encourage IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria. (Directive to Take Action).

Your Reference Committee recognizes the importance of the issues addressed in Board of Trustees Report 27 and agrees with the report's recommendations. Therefore, your Reference Committee recommends adoption of Board of Trustees Report 27 in lieu of Resolution 222 A-12.

(4) RESOLUTION 203 – NEEDLE EXCHANGE PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 203 be adopted.

HOD ACTION: Resolution 203 adopted.

Resolution 203 asks that our American Medical Association amend Policy H-95.958 by insertion and deletion to read as follows: The AMA: (1) encourages needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation ~~revoking the 1988 federal ban on~~ providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes. (Modify Current HOD Policy)

Your Reference Committee received testimony supporting adoption of Resolution 203. Your Reference Committee believes that reinstating federal funding for needle exchange programs is an important goal, and that our AMA should encourage states to establish needle exchange programs if they have not done so already. Your Reference Committee also believes that such programs should contain protections for program employees, since in some cases employees have experienced harassment. Therefore, your Reference Committee recommends that Resolution 203 be adopted.

(5) RESOLUTION 204 – PROGRAMS TO COMBAT FOOD DESERTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 204 be adopted.

HOD ACTION: Resolution 204 adopted.

Resolution 204 asks that our American Medical Association amend Policy D-150.978 by insertion and deletion to read as follows: "Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through ~~the US Farm Bill~~ tax incentive programs, community-level initiatives and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. (Modify Current HOD Policy)

Your Reference Committee received testimony in support of Resolution 204, and therefore, recommends that Resolution 204 be adopted.

(6) RESOLUTION 205 – PREVENTING PENALTIES FOR PHYSICIANS WHO PROVIDE CARE TO MILITARY PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 205 be adopted.

HOD ACTION: Resolution 205 adopted.

Resolution 205 asks that our American Medical Association work with the Center 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 meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony in favor of adopting Resolution 205. Your Reference Committee agrees that our AMA should support and advocate for physicians who may be facing the concerns expressed in this resolution and recommends adoption.

(7) RESOLUTION 209 – EXTRAPOLATION BY MEDICARE RECOVERY AUDIT CONTRACTORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 209 be adopted.

HOD ACTION: Resolution 209 adopted.

Resolution 209 asks (1) that our American Medical Association petition the Centers for Medicare & Medicaid Services (CMS) to amend CMS' rules governing the use of extrapolation in the Recovery Audit Contractor (RAC) audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation (Directive to Take Action); and (2) that our AMA insist that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post- payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 209. Your Reference Committee notes that this resolution is consistent with AMA policy and, therefore, recommends that Resolution 209 be adopted.

(8) RESOLUTION 228 – THE SAFE ACT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 228 be adopted.

HOD ACTION: Resolution 228 adopted.

Resolution 228 asks that our American Medical Association seek immediately an opinion and guidance from Health and Human Services Office of Civil Rights regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in light of the conflicting standards set forth by the State SAFE Act and federal HIPAA Regulations. (Directive to Take Action)

Resolution 228 was considered with Resolutions 221 and 222. Your Reference Committee heard strong testimony in support of Resolution 228, along with comments that the subject matter of this resolution was distinct from Resolutions 221 and 222 and that Resolution 228 should be considered separately. Your Reference Committee agrees. Your Reference Committee believes that Resolution 228 is consistent with AMA policy that supports strong protections for patient privacy and in general requiring physicians to keep patient medical records strictly confidential, except when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality. Your Reference Committee heard a comment that this resolution should be expanded to apply to states other than New York. However, your Reference Committee believes that the SAFE Act is unique to New York State and that the resolution should remain focused on seeking guidance to the physicians who are impacted by this state law.

(9) RESOLUTION 233 – STRONG OPPOSITION TO CUTS IN FEDERAL FUNDING FOR THE INDIAN HEALTH SERVICE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 233 be adopted.

HOD ACTION: Resolution 233 adopted.

Resolution 233 asks 1) that American Medical Association (AMA) Policies H-350.977, Indian Health Service, and H-350.976, Improving Health Care of American Indians, be reaffirmed (Reaffirm HOD Policy); 2) that our AMA strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers (Directive to Take Action); 3) that our AMA ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service (Directive to Take Action); 4) that our AMA adopt as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction (New HOD Policy); and 5) that, in the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolution 233. Your Reference Committee recognizes the impact that the federal “sequester” has had on the Indian Health Service (IHS). Your Reference Committee understands that there are a number of states with large Native American populations, who depend upon IHS for their health care. According to testimony, these populations have been severely affected by cuts to IHS funding and are facing the likelihood of significant reductions in services offered, with potentially life-threatening consequences for an untold number of patients. Your Reference Committee, therefore, agrees with testimony that it is critical that funding for IHS be restored and maintained at appropriate levels. Your Reference Committee recommends adoption.

(10) RESOLUTION 235 – EXEMPT PHYSICIAN-ADMINISTERED DRUGS FROM MEDICARE SEQUESTRATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 235 be adopted.

HOD ACTION: Resolution 235 adopted.

Resolution 235 asks that our American Medical Association support passage of federal legislation 1) exempting payments for biologics and other drugs provided under Medicare Part B from sequestration cuts, and 2) reimbursing providers for reductions in payments for biologics and other drugs furnished under Medicare Part B on or after April 1, 2013. (New HOD Policy)

Your Reference Committee heard unanimous testimony in support of Resolution 235. Your Reference Committee recognizes that physician practices continue to struggle with the inadequate reimbursement offered by Medicare for physician administered drugs. These drugs often impact some of our most vulnerable patients, resulting in these patients often seeking physician administered drugs from someone other than their regularly treating physician and in more costly settings, such as hospital out-patient offices. Your Reference Committee recognizes that our AMA has continued to advocate to the Centers for Medicare and Medicaid Services for the need to address this situation. Your Reference Committee also recognize that our AMA has existing policy opposing sequestration cuts impacting Medicare, as well as policy supporting the advancement of an improved methodology to calculate reimbursement for Medicare Part B drugs. Because Resolution 235 is broadly consistent with this existing AMA policy, your Reference Committee recommends adoption.

(11) RESOLUTION 238 – ELIGIBILITY OF SUGAR-SWEETENED BEVERAGES FOR SNAP

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 238 be adopted.

HOD ACTION: Resolution 238 adopted.

Resolution 238 asks 1) that our American Medical Association publish an educational brief to educate physicians about the effects of sugar-sweetened beverages (SSBs) on obesity and overall health, and encourage them to educate their patients in turn (Directive to Take Action); 2) that our AMA encourage state health agencies to include educational materials about nutrition and health food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (SNAP) recipients along with the revised eligible foods and beverages guidelines (Directive to Take Action); and 3) that our AMA work to remove SSBs from SNAP. (Directive to Take Action)

Testimony on Resolution 238 generally supported adoption. Therefore, your Reference Committee recommends that Resolution 238 be adopted.

(12) RESOLUTION 240 – AMA SUPPORT FOR STATES IN THEIR DEVELOPMENT OF LEGISLATION TO SUPPORT PHYSICIAN-LED, TEAM BASED CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 240 be adopted.

HOD ACTION: Resolution 240 adopted.

Resolution 240 asks that our American Medical Association (AMA) 1) continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners; 2) that our AMA assist state medical societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician-led team based model structured to efficiently deliver optimal quality patient care and to assure patient safety; and 3) actively oppose health care teams that are not physician-led.

Your Reference Committee heard compelling testimony related to the need for our AMA to continue its vigorous support for physician-led team-based care. Your Reference Committee acknowledges the work of our AMA on this important issue, specifically its development of a state-based campaign related to team-based care. This campaign, which includes model state legislation, talking points and other relevant state-based advocacy tools, has been distributed to all state and national medical specialty societies. Moreover, through the work of its Scope of Practice

Partnership, our AMA and its partner medical associations have supported a number of states in their promotion of coordinated and fully integrated models of care (e.g., team-based care).

Your Reference Committee also concurs with testimony that data development related to the benefits of physician-led team-based care is critical to the success of this effort. Your Reference Committee notes that our AMA is continuously investigating the existence of data, including in its meetings and discussions with large integrated physician-led systems across the country. Moreover, our AMA continues to support the ongoing efforts of national medical specialty societies to pursue opportunities to collect, analyze, and disseminate data that demonstrate the benefits of team-based care in terms of quality, cost, and access. Once these studies are completed, our AMA will integrate the results into ongoing advocacy in support of physician-led health care teams.

Your Reference Committee agrees with testimony that these efforts are critical and must continue. Therefore, your Reference Committee recommends that Resolution 240 be adopted.

(13) BOARD OF TRUSTEES REPORT 4 – CLEAR AND CONVINCING EVIDENCE (RESOLUTION 207-A-12)

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 4 be amended by addition to read as follows:

1. Our AMA will continue to work with interested state and specialty societies on legislation adopting the clear and convincing evidence standard.

2. The Board of Trustees believes that this report fulfills the request for additional study regarding the implications of adopting Resolution 207-A-12 and therefore recommends that Resolution 207-A-12 44 not be adopted and the remainder of the report be filed.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 4 be adopted as amended, and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 4 adopted as amended, and the remainder of the report filed.

The Board of Trustees believes that this report fulfills the request for additional study regarding the implications of adopting Resolution 207-A-12 and therefore recommends that Resolution 207-A-12 44 not be adopted and the remainder of the report be filed.

Your Reference Committee heard testimony in support of Board of Trustees Report 4. Your Reference Committee also heard testimony requesting that our AMA continue to work with interested state and specialty societies on legislation adopting the clear and convincing evidence standard. Based on the testimony, therefore, your Reference Committee recommends adoption of Board of Trustees Report 4 as amended.

(14) BOARD OF TRUSTEES REPORT 16 – INVASIVE PROCEDURES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 16 be amended by deletion of Recommendation 2.

2. That our AMA adopt the following guidelines on Invasive Procedures

~~Invasive procedures include interventions in the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post-operative course of care, as described in AMA Policy H-00.000 Invasive Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy [Reference to this policy is contingent on the House of Delegates' adoption of Recommendation 3].~~

~~Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of invasive procedures are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards.~~

~~Invasive procedures require physician level training. However, technical aspects of certain invasive procedures may be performed by appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing. (New HOD Policy)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 16 be amended by addition and deletion to read as follows:

3. That our AMA adopt the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications, and collaboration with other health care providers.

Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post-operative course of care. ~~Interventional~~ Invasive pain management techniques include:

1. ablation of targeted nerves;
2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and
3. surgical techniques, such as laser or endoscopic discectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.

~~This does not apply to~~ At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.

When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be performed only by physicians with appropriate training and credentialing. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 16 be amended by addition of the following paragraph:

Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 16 be adopted as amended.

HOD ACTION: Board of Trustees Report 16 adopted as amended.

Revised Board of Trustees Report 16, which was included in the Sunday tote, recommends that our AMA adopt policy on invasive procedures, and that our AMA adopt policy on invasive procedures for the treatment of chronic pain. Revised Board of Trustees Report 16 also recommends reaffirmation of various AMA policies, including Policy H-475.983, Definition of Surgery.

Your Reference Committee commends our Board of Trustees for writing a thorough, informative, and timely report, and recognizes the complexity and difficulty in addressing this complex topic. Your Reference Committee also commends the commitment of the assigned task force members representing our AMA Board of Trustees, Council of Medical Education, Council on Legislation, and Council on Medical Service, as well as the American Society of Anesthesiology, American College of Radiologists and Society of Interventional Radiologists (1 individual representing both), American College of Surgeons, Iowa Medical Society, and Tennessee Medical Association, all of whom worked for over nine months on this report. Your Reference Committee heard testimony clearly expressing a sense of urgency regarding the topics addressed in this report, and believes that it is critical for our House of Delegates to come to a consensus at this meeting on invasive pain management procedures, which your Reference Committee notes have been debated since the initial 2010 resolution underlying this report. Your Reference Committee recognizes the need to provide guidance to state medical associations, which are facing increasing legislative pressure to defend against the expansion of non-physician provider scope of practice into invasive pain management procedures. Your Reference Committee, therefore, agrees that policy on invasive pain management procedures is timely and needs to address further intrusion of non-physicians into the practice of medicine.

Testimony in opposition to Board of Trustees Report 16 expressed concern that the recommended changes to AMA policy related to the definition of surgery would cause AMA policy to no longer be identical to that of the American College of Surgeons, suggesting that it is in the best interest of organized medicine to have uniform definitions. However, your Reference Committee notes that Revised Board of Trustees Report 16, contained in the Sunday tote, resolved this issue by addressing concerns by reaffirming existing policy related to the definition of surgery. Testimony also suggested that the proposed modifications would prohibit non-physicians from performing certain procedures that are currently accepted medical practice. Testimony in support of Board of Trustees Report 16 suggested that the proposed modifications to current AMA policy are necessary to ensure that our AMA is prepared to address all future challenges to the practice of medicine.

Because of the concerns expressed, your Reference Committee recommends that our existing Policy H-475.983, Definition of Surgery, be reaffirmed, as stated in the Revised Board of Trustees Report 16. Your Reference Committee also recommends that Recommendation 3 of Board of Trustees Report 16 be amended to clarify that the new policy proposed in Recommendation 3 applies only to invasive pain management procedures. Your Reference Committee's amendment to Recommendation 3 also reflects that, while invasive pain management procedures require physician-level training, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Your Reference Committee heard the concerns raised, including those related to the practice of physician assistants in physician-led health care teams, and believes the proffered amendments address these concerns. Therefore, your Reference Committee recommends that Board of Trustees Report 16 be adopted as amended.

(15) BOARD OF TRUSTEES REPORT 28 – COUNCIL ON LEGISLATION
SUNSET REVIEW OF 2003 HOUSE POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 28 be amended by addition, to read as follows:

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, with the exception of Policy D-435.990 which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 28 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 28 adopted as amended and the remainder of the report filed.

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

Your Reference Committee considered Board of Trustees Report 28, and agrees with the recommendations for the policies in the Sunset Review. Your Reference Committee also agrees with testimony supporting reaffirmation of Policy D-435.990, which calls on our AMA to work with state medical societies to educate physicians about the Good Samaritan laws of their states, and the extent of liability immunity for physicians when they act as Good Samaritans. Your Reference Committee, therefore, recommends adoption of Board of Trustees Report 28 as amended.

(16) RESOLUTION 206 – PRESERVATION OF THE PUBLIC HEALTH INFRASTRUCTURE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second Resolve of Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA recognize a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources ~~work to increase these funds, to be distributed equitably to states and local jurisdictions to protect and preserve core public health functions for community health assessment, public health policy development, and the assurance that the health of the public and the environment are preserved~~ (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

Resolution 206 asks (1) that our American Medical Association work with Congress and the Administration to prevent further cuts in the funds dedicated under the Patient Protection and Affordable Care Act to preserve state and local public health functions and activities to prevent disease (Directive to Take Action); (2) that our AMA work to increase these funds, to be distributed equitably to states and local jurisdictions to protect and preserve core public health functions for community health assessment, public health policy development, and the assurance that the health of the public and the environment are preserved (Directive to Take Action); and (3) that our AMA, in concert with state and local medical societies, continue to support the work of the Centers for Disease Control and Prevention, and the efforts of state and local health departments working to improve community health status, lower the risk of disease and protect the nation against epidemics and other catastrophes. (Directive to Take Action)

Your Reference Committee received testimony supporting Resolution 206 and existing AMA policy. Your Reference Committee also heard a request that our AMA recognize a crisis of inadequate public health funding, most intense at the local and state health jurisdiction levels, and encourage all medical societies to work toward restoration of adequate local and state public health functions and resources. Your Reference Committee believes strongly that our AMA should continue to support the preservation of the public health infrastructure. Your Reference Committee, therefore, recommends that Resolution 206 be adopted as amended.

(17) RESOLUTION 208 – ALLOW PHYSICIANS TO RECEIVE “DUAL USE” SUPPLIES FOR IN-OFFICE BLOOD COLLECTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 208 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association ~~propose and support new~~ legislation allowing physicians to receive a limited supply of dual use supplies proportionate with the number of specimens received by a lab each month.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 208 be adopted as amended.

HOD Action: Resolution 208 adopted as amended.

Resolution 208 asks that our American Medical Association propose and support new legislation allowing physicians to receive a limited supply of dual use supplies proportionate with the number of specimens received by a lab each month. (Directive to Take Action)

Your Reference Committee received testimony supporting this resolution, and believes that our AMA should support the advocacy efforts described in Resolution 208. Also, your Reference Committee believes the word “propose” should be deleted from the resolution since our AMA does not technically propose legislation. Your Reference Committee shares the concern of those who testified that the Stark law prohibits laboratories from supplying physicians with “dual use” supplies for blood collection, i.e., gloves, alcohol wipes, gauze, etc. Your Reference Committee, therefore, recommends the adoption of Resolution 208, as amended.

(18) RESOLUTION 211 – CALL FOR ACTION FOR SUPPORT OF CONTINUATION OF CO-OP APPLICATIONS**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that the second resolved of Resolution 211 be amended by addition to read as follows:

RESOLVED, That our AMA work with the National Alliance of State Health Co-Ops (NASHCO) and other stakeholders to request the United States Congress and the US Department of Health and Human Services to re-establish funding to support new health insurance Co-Ops, which had applied prior to the enactment of the American Tax Relief Act of 2012.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 211 be adopted as amended.

HOD ACTION: Resolution 211 adopted as amended.

Resolution 211 asks (1) that our American Medical Association take action to restore necessary funding for new health insurance co-operatives which had applied prior to enactment of the American Tax Relief Act of 2012, which eliminated this funding (Directive to Take Action); and (2) that our AMA work with the National Alliance of State Health Co-Ops (NASHCO) to request the United States Congress and the US Department of Health and Human Services to re-establish funding to support new health insurance Co-Ops, which had applied prior to the enactment of the American Tax Relief Act of 2012. (Directive to Take Action)

Your Reference Committee recognizes the importance of competition in health insurance markets, and the key role that CO-OPs may play in fostering competition, as well as other benefits that CO-OPs may make available to physicians and consumers. Our AMA has advocated strongly for physicians with respect to the formation of the ACA CO-OP program through extensive regulatory comment letters. Accordingly, your Reference Committee feels strongly that our AMA should advocate for the restoration of federal funding for the CO-OP program. Your Reference Committee believes, however, that the second resolved be amended by adding the phrase “and other stakeholders” so that our AMA is at liberty to work with interested parties in addition to NASHCO. Your Reference Committee, therefore, recommends adoption of Resolution 211, as amended.

- (19) RESOLUTION 221 – GUN CONTROL AND MENTAL ILLNESS
RESOLUTION 222 – NATIONAL VIOLENT DEATH REPORTING
SYSTEM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 221 be adopted in lieu of Resolutions 221 and 222.

HOD ACTION: Substitute Resolution 221 adopted in lieu of Resolutions 221 and 222.

RESOLVED, That our American Medical Association support: 1) federal and state research on firearm-related injuries and deaths; 2) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; 3) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; 4) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; 5) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; and 6) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and be it further

RESOLVED, That our AMA support initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Substitute Resolution 221 be changed to read as follows:

**FIREARM SAFETY AND RESEARCH, REDUCTION IN FIREARM
VIOLENCE, AND ENHANCING ACCESS TO MENTAL HEALTH CARE**

Resolution 221 asks (1) that our American Medical Association support and advocate for legislation in the United States to enhance access to mental health care and pay greater attention to the diagnosis and management of mental illness and concurrent substances abuse disorders (New HOD Policy); (2) that our AMA work with the component parts of our AMA to identify and develop standardized approaches to mental health assessment for potential violent behavior together with interested stakeholders at the national level (Directive to Take Action); and (3) that our AMA actively engage in the national debate on gun control. (Directive to Take Action) Resolution 222 asks that our American Medical Association support the President’s call to increase funding for the National Violent Death Reporting System and urge the Congress to expand the program to all 50 states and US territories. (Directive to Take Action).

Your Reference Committee received testimony supporting these resolutions. Your Reference Committee is recommending a substitute resolution that encompasses the goals expressed in Resolutions 221 and 222. Your Reference Committee believes that the language of the substitute resolution captures the concerns expressed in the testimony presented and is sufficiently broad to maximize the flexibility of AMA advocacy opportunities. The substitute resolution would, for example, encompass existing AMA policy to support the collection, analysis, and reporting of data by the Centers for Disease Control and Prevention on firearm-related injuries and deaths, see e.g., D-145.999 Epidemiology of Firearm Injuries, stating in part that “Our AMA will: (1) strongly urge the

Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths....” The substitute resolution would also broaden AMA policy by requiring our AMA to support legislation, executive orders, etc. providing similar backing (and repeal of restrictions) that might now exist with respect to other federal agencies or other parts of the Executive Branch, state governmental entities, or research by private parties performed under the auspices of the federal government or state governments. Your Reference Committee heard concerns about linking mental illness with violence and/or the use of firearms and concurs with these concerns. Therefore, your Reference Committee recommends a separate resolve addressing mental illness.

Based on supporting testimony, and consideration of existing AMA policy, your Reference Committee, therefore, recommends that Substitute Resolution 221 be adopted in lieu of Resolutions 221 and 222. Your Reference Committee also recommends a change in the title of the substitute resolution to reflect the general subject matter of the resolution.

- (20) RESOLUTION 216 – PRIVATE PRACTICE IN THE ERA OF PAYMENT REFORM AND GLOBAL HEALTH CARE BUDGETING
 RESOLUTION 217 – AMA HOD SUPPORT OF THE PHYSICIAN-LED, MULTI-SPECIALTY, INTEGRATED ACCOUNTABLE PRACTICE MODEL (APM) AS A MEANS OF REPLACING THE SGR
 RESOLUTION 232 – FEE-FOR-SERVICE
 RESOLUTION 239 – RECOGNIZING THE DIVERSITY OF PRACTICE MODES IN THE TRANSITION FROM THE SGR TO A HIGHER PERFORMING MEDICARE PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 216 be adopted in lieu of Resolutions 216, 217, 232, and 239 to read as follows:

HOD ACTION: Substitute Resolution 216 adopted as amended.

RESOLVED, That our American Medical Association continue to advocate for a transition from the sustainable growth rate payment formula to new payment models that:

1. Emphasize the importance of physician leadership and accountability to deliver high quality and value to our patients;
2. Reflect and preserve the diversity of physician-led practice models (including, for example, integrated systems of care, patient-centered medical homes, regional health collaboratives, and other practice models, including private practice); and
3. Provide opportunities for physicians to determine payment models that work best for their patients, their practices, their specialties, and their regions (Directive to Take Action); and be it further

RESOLVED, That our AMA, while working to help implement new payment models, continue to advocate that:

1. fee-for-service, as well as private practice medicine, be included as continued options that can provide efficient, ethical, high quality, high value, patient-centered care;
2. the viability of a private practice option be preserved for the benefit of patients and our members; and
3. physicians should be free to determine the basic method of payment for their services, and have the right to establish their compensation arrangements including private contracting at a level which they believe

fairly reflects the value of their professional judgment and services (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to educate members on Medicare payment and delivery issues as they develop.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 216 be changed to read as follows: to read as follows:

RECOGNIZING THE DIVERSITY OF PRACTICE MODELS IN THE TRANSITION FROM THE SGR TO A HIGHER PERFORMING MEDICARE PROGRAM

Resolution 216 asks (1) that our American Medical Association, while working to help implement new alternative payment models, continue to advocate that fee-for-service as well as private practice medicine be included as continued options that can provide efficient, ethical, high quality, high value, patient-centered care (Directive to Take Action); (2) that our American Medical Association, when advocating for health system reform, enthusiastically advocate for preserving the viability of a private practice option, for the benefit of patients and our members (Directive to Take Action); and (3) That our American Medical Association continue to update its Practice Management Center to educate members on these issues as they develop. (Directive to Take Action) Resolution 217 asks (1) that our American Medical Association advocate for a CMS replacement to the SGR system that is predicated upon physicians practicing in Accountable Payment Models with partial or total and bonus reimbursements based upon tiered levels of Accountable Physician Points awarded for meeting performance metrics (New HOD Policy); and (2) that our AMA also advocate that multi-specialty, physician-led group practices, integrated delivery systems, and other organized systems of care be the standard of coordinated, comprehensive, accountable, patient-centric care that all physicians and medical practices should seek to emulate. (New HOD Policy) Resolution 232 asks 1) that our American Medical Association advocate that physicians should be free to choose basic method of payment for their services, and have the right to establish their compensation arrangements at a level which they believe fairly reflects the value of their professional judgment and services (Reaffirm HOD Policy); 2) that while our AMA recognizes the validity of a pluralistic approach to physician payment methodologies, it also believes that the fee-for-service model has many positive aspects, and should continue to be a viable payment model available to patients and physicians (New HOD Policy); and 3) that our AMA work with Congress, CME, payors and the profession to preserve the fee-for-service payment methodology in public and private insurance programs. (Directive to Take Action) Resolution 239 asks that our American Medical Association (AMA) continue to advocate for a transition from the sustainable growth rate payment formula to new payment models that: 1) Emphasize the importance of physician leadership and accountability to deliver high quality and value to our patients; 2) Reflect and preserve the diversity of physician-led practice models (including, for example, integrated systems of care, patient-centered medical homes, regional health collaboratives, and other practice models), and 3) Provide opportunities for physicians to choose payment models that work best for their patients, their practices, their specialties, and their regions.

Your Reference Committee heard unanimous testimony supporting Resolutions 216 and 232. This testimony emphasized the need to continue advocating for fee-for-service as an appropriate physician payment methodology and independent private practice as a viable alternative to practicing within integrated delivery systems or multispecialty groups. Testimony also supported Resolution 239, which encompasses both private practice and fee-for-service, in addition to alternative payment models.

Your Reference Committee heard testimony largely opposed to Resolution 217, expressing a concern that Resolution 217 would too narrowly focus AMA advocacy on the concerns of large multispecialty practices and integrated delivery systems. While our AMA has advocated strongly with respect to alternative payment models and integrated and multispecialty groups, our AMA's policies support, and our AMA advocacy activities pursue, a pluralistic approach to physician payment and practice settings, and do not favor one particular payment method or practice setting. For example, our AMA is advocating for a replacement to the sustainable growth rate (SGR) that will be applicable to physicians in all practice settings. Your Reference Committee also noted that, as part of our AMA's advocacy to eliminate and replace the SGR, our AMA joined with 110 state and national specialty medical societies on a joint letter to Congress entitled "Transitioning from the SGR to a High Performing Medicare Program:

Driving Principles and Core Elements.” (see www.ama-assn.org/resources/doc/washington/medicare-sustainable-growth-rate-transition-principles.pdf) The principles outlined in this letter reflect the diversity of physician practices and the need to provide opportunities for physicians to choose payment models that work for their patients, practice, specialty, and region. Considering the strong support for these principles, as well as existing AMA policy on preserving the private practice of medicine, your Reference Committee recommends against including the language from Resolution 217 in the substitute resolution.

Although your Reference Committee agrees with testimony that Resolution 217 is too narrowly drawn, your Reference Committee believes that the substitute resolution encompasses all types of practice settings and payment models, from fee-for-service and independent private practice to alternative payment methodologies and integrated delivery systems and multispecialty groups. Therefore, your Reference Committee recommends adoption of Substitute Resolution 216 in lieu of Resolutions 216, 217, 232, and 239.

(21) RESOLUTION 218 – AMA RESPONSE TO DRUG STORE CHAIN
INTRUSION INTO MEDICAL PRACTICE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 218 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA deem ~~routine calls~~ inappropriate inquiries from ~~pharmacies~~ pharmacists to verify the medical rationale behind prescriptions, ~~diagnoses~~ diagnosis and treatment plans to be an ~~inappropriate~~ interference with the practice of medicine and unwarranted; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 218 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with pharmacy associations such as the National Association of Chain Drug Stores to engage with the Drug Enforcement Administration, the federal Department of Justice, and other involved federal regulators and stakeholders, for the benefit of patients, to develop appropriate policy for pharmacists to work with physicians in order to reduce the incidence of drug diversion and inappropriate dispensing ~~communicate its policy on routine pharmacist prescription diagnosis verification calls with involved companies, the Federal Drug Enforcement Administration, and other involved state and federal regulators and legislators~~ and be it further (Directive to Take Action);

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the third resolve of Resolution 218 be amended by addition and deletion.

RESOLVED, That if the ~~routine inappropriate~~ pharmacist prescription ~~diagnosis~~ verification requirements and inquiry issues ~~is~~ are not eliminated ~~resolved promptly quickly~~, our AMA will advocate for legislation to eliminate any such requirement legislative and regulatory solutions to prohibit pharmacies and pharmacists from denying medically necessary and legitimate therapeutic treatments to patients.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 218 be adopted as amended.

HOD ACTION: Resolution 218 adopted as amended with a change in title.

AMA RESPONSE TO PHARMACY INTRUSION INTO MEDICAL PRACTICE

Resolution 218 asks (1) that our American Medical Association deem routine calls from pharmacists to verify the rationale behind prescriptions, diagnosis and treatment plan to be an inappropriate interference with the practice of medicine and unwarranted (Directive to Take Action); (2) that our AMA communicate its policy on routine pharmacist prescription diagnosis verification calls with involved companies, the Federal Drug Enforcement Administration, and other involved state and federal regulators and legislators (Directive to Take Action); and (3) that if the routine pharmacist prescription diagnosis verification call issue is not eliminated quickly, our AMA will advocate for legislation to eliminate any such requirement. (Directive to Take Action)

The majority of the testimony received by your Reference Committee supported Resolution 218. Your Reference Committee noted, however, that a significant amount of testimony expressed concern that the issues addressed by Resolution 218 were complicated and warranted referral. Your Reference Committee appreciates both of these respective positions. Because your Reference Committee recognizes the pressing nature of Resolution 218, your Reference Committee believes that there is an immediate need to adopt relevant policy acknowledging the inappropriate inquiries that physicians have received from pharmacies. At the same time, your Reference Committee believes that the complexity of the relevant issues supports the need for our AMA to attempt to work with organizations such as the National Association of Chain Drug Stores to achieve an expedient resolution of the concerns raised in Resolution 218. Accordingly, your Reference Committee recommends adoption of an amended Resolution 218 that calls for our AMA to recognize inappropriate inquiries, work with other parties to achieve a prompt resolution, and failing a prompt resolution, pursue a legislative or regulatory solution.

(22) RESOLUTION 225 – REGULATORY MODERNIZATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 225 be amended by deletion of the second resolve.

~~RESOLVED, That our AMA work with regulatory bodies at the national level to review regulations on a scheduled basis of not less than every 10 years to continually modernize them to better reflect the current state of medical practice.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 225 be adopted as amended.

HOD ACTION: Resolution 225 adopted as amended.

Resolution 225 asks (1) that our American Medical Association work with regulatory bodies at the national level to identify outdated regulations and modernize them to better reflect the current state of medical practice (Directive to Take Action); and (2) that our AMA work with regulatory bodies at the national level to review regulations on a scheduled basis of not less than every 10 years to continually modernize them to better reflect the current state of medical practice. (Directive to Take Action)

Your Reference Committee received testimony generally supportive of this resolution. Your Reference Committee recognizes the tenacious and on-going advocacy efforts of our AMA at the national level to identify outdated regulations and modernize them to better reflect the current state of medical practice. Your Reference Committee also believes with testimony that the second resolved of Resolution 225 is subsumed in the first resolved. Your

Reference Committee acknowledges that our AMA's current efforts to identify and modernize outdated regulations occur on a scheduled basis that is significantly less than every 10 years. Your Reference Committee, therefore, recommends that Resolution 225 be adopted as amended.

(23) RESOLUTION 226 – SUBMITTING RECOMMENDATIONS TO MEDICARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 226 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services and seek federal legislation, if necessary, to provide ~~for the following: 1) that the Center for Medicare and Medicaid Innovation Center website accept suggestions from physicians to improve health care and/or reduce costs from physicians, acknowledge submission by receipt, and later notify the individual of the decision on possible implementation with an explanation of the reasons for the decision and, if the decision is deemed worthy, the submitter should be informed kept in the loop and encouraged to participate in further developing the idea if they wish to remain involved; 2) to facilitate evaluation of ideas or policies that involve patient care and affect the patient-physician relationship, both newly suggested and those already in place, appoint a panel of practicing clinicians including primary care physicians, to assess suggested old and new ideas and policies; and 3) because the expected volume of suggestions will be high, consider delegating the responsibility of assessing ideas and policies to each of the state medical societies who will in turn forward recommendations to the American Medical Association or directly to the Innovation Center.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 226 be adopted as amended.

HOD ACTION: Resolution 226 adopted as amended.

Resolution 226 asks that our American Medical Association work with the Centers for Medicare & Medicaid Services and seek federal legislation, if necessary, to provide for the following: 1) that the Center for Medicare and Medicaid Innovation Center website accept suggestions to improve health care and/or reduce costs from physicians, acknowledge submission by receipt, and later notify the individual of the decision on possible implementation with an explanation of the reasons for the decision and if the decision is deemed worthy, the submitter should be kept in the loop and encouraged to participate in further developing the idea if they wish to remain involved; 2) to facilitate evaluation of ideas or policies that involve patient care and affect the patient-physician relationship, both newly suggested and those already in place, appoint a panel of practicing clinicians including primary care physicians, to assess suggested old and new ideas and policies; and 3) because the expected volume of suggestions will be high, consider delegating the responsibility of assessing ideas and policies to each of the state medical societies who will in turn forward recommendations to the American Medical Association or directly to the Innovation Center.
(Directive to Take Action)

Your Reference Committee recognizes the importance of the Center for Medicare and Medicaid Innovation's (CMMI) receiving and considering physicians' suggestions concerning health care improvement and/or cost reduction. However, your Reference Committee heard testimony that the CMMI currently features on its main web page a "Share Your Ideas" web portal that invites any interested party to share ideas to help shape the development of future payment and service delivery models. The website makes clear that CMMI seeks ideas across the health care delivery continuum that achieve better care for patients, better health for communities, and lower costs through improvement to our health care system. Your Reference Committee heard that CMMI is unable to respond to every

idea submitted, but that comments will be utilized along with others received in conjunction with a variety of open forums and other vehicles (e.g., direct meetings and discussions with CMMI) to help improve and shape CMMI work on an ongoing basis. Ideas submitted may be used by CMMI to develop requests for proposals, applications, studies, or models to be tested.

Your Reference Committee understands that, while the CMMI already accepts suggestions as described in the first numbered clause, it is important that the government be responsive and perform the acknowledgements described in that clause. However, your Reference Committee believes that processes are already in place that cover the concerns expressed in the second and third clauses. Your Reference Committee, therefore, recommends adoption of Resolution 226, as amended.

(24) RESOLUTION 227 – THE FUTURE OF GENITO-URINARY TREATMENT AND RESEARCH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 227 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~seek support~~ legislation and/or regulations to ensure both Active Duty members of the Armed Forces and Veterans suffering from genito-urinary injuries receive the best possible surgical and ~~psychological~~ mental health care ~~for the duration of injury~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 227 be adopted as amended.

HOD ACTION: Resolution 227 adopted as amended.

Resolution 227 asks (1) that our American Medical Association seek legislation and/or regulations to ensure both Active Duty members of the Armed Forces and Veterans suffering from genito-urinary injuries receive the best possible surgical and psychological care for the duration of injury (Directive to Take Action); and (2) that our AMA, in consultation with relevant medical specialty societies, promote the study of genito-urinary trauma in members of the Armed Forces and Veterans to improve the diagnosis, prevention and treatment of genito-urinary injuries. (Directive to Take Action)

Your Reference Committee heard testimony strongly in support of Resolution 227. Your Reference Committee also heard requests that “mental health” would be a more appropriate term to describe the care needed by active duty members of the armed forces and veterans suffering from genito-urinary injuries. Your Reference Committee agrees that this topic is an example of how public and private aspects of medicine can be used to improve care for the country’s active duty members of the armed forces and veterans. Your Reference Committee, therefore, recommends that Resolution 227 be adopted as amended.

(25) RESOLUTION 229 – REQUIRE PHYSICIAN RAC REVIEW AND APPROVAL

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association, in coordination with other stakeholders such as the American Hospital Association, seek to influence Congress to eliminate the current Recovery Audit Contractor (RAC) system and

ask the Centers for Medicare and Medicaid Services (CMS) to consolidate its ~~cumbersome and duplicative~~ audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians ~~will provide necessary oversight to prevent fraud and abuse, but will not increase administrative burdens unnecessarily on physicians and hospitals and which will not deny appropriate payment for appropriate services provided~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, That ~~until that is accomplished,~~ our AMA seek to influence CMS and ~~or~~ Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making (Directive to Take Action); and be it further

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the third resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, That ~~until that is accomplished,~~ our AMA seek to influence CMS and ~~or~~ Congress to allow physicians and hospitals to be paid any denied claim if appropriate services are rendered ~~rebill any denied claim if appropriate services were rendered~~ (Directive to Take Action); and be it further

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the fourth resolve of Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA seek the enactment of fines, ~~and~~ penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs. (Directive to Take Action)

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Resolution 229 be adopted as amended.

HOD ACTION: Resolution 229 adopted as amended.

Resolution 229 asks 1) that our American Medical Association, in coordination with other stakeholders such as the American Hospital Association, seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its cumbersome and duplicative audit systems into a more balanced, transparent, and fair system, which will provide necessary oversight to prevent fraud and abuse, but will not increase administrative burdens unnecessarily on physicians and hospitals and which will not deny appropriate payment for appropriate services provided (Directive to Take Action); 2) that until that is accomplished, our AMA seek to influence CMS or Congress to require that a physician and not a lower level provider review and approve any RAC claim against physicians or physician-decision making (Directive to Take Action); 3) that until that is accomplished, our AMA seek to influence CMS or Congress to allow physicians and hospitals to rebill any denied claim if appropriate services were rendered (Directive to Take Action); and 4) that our AMA seek the enactment of fines and penalties against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs. (Directive to Take Action)

Reference Committee testimony supported reaffirmation of our AMA's ongoing commitment to advocate for the repeal of the Recovery Audit Contractor (RAC) program. In addition, your Reference Committee heard that our AMA has advocated with Congress and the Administration that the Centers for Medicare and Medicaid Services (CMS) should consolidate its duplicative audit programs into a more transparent, balanced, and fair system, and has made clear that the administrative burden of RAC audits is inequitable. Your Reference Committee also heard that our AMA has also advocated for physician review of audited claims, and for penalties and fines against RACs for appeal errors. This advocacy message was strongly relayed in our AMA's recent White Paper on Program Integrity, which was submitted to Congress and the Administration (see <http://www.ama-assn.org/resources/doc/washington/program-integrity-white-paper.pdf>).

Your Reference Committee heard testimony that the original third resolved of Resolution 229 is inconsistent with AMA advocacy and policy by referencing hospitals. CMS recently published a proposed rule on hospital rebilling, which would allow hospitals, upon a determination that an inpatient admission was not medically necessary, to rebill Part A inpatient claims as Part B inpatient claims for up to a year following the date of service. Our AMA, in accordance with AMA policy D-330.921, advocated that physicians should be held harmless from audits resulting from the proposed rebilling policy, and also noted the problems that the policy could pose for Medicare beneficiaries (e.g., unexpected higher copays).

Your Reference Committee also heard strong testimony regarding the need for both physicians and hospitals to be paid any denied claim if appropriate services were rendered, as a pending federal bill would allow only hospitals the right to rebill for these services. Similarly, your Reference Committee heard support for physicians to recover costs of defending against RACs whenever an appeal against them is won, in order to discourage inappropriate and illegitimate work by RACs. Your Reference Committee also heard that the advocacy sought by Resolution 229 should not be predicated on any accomplishing any action item, but rather, should be ongoing advocacy efforts in opposition to RACs. Your Reference Committee, therefore, recommends that Resolution 229 be adopted as amended.

(26) RESOLUTION 234 - FLEXIBILITY IN MEDICARE OPT-OUT AND NEW SAFE HARBOR

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 234 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association seek regulation or legislation to amend the Medicare law to allow physicians to opt out of the Medicare program without a requirement to reaffirm that opt-out. ~~A physician who chooses to opt out of the program must do so for at least two years.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 234 be adopted as amended.

HOD ACTION: Resolution 234 adopted as amended.

Resolution 234 asks 1) that our American Medical Association seek legislation to amend the Medicare law to allow physicians to opt out of the Medicare program without a requirement to reaffirm that opt-out. A physician who chooses to opt out of the program must do so for at least two years. The opt-out period will then be effective indefinitely until the physician chooses to terminate his or her status and rejoin Medicare as a participating or nonparticipating physician; and 2) that our AMA seek legislation and work with the Centers for Medicare & Medicaid Services, as appropriate, to allow for a safe-harbor period for a physician to continue to remain opted out of the Medicare program, without penalty or possibility of recoupment, in those circumstances where the physician has mistakenly not been reaffirming an intention to be opted out. (Directive to Take Action)

Your Reference Committee heard unanimous testimony concerning Resolution 234. Testimony indicated that, in order to maintain their opt-out status, physicians had to satisfy the unnecessary burden of submitting opt-out documentation every two years, and that failure to submit such documentation may expose physicians to significant penalties. Rather than having to renew opt-out status every two years, testimony indicated that opt-out should be permanent until such time as the physician wishes to discontinue opt-out status. To ensure that our AMA has maximum flexibility to address this concern, your Reference Committee recommends amending Resolution 234 to allow our AMA to pursue regulatory as well as legislative solutions. Also, your Reference Committee believes that the second sentence of the resolve is unnecessary and should be deleted.

- (27) RESOLUTION 212 - RESTRICTING PRESCRIPTIONS TO MEDICARE BENEFICIARIES
RESOLUTION 230 - RIGHTS OF MEDICARE BENEFICIARIES TO RECEIVE COVERED SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolutions 212 and 230 be referred.

HOD ACTION: Resolutions 212 and 230 referred.

Resolution 212 asks that our American Medical Association support federal legislation to repeal provisions in 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. (New HOD Policy) Resolution 230 asks 1) that our American Medical Association recognize the legitimacy of a contractual right of a Medicare Part B beneficiary to receive the benefits of coverage for any item or service that is covered by Medicare Part B and provided by an enrolled provider or supplier, regardless of whether the ordering or certifying physician or eligible professional is enrolled in the Medicare program (New HOD Policy); 2) that our AMA challenge by appropriate legal means the Affordable Care Act, Section 6405, requirement that physicians and eligible professionals must enroll in Medicare to order and certify certain Medicare covered items and services including home health, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), imaging, and clinical laboratory, and will also seek repeal of these provisions. (Directive to Take Action)

Your Reference Committee heard testimony highlighting the complexity and confusion concerning the ordering and referring requirements relating to enrollment in the Medicare and Medicaid Programs. Your Reference Committee acknowledges that the enrollment issues covered under Resolutions 212 and 230 are complicated, differ across Medicare and Medicaid, and may not be fully understood by our AMA members. Given the potential of confusion and to better educate physicians, your Reference Committee, in accordance with testimony received, recommends referral in order to clarify for physicians the issues addressed by Resolutions 212 and 230.

- (28) RESOLUTION 210 - HIGH FEDERAL TAXES ON GOOD HEALTH INSURANCE PLANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 210 not be adopted.

HOD ACTION: Resolution 210 not adopted.

Resolution 210 asks that our American Medical Association support the adoption of federal legislation to repeal the component of Patient Protection and Affordable Care Act that imposes excise taxes on comprehensive health insurance policies starting in 2018. (New HOD Policy)

Your Reference Committee received mixed testimony regarding this resolution. Your Reference Committee notes that the revenues generated by the excise tax described in Resolution 210 are one of the ways in which

implementation of the Affordable Care Act and expanded coverage to the uninsured will be funded. Your Reference Committee is concerned that if our AMA is asked to advocate for repeal of the tax, replacement revenue may be sought from funds that may currently be allocated to physicians or programs of greater concern to physicians than excise tax repeal. Therefore, your Reference Committee recommends that Resolution 210 not be adopted.

(29) RESOLUTION 219 - DISCRIMINATION AGAINST DIABETIC TRUCK DRIVERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 219 not be adopted.

HOD ACTION: Resolution 219 not adopted.

Resolution 219 asks (1) that our American Medical Association actively pursue striking Federal Law Item 183, Code Section 391.41 from the current DOT laws (Directive to Take Action); and (2) that our AMA inform appropriate state authorities of this national change when accomplished in order to ensure state policy changes consistent with this resolution. (Directive to Take Action)

Your Reference Committee received mixed testimony concerning Resolution 219. Resolution 219 asks our AMA to pursue striking Code Section 391.41 in its entirety, which addresses many more physical conditions relevant to driver qualifications than diabetes. Additionally, the U.S. Department of Transportation already has in place a Diabetes Exemption Program, under which persons with diabetes may obtain permission to drive commercial vehicles. Your Reference Committee received testimony describing cases where commercial truck drivers refuse to take insulin, for risk of losing DOT classification. Also, your Reference Committee heard compelling testimony that Code Section 391.41 addresses an important safety issue, and as such, should be retained. Your Reference Committee, therefore, recommends that Resolution 219 not be adopted.

(30) Resolution 207 - PHYSICIAN EXTENDERS REIMBURSEMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-390.971, H-330.932, and H.360.988 be reaffirmed in lieu of Resolution 207.

HOD ACTION: Policies D-390.971, H-330.932, and H.360.988 reaffirmed in lieu of Resolution 207.

Resolution 207 asks (1) that our American Medical Association immediately lobby Congress for an increase in physician payment commensurate with training, experience and responsibility (Directive to Take Action); and (2) that our AMA lobby Congress so that physicians collaborating with or supervising physician extenders should be paid for this role because of the increased expertise they must provide and responsibility they must accept. (Directive to Take Action)

Your Reference Committee heard testimony that, as physician extenders are being increasingly utilized to provide primary and specialty patient care, insurance companies including Medicare and Medicaid reimburse physician extenders at rates equal or near to the reimbursement provided to patients per unit of service, despite the differences in education and training of physicians and physician extenders. Your Reference Committee also heard testimony regarding the increased expertise and responsibility a physician supervising or collaborating with a physician extender must accept. However, our AMA has policy that already addresses the concerns expressed in this resolution. Therefore, your Reference Committee recommends reaffirmation of existing AMA Policies D-390.971, H-330.932, and H-360.988 in lieu of Resolution 207.

D-390.971 Medicare Reimbursement for Anesthesiologists

Our AMA will continue its advocacy to replace the flawed SGR payment formula, resulting in increases to the Medicare conversion factors and payments to all physicians. (BOT Action in response to referred for decision Res. 718, I-05)

H-330.932 Cuts in Medicare and Medicaid Reimbursement

Our AMA: (1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients; (2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology; (3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and (5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases. (Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05)

H-360.988 Nurse Practitioner Reimbursement under Medicare

Our AMA supports provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician's supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. With regard to physician assistants, such supervision in most settings includes the personal presence or participation of the physician. In certain practice settings where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, appropriate site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. (BOT Rep. UU, A-90; Reaffirmed: CMS Rep. 1, I-934; Reaffirmed: Res. 240 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)

(31) RESOLUTION 215 - REFORM THE U.S. FARM BILL TO IMPROVE U.S. PUBLIC HEALTH AND FOOD SUSTAINABILITY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that that Policies D-150.978, H-150.937, H-150.944 and H-150.953 be reaffirmed in lieu of Resolution 215.

HOD ACTION: Resolution 215 adopted.

Resolution 215 asks that our AMA support the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. (Directive to Take Action)

Your Reference Committee received testimony supporting Resolution 215, and understands the importance of this resolution's goals. Your Reference Committee believes that this resolution is covered by a number of AMA policies and the goals of Resolution 215 are currently being addressed by AMA advocacy. Your Reference Committee, therefore, recommends reaffirmation of existing AMA policies D-150.978, H-150.937, H-150.944, and H-150.953.

D-150.978 Sustainable Food

Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. (CSAPH Rep. 8, A-09; Reaffirmed in lieu of Res. 411, A-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 205, A-12)

H-150.937 Reducing the Price Disparity Between Calorie-Dense, Nutrition-Poor Foods and Nutrition-Dense Foods

Our AMA supports: (1) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (2) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program. (Res. 414, A-10; Reaffirmation A-12)

H-150.944 Combating Obesity and Health Disparities

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07; Reaffirmation A-12)

H-150.953 Obesity as a Major Public Health Program

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12)

(32) RESOLUTION 231 - REDEFINING AMA'S POSITION ON ACA AND HEALTHCARE REFORM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-155.960, H-165.833, H-165.838, H-165.845, H-165.920, H-185.959, H-290.982, H-330.889, H-450.944, D-155.996, D-390.957, D-390.960, and D-390.969, be reaffirmed in lieu of Resolution 231.

HOD ACTION: Resolution 231 adopted as amended.

RESOLVED, That our American Medical Association develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:

1. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines;
2. Repeal and appropriate replacement of the SGR;
3. Repeal and replace of the Independent Payment Advisory Board (IPAB); with a payment mechanism that complies with AMA principles and guidelines
4. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting");
5. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations (Directive to Take Action);
6. Repeal the non-physician provider non-discrimination provisions of the ACA; and be it further

RESOLVED, That our AMA immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals (Directive to Take Action); and be it further

~~RESOLVED, That if the federal government fails to correct these problems, our AMA publicly withdraw its support of ACA. (Directive to Take Action)~~

RESOLVED, That there be a report back at each meeting of the AMA HOD to the AMA HOD in I-13.

Resolution 231 asks 1) that our AMA immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals (Directive to Take Action); and 2) that if the federal government fails to correct these problems, our AMA publicly withdraw its support of ACA. (Directive to Take Action)

Your Reference Committee heard mixed testimony regarding Resolution 231. Those in support of adoption expressed strong views that our AMA engage in a well-funded grassroots campaign to accomplish the goals of the resolution. Those opposed pointed out that our AMA is already engaged in substantial advocacy efforts to accomplish the goals of the resolution, and that politics around opposing the Affordable care Act (ACA) is one of the reasons why our profession has been unable to successfully persuade Congress to take up legislation to refine the law. Your Reference Committee recognizes that our AMA has extensive policy strongly supporting the goals enumerated in the first resolved. Your Reference Committee also recognizes that our AMA vigorously advocates to achieve these goals, and commits significant resources to support those efforts. A specific description of our AMA efforts can be accessed at www.ama-assn.org/resources/doc/washington/affordable-care-act-the-road-ahead.pdf. In addition, our AMA's advocacy efforts on the issues included in the resolution and other health system reform efforts can be found at www.ama-assn.org/ama/pub/advocacy/federal-advocacy.page.

Your Reference Committee does not recommend adoption of the third resolve. Adoption of a commitment to publicly withdraw our AMA support of the ACA if the federal government fails to repeal and replace the Sustainable Growth Rate (SGR), repeal the Independent Payment Advisory Board (IPAB), and support private contracting, would prove counterproductive and hinder our AMA's ongoing advocacy efforts. In the current political environment, asking our AMA to withdraw its support from the law in its entirety could further discourage the Congress from repealing specific problematic provisions of the ACA, including those cited in Resolution 231.

Therefore, your Reference Committee recommends reaffirmation of Policies H-155.960, H-165.833, H-165.838, H-165.845, H-165.920, H-185.959, H-290.982, H-330.889, H-450.944, D-155.996, D-390.957, D-390.960, and D-390.969, in lieu of Resolution 231.

H-155.960 Strategies to Address Rising Health Care Costs

Our AMA: (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government; (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote “value-based decision-making” at all levels; (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training; (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers; (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors; (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings; (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are reduced for maintenance medications used to treat chronic medical conditions, particularly when non-compliance poses a high risk of adverse clinical outcome and/or high medical costs. Consideration should be given to tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. 9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system. (CMS Rep. 8, A-07; Reaffirmed: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08; Reaffirmation A-09; Reaffirmation I-09; Reaffirmation A-11; Reaffirmation I-11; Appended: Res. 239, A-12; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: CMS Rep. 1, I-12)

H-165.833 Amend the Patient Protection and Affordable Care Act (PPACA)

Our AMA continues to advocate to achieve needed reforms of the many defects of the federal Patient Protection and Affordable Care Act (PPACA) law so as to protect the primacy of the physician-patient relationship. These needed changes include but are not limited to: - repeal of the Independent Payment Advisory Board (IPAB); - study of the Medicare Cost/Quality Index; - repeal of the non-physician provider non-discrimination provision; - enactment of comprehensive medical liability reform; - enactment of long term Medicare physician payment reform including permitting patients to privately contract with physicians not participating in the Medicare program; - enactment of antitrust reform to permit independently practicing physicians to collectively negotiate with health insurance companies; and - expanding the use of health savings accounts as a means to provide health insurance coverage. 2. Our AMA will vigorously work to change the PPACA to accurately represent our AMA Policy. (Res. 217, A-11; Reaffirmation A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12)

H-165.838 Health System Reform Legislation

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

- a. Health insurance coverage for all Americans
- b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps

- c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
 - d. Investments and incentives for quality improvement and prevention and wellness initiatives
 - e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
 - f. Implementation of medical liability reforms to reduce the cost of defensive medicine
 - g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
 3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
 4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
 5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
 6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
 7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
 8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
 - a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
 - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
 - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
 - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
 - e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
 - f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
 9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
 10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
 11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
 12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
 13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of

Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12)

H-165.845 State Efforts to Expand Coverage to the Uninsured

Our AMA supports the following principles to guide in the evaluation of state health system reform proposals: 1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level. 2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage. 3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable. 4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care. 5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations. (CMS Rep. 3, I-07; Reaffirmed: Res. 239, A-12)

H-165.920 Individual Health Insurance

Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will: (a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons; (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures; (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided

plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax; (13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. (15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. (BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-12)

H-185.959 Health Care Benefit Discrepancies for Small Employers Under COBRA

Our AMA: (1) supports the principle that small employers who provide their employees with a group health insurance benefit, and who can afford to do so, should be encouraged to provide continuation coverage for their former employees, ideally consistent with the 18 months of coverage under COBRA; and (2) encourages small employers to establish individual Medical Savings Accounts for their employees. (CMS Rep. 3, A-03, Renumbered: CMS Rep. 7, I-05)

H-185.989 Continuity of Insurance Coverage

Our AMA opposes any attempt by life or health insurers to cancel, reduce, refuse to renew, or increase the individual's premium for coverage under either individual or group policies based on an illness occurring during the time insurance is in force. (CMS Rep. J, A-89; Reaffirmed: Sub. Res. 828, A-99; Reaffirmed: CMS Rep. 5, A-09)

H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in

locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency; (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care; (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income; (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care; (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs; (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance; (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living; (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations. (BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11)

H-330.889 Strengthening Medicare for Current and Future Generations

1. It is the policy of our AMA that a Medicare defined contribution program should include the following:

- a. Enable beneficiaries to purchase coverage of their choice from among competing health insurance plans, which would be subject to appropriate regulation and oversight to ensure strong patient and physician protections.
- b. Preserve traditional Medicare as an option.
- c. Offer a wide range of plans (e.g., HMOs, PPOs, high-deductible plans paired with health savings accounts), as well as traditional Medicare.
- d.

Require that competing private health insurance plans meet guaranteed issue and guaranteed renewability requirements, be prohibited from rescinding coverage except in cases of intentional fraud, follow uniform marketing standards, meet plan solvency requirements, and cover at least the actuarial equivalent of the benefit package provided by traditional Medicare e. Apply risk-adjustment methodologies to ensure that affordable private health insurance coverage options are available for sicker beneficiaries and those with higher projected health care costs. f. Set the amount of the baseline defined contribution at the value of the government's contribution under traditional Medicare. g. Ensure that health insurance coverage is affordable for all beneficiaries by allowing for adjustments to the baseline defined contribution amount. In particular, individual defined contribution amounts should vary based on beneficiary age, income and health status. Lower income and sicker beneficiaries would receive larger defined contributions. h. Adjust baseline defined contribution amounts annually to ensure that health insurance coverage remains affordable for all beneficiaries. Annual adjustments should reflect changes in health care costs and the cost of obtaining health insurance. i. Include implementation time frames that ensure a phased-in approach. 2. Our AMA will advocate that any efforts to strengthen the Medicare program ensure that mechanisms are in place for financing graduate medical education at a level that will provide workforce stability and an adequate supply of physicians to care for all Americans. 3. Our AMA will continue to explore the effects of transitioning Medicare to a defined contribution program on cost and access to care. (CMS Rep. 5, I-12)

H-450.944 Protecting Patients Rights

Our AMA opposes Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet our AMA's "Principles and Guidelines for Pay-for-Performance," which include the following five Principles: (1) ensure quality of care; (2) foster the patient/physician relationship; (3) offer voluntary physician participation; (4) use accurate data and fair reporting; and (5) provide fair and equitable program incentives. (Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation A-07)

D-155.996 Health Care Expenditures

1. Our AMA will work to improve our health care system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies. 2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed. (Res. 103, A-05; Appended: Res. 121, A-10)

D-165.963 Health Savings Accounts

The AMA will: (1) strongly encourage employers to consider offering Health Savings Accounts as an option for their employees; and (2) will continue to examine alternative means for the financing of health care consistent with AMA policy and sound principles of medical practice. (CMS Rep. 6, A-04)

D-390.957 A Grassroots Campaign to Earn the Support of the American People for the Medicare Patient Empowerment Act

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

D-390.960 Assuring Patients' Continued Access to Physician Services

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

D-390.969 Parity in Medicare Reimbursement

Our AMA will continue its comprehensive advocacy campaign to: (1) repeal the Medicare physician payment formula, the sustainable growth rate (SGR); (2) repeal or delay the reductions in Medicare payment for imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005; (3) pass legislation allowing physicians to share in Medicare Part A savings that are achieved when physicians provide medical care that results in fewer in-patient complications, shorter lengths-of-stays, and fewer hospital readmissions; and (4) advocate for other mechanisms to ensure adequate payments to physicians, such as balance billing and gain sharing (BOT Action in response to referred for decision Res. 236, A-06; Reaffirmation I-08)

(33) RESOLUTION 236 - ACTION TO ELIMINATE IMPLEMENTATION OF ICD-10

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy D-70.952 be reaffirmed in lieu of Resolution 236.

HOD Action: Resolution 236 adopted as amended with the addition of a third Resolve clause.

RESOLVED, That our American Medical Association support federal legislation to mandate a two-year “implementation” period by all payers, including CMS, if ICD-10 or ICD-11 is implemented. During this time, payers will not be allowed to deny payment based on specificity of ICD-10/11 diagnosis. However, they will be required to provide feedback for incorrect diagnosis.

In addition, no payer will be allowed to ask for “takebacks” due to lack of ICD-10/11 diagnosis code specificity for the aforementioned two-year implementation period.

Resolution 236 asks 1) that our American Medical Association educate US physicians on the burdens of ICD-10 and how our AMA is fighting to repeal the onerous ICD-10 requirements on their behalf; and 2) that our AMA support federal legislation to stop the implementation of ICD-10 and remain with ICD-9 until ICD-11 can be properly evaluated. (Directive to take Action)

Your Reference Committee heard testimony supporting Resolution 236. Your Reference Committee recognizes, however, that our AMA's House of Delegates (HOD) adopted policy in November 2011 calling on our AMA to oppose the implementation of the ICD-10 code set. Our AMA continues to alert CMS that: (1) the ICD-10 transition comes at a time when physicians have to spend significant time and resources trying to meet requirements of various Medicare programs, including ePrescribing, meaningful use of electronic health records and Physician Quality Reporting System participation; (2) failure to meet separate, distinct requirements of these three federal programs can result in monetary penalties; and (3) these regulatory burdens also deter physicians from participating in new models of care delivery in order to improve the value and quality of care in our nation's health care system. Additionally, as a result of AMA advocacy, legislation (“Cutting Costly Codes Act of 2013, H.R. 1701) has been introduced in both the House of Representatives and the Senate to set aside the implementation of ICD-10 and seek solutions that mitigate the disruption to physician practices when advancing to a new diagnostic code set. Our AMA continues to educate Members of Congress on the substantial differences between ICD-9 and ICD-10, and that physicians are overwhelmed by the prospect of tremendous administrative and financial burdens of transitioning to the ICD-10 diagnosis code set with its 68,000 codes—a five-fold increase from the approximately 13,000 diagnosis codes currently in ICD-9. Accordingly, your Reference Committee recommends that that AMA Policy D-70.952 be reaffirmed in lieu of Resolution 236.

D-70.952 Stop the Implementation of ICD-10

1. Our AMA will: (A) vigorously work to stop the implementation of ICD-10 and to reduce its unnecessary and significant burdens on the practice of medicine; (B) do everything possible to let the physicians of

America know that our AMA is fighting to repeal the onerous ICD-10 requirements on their behalf; (C) work with other national and state medical and informatics associations to assess an appropriate replacement for ICD-9; and (D) evaluate the feasibility of moving from ICD-9 to ICD-11 as an alternative to ICD-10 and report back to the House of Delegates. 2. In order to alleviate the increasing bureaucratic and financial burden on physicians, our AMA will vigorously advocate that the Centers for Medicare & Medicaid Services eliminate the implementation of ICD-10. 3. Our AMA will immediately reiterate to the Centers for Medicare & Medicaid Services that the burdens imposed by ICD-10 will force many physicians in small practices out of business. This communication will be sent to all in Congress and displayed prominently on our AMA website. (Sub. Res. 216, I-11; Appended: Res. 236, A-12; Appended: Res. 209, I-12)

(34) RESOLUTION 237 - TRANSPARENCY OF OUR AMERICAN MEDICAL ASSOCIATION'S POLICY CONCERNING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Policy D-165.940 be amended by addition to read as follows:

D-165.940 Monitoring the Affordable Care Act

Our AMA will assess the progress of implementation of the Patient Protection and Affordable Care Act based on AMA policy, as well as the estimated budgetary, ~~and~~ coverage and physician-practice impacts of the law, and report back to the House of Delegates at the 2013 Interim Meeting. (Res. 210, I-12)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that amended Policy D-165.940 be adopted in lieu of Resolution 237.

HOD ACTION: Policy D-165.940 adopted as amended in lieu of Resolution 237.

Resolution 237 asks 1) that our American Medical Association prepare in a concise format analyses (including relevant AMA policy and public positions) of all aspects of the Patient Protection and Affordable Care Act that could harm patients' access to care and/or dilute physician autonomy, and make that information broadly available for physicians and the public (Directive to Take Action); 2) that our AMA prepare in a concise format and in accordance with Policies D-270.988 and H-165.835 a report identifying the portions of the PPACA that are in accordance with AMA policy and those that are not, including a review of the costs for full implementation of the PPACA (Directive to Take Action); and 3) that our AMA report this information at the 2013 Interim Meeting of the AMA House of Delegates. (Directive to Take Action)

Your Reference Committee heard mixed testimony in support of the intent of Resolution 237. Your Reference Committee heard remarks from a member of our AMA Council on Medical Service (CMS) that Resolution 237 is asking our AMA to prepare information that is very similar to Resolution 210 (I-12), which directs our AMA to monitor implementation of the ACA. While Resolution 237 asks for specific studies on particular provisions of the ACA and identification of AMA policy, your Reference Committee agrees with the CMS representative, as well as similar remarks by representatives from our AMA Board and Council on Legislation, that the intent of Resolution 237 could be achieved more efficiently and economically through the pending CMS report that will be submitted to the House of Delegates at the I-13 meeting. Therefore, your Reference Committee recommends adopting a substitute resolution proposed by CMS that amends existing policy D-165.940 by addition to read as follows: "Our AMA will assess the progress of implementation of the Patient Protection and Affordable Care Act based on AMA policy, as well as the estimated budgetary and coverage impacts of the law, and report back to the House of Delegates at the 2013 Interim Meeting."

(35) BOARD OF TRUSTEES REPORT 25 – EVALUATION OF ICD-11 AS A NEW DIAGNOSTIC CODING SYSTEM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 25 be filed.

HOD ACTION: Board of Trustees Report 25 referred.

Board of Trustees Report 25 is an informational report that provides an overview of the feasibility of moving from ICD-9 directly to ICD-11. While your Reference Committee heard testimony from those who raised concerns about the report, your Reference Committee believes that this report achieves the goal of discussing the feasibility of moving directly from ICD-9 to ICD-11. Board of Trustees Report 25 provides an overview of the development of ICD-11, a comparison of the implementation of ICD-10 versus ICD-11, and advantages and disadvantages of moving from ICD-9 to ICD-11. Your Reference Committee thanks the Board of Trustees for its report, and recommends that Board of Trustees Report 25 be filed.

(36) BOARD OF TRUSTEES REPORT 32 – PATIENT PROTECTION AND AFFORDABLE CARE ACT NON-DISCRIMINATION LANGUAGE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 32 be filed.

HOD ACTION: Board of Trustees Report 32 filed.

Board of Trustees Report 32 is an informational report that provides an update to the House of Delegates (HOD) on AMA efforts to implement Policy H-35.968 and the additional directives adopted by the HOD. Your Reference Committee heard testimony that our AMA has policy, which has been reaffirmed, to seek to repeal the non-discrimination language. Your Reference Committee also heard that Board of Trustees Report 8-I-12 informed the House that opportunities to refine the Affordable Care Act (ACA) did not present themselves in the 2012 election year. Subsequently, at the 2012 Interim Meeting, the House voted again to reaffirm AMA policy and to require another report to the House at the 2013 Annual Meeting. Testimony noted that there have been no opportunities to open the ACA for refinement, and that no regulations have been issued to implement this provision. Testimony also reaffirmed that our AMA will continue to seek opportunities to address this issue. Finally, your Reference Committee heard a concern that highlighting the non-discrimination provision through an aggressive grassroots or media campaign would be counterproductive, given the ongoing advocacy efforts of our AMA to repeal the SGR. Absence any recommendations, your Reference Committee recommends that Board of Trustees Report 32 be filed.

REPORT OF REFERENCE COMMITTEE C

- (1) COUNCIL ON MEDICAL EDUCATION REPORT 2 - SUNSET REVIEW OF 2003 HOUSE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 2 adopted and the remainder of the report filed.

Council on Medical Education Report 2, Sunset Review of 2003 House Policies, is a review of House of Delegates' policies related to medical education last considered in 2003, and contains Council on Medical Education recommendations for retention or rescission of policies.

The Council on Medical Education 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.

Your Reference Committee believes that this report should be adopted. No testimony was received on this report.

- (2) COUNCIL ON MEDICAL EDUCATION REPORT 3 - IMPLEMENTATION OF ACCREDITATION STANDARDS RELATED TO MEDICAL SCHOOL DIVERSITY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Council on Medical Education Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 3 adopted and the remainder of the report filed.

Council on Medical Education Report 3, Implementation of Accreditation Standards Related to Medical School Diversity, 1) summarizes the status of implementation of the Liaison Committee on Medical Education (LCME) diversity standards and describes the steps taken by the LCME to assist schools in achieving compliance; 2) provides data on trends in medical student, resident, and faculty diversity; and 3) describes current strategies to enhance medical school diversity. This report recommends: 1) That American Medical Association Policy D-295.963 (# 2) be reaffirmed. 2) That AMA Policy D-295.963 (# 3) be rescinded.

Your Reference Committee heard limited but supportive testimony in favor of this report. It was noted that increased diversity enhances the educational experience for all students. The report's recommendations support diversity in medical education and represent a positive step towards the mitigation of health disparities. For these reasons, your Reference Committee recommends adoption of this report.

- (3) COUNCIL ON MEDICAL EDUCATION REPORT 6 - CURRICULA FOR PAIN EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 6 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 6 adopted and the remainder of the report filed.

Resolution 325-A-12, introduced by the American Academy of Pain Medicine, asked that our AMA work with all agencies, government bodies, and other stakeholder organizations associated with developing, coordinating, and maintaining curricula for pain education, in cooperation with relevant medical specialty societies, to provide education about pain neurobiology, evaluation, and treatment to all medical students.

Council on Medical Education Report 6, Curricula for Pain Education, recommends that our American Medical Association reaffirm the following policies: D-295.982, Model Pain Management Program for Medical School Curricula, and D-300.996, Voluntary Continuing Education for Physicians in Pain Management.

Your Reference Committee heard limited but supportive testimony on CME Report 6, which recommends reaffirmation of existing AMA policy.

(4) COUNCIL ON MEDICAL EDUCATION REPORT 7 - RETENTION AND AVAILABILITY OF CONTINUING MEDICAL EDUCATION PARTICIPATION RECORDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 7 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 7 adopted and the remainder of the report filed.

Resolution 327-A-12, introduced by the Michigan Delegation, asked that our AMA: 1) Work with the Accreditation Council for Continuing Medical Education (ACCME) and continuing medical education (CME) providers that it accredits to ensure that each CME provider will make available to a central data repository a transcript of all CME credits earned by a physician from the CME provider, including date, credits earned, and program title; and 2) Work with the ACCME to make physician CME transcripts available to the physician online and in real time in a format suitable for submission to licensing and other organizations without cost to the physician.

Council on Medical Education Report 7, Retention and Availability of Continuing Medical Education Participation Records recommends: 1) That our American Medical Association (AMA) reaffirm Policy, D-300.999, Registration of Accredited CME Sponsors, to reinforce that the AMA will continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician's Recognition Award (PRA) policy when designating AMA PRA credit. 2) That our AMA remind all CME accredited providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.

Your Reference Committee heard limited but supportive testimony on CME Report 7. In his testimony, the author of Resolution 327-A-12 recognized the Council for developing a report that accurately portrays the challenges and costs to creating a central registry for CME. We, therefore, recommend adoption of CME Report 7 as written.

(5) COUNCIL ON MEDICAL EDUCATION REPORT 9 - STUDENT MISTREATMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 9 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 9 adopted and the remainder of the report filed.

Council on Medical Education Report 9, Student Mistreatment, provides a summary of Liaison Committee on Medical Education standards that went into effect in 2009 and AMA activities underway to address the student mistreatment.

The report recommends: 1) That our American Medical Association (AMA) reaffirm policy H-295.955, which recommends that each medical education institution have a widely disseminated policy that sets forth the expected standards of behavior of the teacher and learner and delineates procedures for dealing with breaches of that standard and specifies a Code of Behavior for all medical programs to utilize as a guide in developing standards of behavior for both teachers and learners. 2) That our AMA reaffirm policy H-295.900, which encourages the development of a model student orientation program that addresses standards of behavior for teachers and learners. 3) That our AMA ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment. 4) That our AMA, through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship. 5) That our AMA encourage the Association of American Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) to identify best practices and strategies to assure an appropriate learning environment for medical students.

Your Reference Committee heard virtual testimony and live testimony that was supportive of CME Report 9. An additional recommendation was inserted following virtual testimony, suggesting that our AMA ask medical school accreditation bodies to develop policy requiring that mistreatment reporting data include the institution, site and rotation of reported mistreatment and that these data be made directly available to students, residents and faculty annually. At the live hearing, however, significant testimony was heard that this new recommendation could be counterproductive and lead to less reporting of legitimate mistreatment due to concerns about anonymity and confidentiality. It was also noted in testimony that the LCME has extensive policy on student mistreatment, and that the AAMC collects and publishes aggregate data on this issue on an annual basis. Your Reference Committee therefore supports the original language of the report and recommends adoption of CME Report 9.

(6) RESOLUTION 305 - STUDY ON DECERTIFICATION OF PHYSICIANS PRACTICING WITH A LIMITED LICENSE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 305 be adopted.

HOD ACTION: Resolution 305 adopted.

Resolution 305 asks our AMA to encourage national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license.

Your Reference Committee heard limited testimony in support of this resolution. Our AMA has been working with the American Board of Medical Specialties (ABMS), the ABMS Member Boards, and the Federation of State Medical Boards (FSMB) to understand how specialty board certification and state medical licensure and disciplinary actions are related and to look at ways to enhance transparency and consistency at the state board and specialty board levels in how they take and define various actions against licensure and certificates. The FSMB and ABMS are currently studying the impact these regulations have on the workforce and this recommendation is appropriate at this time. Your Reference Committee recommends that Resolution 305 be adopted.

(7) RESOLUTION 320, SUPPORT FOR QUALITY IN GRADUATE MEDICAL EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 320 be adopted.

HOD ACTION: Resolution 320 adopted.

Resolution 320 asks our AMA to collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

Your Reference Committee heard strong testimony in support of Resolution 320. With a growing number of graduates unable to obtain a residency program slot, expansion of GME positions is critical. It was noted in testimony that the AMA does not have policy related to quality outcomes and GME funding. With a number of current legislative efforts at play in Washington that link GME funding to quality outcomes, developing such policy will help the AMA have a seat at the table as these efforts move forward. In addition, the resolution commits the AMA only to explore these evidence-based approaches to quality and accountability. Finally, the Council on Medical Education has offered to author a future report on the specifics of what such quality and accountability approaches might look like. For these reasons, your Reference Committee recommends adoption of Resolution 320.

(8) COUNCIL ON MEDICAL EDUCATION REPORT 4 - AN UPDATE ON MAINTENANCE OF CERTIFICATION, OSTEOPATHIC CONTINUOUS CERTIFICATION, AND MAINTENANCE OF LICENSURE
RESOLUTION 308 - BOARD CERTIFICATION/MAINTENANCE OF CERTIFICATION
RESOLUTION 309 - MAINTENANCE OF CERTIFICATION AND LICENSURE VERSUS BOARD CERTIFICATION, CONTINUING MEDICAL EDUCATION AND LIFELONG COMMITMENT TO LEARNING
RESOLUTION 311 - TRANSPARENCY AND ACCOUNTABILITY FOR SPECIALTY BOARDS AND MAINTENANCE OF CERTIFICATION
RESOLUTION 315 - OPPOSITION TO MANDATORY MAINTENANCE OF CERTIFICATION
RESOLUTION 319 - MAINTENANCE OF CERTIFICATION - PART IV AND OSTEOPATHIC CONTINUOUS CERTIFICATION - COMPONENT 4

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be amended by addition of a new recommendation, to read as follows:

4. That our AMA will continue to monitor the evolution of Maintenance of Certification (MOC), Osteopathic Continuous Certification (OCC), and Maintenance of Licensure (MOL), continue its active engagement in the discussions regarding their implementation, and report back to the House of Delegates on these issues. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be amended by addition of a new recommendation, to read as follows:

5. That our AMA will 1) work with the American Board of Medical Specialties (ABMS) and ABMS specialty boards to continue to examine the evidence

supporting the value of specialty board certification and MOC and to determine the continued need for the mandatory high-stakes examination; and 2) work with the ABMS to explore alternatives to the mandatory high-stakes examination. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be amended by addition of a new recommendation, to read as follows:

6. That our AMA encourage the ABMS to ensure that all ABMS specialty boards provide full transparency related to the costs of preparing, administering, scoring, and reporting MOC and certifying/recertifying examinations and ensure that MOC and certifying/recertifying examinations do not result in significant financial gain to the ABMS specialty boards. (Directive to Take Action)

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be amended by addition of a new recommendation, to read as follows:

7. That our AMA work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications, in particular to ensure that MOC is specifically relevant to the physician's current practice. (Directive to Take Action)

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be amended by addition of a new recommendation, to read as follows:

8. That our AMA work with the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards to prospectively study the impact of MOC, OCC, and MOL on the physician workforce. That our AMA solicit an independent entity (i.e. IOM, Physicians Foundation) to commission and pay for a study to evaluate the impact that MOL and MOC requirements have on physicians' practices, including but not limited to: physician workforce, physicians' practice costs, patient outcomes, patient safety and patient access. Such study will look at the examination processes of the ABMS, the American Osteopathic Association, and the Federation of State Medical Boards. Such study is to be presented to the AMA HOD, for deliberation and consideration before any entity, agency, board or governmental body requires physicians to sit for MOL licensure examinations. Progress report is to be presented at Annual 2014; complete report by Annual 2015 (Directive to Take Action)

RECOMMENDATION F:

Mr. Speaker, your Reference Committee recommends that Council on Medical Education Report 4 be amended by addition of a new recommendation, to read as follows:

9. That our AMA 1) support ongoing ABMS specialty board efforts to allow other physician educational and quality improvement activities to count for MOC; 2) support specialty board activities in facilitating the use of MOC quality

improvement activities to count for other accountability requirements or programs such as pay for quality/performance or PQRS reimbursement; 3) encourage the ABMS specialty boards to enhance the consistency of such programs across all boards; and 4) work with specialty societies and specialty boards to develop tools and services that facilitate the physician's ability to meet MOC requirements. (Directive to Take Action)

RECOMMENDATION G:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 4 be adopted as amended in lieu of Resolutions 308, 309, 311, 315, and 319 and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 4 adopted as amended in lieu of Resolutions 308, 309, 311, 315, and 319 and the remainder of the report filed.

Resolution 917-I-12, introduced by the Indiana Delegation, asked that our AMA adopt the following principles related to certifying and accrediting entities: 1) There should be full transparency related to the costs of preparing, administering, scoring, and reporting the results of board certifying exams. 2) There should be full transparency on the costs of facility documentation, review, facility inspection, scoring, and reporting of accreditation results. 3) There is the expectation that timely and multiple board exam sites will be available so as to minimize the need for physicians to travel long distances or wait long times for exam dates. 4) The accreditation process should be timely and efficient. 5) There is the expectation that certification and accreditation services should not be a source of substantial profit for these entities.

Council on Medical Education Report 4, An Update on Maintenance of Certification, Osteopathic Continuous Certification, Maintenance of Licensure, builds on information provided in three previous Council reports to the House of Delegates on this topic and provides a progress report on maintenance of certification (MOC), osteopathic continuous certification (OCC) and maintenance of licensure (MOL). The report recommends: 1) That our American Medical Association (AMA) Reaffirm Policy H-275.923, Maintenance of Certification/Maintenance of Licensure, to reinforce that our AMA encourages rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. 2) That our AMA Reaffirm AMA Policy H-275.924, Maintenance of Certification, to reinforce that any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones). 3) That our AMA Rescind Policy D-275.960 (2), An Update on Maintenance of Certification, Osteopathic Continuous Certification, and Maintenance of Licensure, since that has been accomplished through this report.

Resolution 308 asks our AMA to 1) oppose mandatory specialty board recertification by examination; and 2) recommend that recertification by examination not be a requirement for hospital credentialing.

Resolution 309 asks our AMA to 1) pursue to uphold and maintain the importance of the patient-physician relationship independent of outside interference as the key to excellent medical care, that physicians are bound by generally accepted professional and ethical values in pursuit of best care for patients; 2) continue to support and advocate lifelong continuing medical education and lifelong Specialty Board Certification as determined by the physician him/herself, to advocate against time-limited specialty medical board certificates, and advocate against discrimination against physicians who are not certified or are certified and choose NOT to engage in corporate recertification programs labeled as "voluntary" by the specialty medical boards; 3) assist states in efforts to seek legislation that will prohibit discrimination by hospitals and any employer, state licensure boards, insurers, Medicare, Medicaid, and other entities, which might restrict a physician's right to practice medicine without interference (including economic discrimination by varying fee schedules) due to lack of certification, lack of participation in FSMB/ABMS prescribed corporate programs including Maintenance of Licensure or expiration of time limited Board Certification; 4) promote and/or implement a policy opposing discrimination by hospitals or employers, state licensure boards, insurers, Medicare, Medicaid, and other entities, which might restrict a physician's right to practice medicine without interference (including economic discrimination by varying fee schedules) due to lack of certification or participation in FSMB/ABMS prescribed corporate programs including

Maintenance of Licensure or time limited Board Certification; and 5) adopt as policy this resolution opposing discrimination by hospitals or employers, state licensure boards, insurers, Medicare, Medicaid, and other entities, which might restrict a physician's right to practice medicine without interference (including economic discrimination by varying fee schedules) due to lack of certification or participation in FSMB/ABMS prescribed corporate programs including Maintenance of Licensure or time limited Board Certification as was suggested by the AMA Young Physicians Section Governing Council in 2007.

Resolution 311 asks our AMA to 1) call on the American Board of Medical Specialties (ABMS) and its component specialty boards to increase their transparency and accountability to the physician community; 2) call upon the ABMS and its specialty boards to publish detailed reports of revenues and expenses, including compensation to board members and senior staff; 3) call upon the ABMS and its component boards, to require all board members and senior staff to annually disclose any potential conflicts of interest, professional or financial, to the physician community; and 4) call upon the ABMS and its component boards, to publish evidence based-data in peer reviewed articles in support of each component of their maintenance of certification processes.

Resolution 315 asks our AMA to 1) acknowledge that the certification requirements within the Maintenance of Certification (MOC) process are costly, time intensive and result in significant disruptions to the availability of physicians for patient care; 2) acknowledge and affirm the professionalism of individual physicians to self-determine the best means and methods for maintenance of their knowledge and skills; and 3) oppose mandating MOC until such time as evidence-based research demonstrates MOC is linked to improved patient outcomes.

Resolution 319 asks our AMA to 1) work with specialty societies, ABMS, and the AOA to create, streamline, and integrate activities that satisfy Part IV / Component 4 of maintenance of certification within existing processes already undertaken by physicians; 2) ask the ABMS and AOA to identify opportunities whereby data collected for the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting System, CMS Incentive Programs ("meaningful use"), or other similar quality initiatives may be used to also satisfy the requirements for data collection for Part IV / Component 4; and 3) AMA ask the ABMS and AOA to jointly encourage specialty societies to demonstrate one or more ways that Part IV requirements can be met through ongoing participation in other quality initiatives.

Your Reference Committee heard mixed testimony on this complex and wide-ranging item. It was noted that CME Report 4 and previous reports on this topic have supported the notion of transparency and evidence-based data in support of this process. However, others noted that there needs to be a stronger evidence base to support the value of board certification, and more transparency and accountability to the physician community. Testimony was also submitted in opposition to mandatory specialty board recertification by examination. However, hospitals frequently require board certification for credentialing, and intervention to prevent this common practice is beyond the scope of this report and our AMA's interests. Testimony also stated that recertification specialty board examination should not be mandated for hospital credentialing. (AMA policy is opposed to mandatory board certification.) Although the need to participate in continuing medical education activities was supported, there was strong support to lessen the burden of MOC on physicians with multiple board certifications and to ensure that MOC is specifically relevant to the physician's current practice. Testimony also supported the need to allow other physicians' activities to count for MOC and for MOC quality improvement activities to count for other accountability requirements or programs such as pay for quality/performance or PQRS reimbursement. There was also continued concern about the impact that MOC, OCC, and MOL may have on the physician workforce. Your Reference Committee expects that our AMA will continue to monitor these issues closely, encourage further investigation by key stakeholders, such as the American Board of Medical Specialties, the American Osteopathic Association, and the Federation of State Medical Boards, and report back to the House of Delegates as appropriate. The related resolutions raise important issues that need to be addressed as part of the monitoring process. On that front, your Reference Committee recommends that CME Report 4 be adopted as amended in lieu of Resolutions 308, 309, 311, 315 and 319.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 5 -PHYSICIAN WORKFORCE SHORTAGE, GOING FORWARD WITH REFORMING GME FINANCING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Council on Medical Education Report 5 be amended by addition of a new recommendation, to read as follows:

4. That our AMA work with the Association of American Medical Colleges and other key stakeholders to continue to examine alternative models of funding for graduate medical education, with a report back at the 2014 Annual Meeting. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 5 adopted as amended and the remainder of the report filed.

Resolution 317-A-12, introduced by the Oklahoma Delegation, asked that our AMA work diligently with the Centers for Medicare and Medicaid Services (CMS) and the U.S. Congress to create a supplemental private funding opportunity in addition to current funding sources to help develop additional residency training positions with private donations to cope with the critical shortage of primary care physicians in our country.

Resolution 329-A-12, introduced by the Mississippi Delegation, asked our AMA to 1) work with all available internal data and other available sources to craft a new national model for sustainable funding of GME programs which includes not only the CMS funding, but also private funding sources as well, and 2) urgently work to implement via legislation and other means this new model for funding GME programs in the United States.

Council on Medical Education Report 5, Physician Workforce Shortage, Going Forward with Reforming GME Financing, provides an update on the AMA efforts to improve GME funding at the federal, state, and regional levels. The report recommends: 1) That our AMA Reaffirm Policies H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," H-310.917, "Securing Funding for Graduate Medical Education," D-305.967, "The Preservation, Stability, and Expansion of Full Funding for Graduate Medical Education," Policy D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy," and D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs." which support adequate and stable funding as well as new sources of funding for graduate medical education from all payers for health care including the federal government, the states, and private payers. 2) That our AMA Reaffirm Policy H-305.929 (4), "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which states that diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions. 3) That our AMA Reaffirm Policy D-305.967 (11), "The Preservation, Stability, and Expansion of Full Funding for Graduate Medical Education," to recognize that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; and to direct our AMA to immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce, and to make increasing support and funding for GME programs and residencies a top priority of our AMA in its national political agenda.

Your Reference Committee heard testimony in support of CME Report 5. Our AMA is working with the Association of American Medical Colleges (AAMC) and all other stakeholders to explore proposals for graduate medical education (GME) financing and continues to advocate that current sources of funding be preserved, and that

all payers, including private insurance companies, should directly contribute to its funding. AMA policy supports an all-payer system of GME funding, with funding from federal, state, and private/commercial payers alike. However, the testimony also articulated the need to explore new alternative models for funding GME such as private trust, corporate, or public sources. Based on the strong testimony heard, your Reference Committee believes that CME Report 5 would benefit from an additional recommendation that calls on our AMA to continue to work with the AAMC and other key stakeholders to examine alternative models of funding for graduate medical education as part of its advocacy efforts. To carry out this recommendation, the Council on Medical Education will create an additional report outlining potential specific policy at the federal and state levels that will inform discussions about possible model legislation. This will be done in a timely fashion given the critical need for expansion of graduate medical education positions and funding. Accordingly, your Reference Committee recommends that CME Report 5 be adopted as amended.

(10) COUNCIL ON MEDICAL EDUCATION REPORT 8 - THE CHANGING TRAINING ENVIRONMENT: ACCESS TO PROCEDURAL TRAINING FOR RESIDENTS AND FELLOWS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that recommendation 1 in Council on Medical Education Report 8 be amended by addition and deletion, to read as follows:

That our American Medical Association (AMA) support the concept that procedural training is a critical portion of resident education and the augmentation of patient care by ~~mid-level non-physician~~ practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that that recommendation 2 in Council on Medical Education Report 8 be amended by addition and deletion, to read as follows:

That our AMA ask the Accreditation Council for Graduate Medical Education to evaluate the trend in the number of cases, and roles in these cases, of graduating residents since the implementation and revision of duty hour restrictions to determine whether duty hour standards may have adversely impacted ~~surgical~~ residents' ability to ~~perform~~ participate in a sufficient number of ~~surgical procedures~~ cases to make them proficient and well qualified for independent practice, and that this information be used to further refine change in resident education under the Next Accreditation System. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 8 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Education Report 8 adopted as amended and the remainder of the report filed.

Resolution 328-A-12, introduced by the Minnesota Delegation, Minority Affairs Section, and Nebraska Delegation, asked that our AMA: 1) Study the trends in numbers of residency training sites that also employ mid-level providers and/or concurrently train students of these mid-level programs; 2) Define a physician-in-training's role in the hospital and specifically make it a high educational priority for trainees to receive the needed exposure to procedures required for them to master competency in their specialty and that these exposures are not delegated to mid-level

providers and mid-level provider trainees; and 3) Study the financial impact for institutional training sites of hiring more mid-level providers versus investing in a physician training program.

Council on Medical Education Report 8, The Changing Training Environment: Access to Procedural Training for Residents and Fellows, recommends: 1) That our American Medical Association (AMA) support the concept that procedural training is a critical portion of resident education and the augmentation of patient care by mid-level practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures. 2) That our AMA ask the Accreditation Council for Graduate Medical Education to evaluate the trend in the numbers of cases, and roles in these cases, of graduating residents since the implementation and revision of duty hour restrictions to determine whether duty hour standards may have adversely impacted surgical residents' ability to perform a sufficient number of surgical procedures to make them proficient and well qualified for independent practice, and that this information be used to further refine change in resident education under the Next Accreditation System.

Your Reference Committee heard virtual and live testimony in support of the recommendations in CME Report 8. With tighter duty hour restrictions, more non-physician practitioners are being used to meet service needs, at the risk of reducing educational opportunities for resident physicians. A wording change was recommended to revise the term "mid-level practitioners," which is seen as derogatory. In addition, edits to Recommendation 2 were proposed to ensure that this item is not limited to the procedures of physicians in surgical specialties. Your Reference Committee urges adoption of CME Report 8 as amended.

- (11) RESOLUTION 301 - POLICY AND ADVOCACY ROTATIONS FOR MEDICAL STUDENTS
RESOLUTION 303 - INSURANCE EDUCATION FOR MEDICAL STUDENTS
RESOLUTION 313 - ADVOCACY TRAINING IN MEDICAL SCHOOL

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 301 be adopted in lieu of Resolution 301, Resolution 303, and Resolution 313.

HOD ACTION: Substitute Resolution 301 adopted in lieu of Resolution 301, Resolution 303, and Resolution 313.

SYSTEMS-BASED PRACTICE EDUCATION FOR MEDICAL STUDENTS AND RESIDENT/FELLOW PHYSICIANS

RESOLVED, That our American Medical Association support the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders (New HOD Policy); and be it further

RESOLVED, That our AMA encourage development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product (New HOD Policy); and be it further

RESOLVED, That our AMA request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician's role in obtaining affordable care for patients; cost

awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes (New HOD Policy).

Resolution 301 asks our AMA to: 1) support the recognition and incorporation of elective advocacy and health policy rotations and fellowships for medical students within the US medical curriculum; and 2) work with state and specialty societies, the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), the Commission on Osteopathic College Accreditation (COCA), and the Liaison Committee on Medical Education (LCME), and other interested organizations to implement health advocacy rotations and fellowships, and develop a set of model guidelines and curricular goals to be used by state and specialty societies. Resolution 303 asks our AMA to work with the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, the Liaison Committee on Medical Education, and the Commission on Osteopathic College Accreditation to encourage integration of medical education curricula on insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid, and the physician's role in obtaining affordable care for patients. Resolution 313 asks our AMA to strongly encourage all United States medical schools and residency programs to incorporate significant, more formalized training in health care policy and patient care advocacy into their curricula to aid in the development of our next generation of physician leaders.

Your Reference Committee heard considerable testimony on Resolutions 301, 303, and 313, which were combined into one substitute resolution in the virtual report. Testimony from both the Council on Medical Education and the Section on Medical Schools on the new substitute Resolution 301 raised concerns about Resolve 3 as specifying curricular mandates. Your Reference Committee believes, however, that this Resolve is not prescriptive but rather descriptive, and it has been revised to state that the AMA simply suggest to the appropriate accrediting bodies potential subjects for inclusion in systems-based practice curricula. In addition, requirements for education in systems-based practice have already been instituted by the Accreditation Council for Graduation Medical Education (ACGME). Other testimony was heard requesting that the AMA develop modules for medical students/resident physicians to learn these concepts; this concept has been integrated into Resolve 2. Your Reference Committee, therefore, recommends adoption of the proposed substitute Resolution 301.

(12) RESOLUTION 302 - COLLABORATIVE EFFORT TO REDUCE FEDERAL LOAN INTEREST RATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 302 be amended by addition and deletion, to read as follows:

RESOLVED that our American Medical Association work in collaboration with other health profession organizations to ~~reduce~~ advocate for a reduction of the current fixed interest rate of the Stafford student loan program. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 302 be adopted as amended.

HOD ACTION: Resolution 302 adopted as amended.

Resolution 302 asks our AMA to work in collaboration with other health profession organizations to reduce the current fixed interest rate.

Your Reference Committee heard testimony to support adoption of this resolution. Decreasing student loan interest rates is an important part of maintaining an adequate physician workforce and addressing our nation's growing

health care needs. Your Reference Committee felt it would be helpful to specify the name of the student loan program. Your Reference Committee recommends adoption of Resolution 302 as amended.

(13) RESOLUTION 304 - RETAINING PUBLIC SERVICE LOAN FORGIVENESS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 304 be amended by deletion of the first Resolve, to read as follows:

~~RESOLVED, That our American Medical Association oppose the reduction of medical student and physician benefits or the creation of more stringent requirements for qualification under Public Service Loan Forgiveness (New HOD Policy); and be it further~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 304 be adopted as amended.

HOD ACTION: Resolution 304 adopted as amended.

Resolution 304 asks our AMA to 1) oppose the reduction of medical student and physician benefits or the creation of more stringent requirements for qualification under Public Service Loan Forgiveness; and 2) support the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness.

Your Reference Committee heard testimony in support of Resolution 304. Resolve 1, however, was seen as essentially redundant to Resolve 2 (restating it as a negative); for that reason, Your Reference Committee recommends its deletion and adoption of Resolution 304 as amended.

(14) RESOLUTION 306 - EVALUATING THE EFFECT OF ACGME RESIDENT-WORK HOURS REFORMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 306 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association recommend that the Accreditation Council for Graduate Medical Education ~~only introduce new duty hour rules if they are use~~, where possible recommendations from respective specialty societies, and evidence-based approaches to any future revision or introduction of resident duty hour rules. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended.

Resolution 306 asks our AMA to recommend that the Accreditation Council for Graduate Medical Education only introduce new duty-hour rules if they are evidence-based.

Your Reference Committee heard testimony in support of the changes to Resolution 306. These were suggested by the Council on Medical Education, which stated that the resolution as originally drafted could unduly limit the ability of the ACGME to address some of the issues identified by program directors and residents which may not yet

have an evidence base. It was also noted that the ACGME is undertaking a five-year review of its duty hour regulations. Other testimony was supportive of this amendment. Suggested language for an additional Resolve was received from the American College of General Surgery, which called for evidence based on patient safety outcome data collected and reported by specialty societies and boards. Your Reference Committee appreciates the intent of this suggestion, but believes that it is preferable to have policy that is less prescriptive in this regard, and therefore urges adoption of Resolution 306 as amended.

(15) RESOLUTION 307 - SUPPORT FOR RESIDENTS AND FELLOWS DURING FAMILY AND MEDICAL LEAVE TIME

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 307 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~work with~~ encourage the specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to ~~develop~~ study alternative mechanisms and pathways based on competency evaluation to graduate for keeping those ensure that individuals who have taken family and medical leave graduate as close to ~~on track within their residency and fellowship training so as to abide by their traditional graduation target~~ their original completion date as possible.
(Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 307 be adopted as amended.

HOD ACTION: Resolution 307 adopted as amended.

Resolution 307 asks our AMA to work with the specialty boards, the Accreditation Council for Graduate Medical Education and Residency Review Committees to develop alternative mechanisms for keeping those individuals who have taken family and medical leave on track within their residency and fellowship training so as to abide by their traditional graduation date.

Your Reference Committee heard testimony in support of Resolution 307. The ongoing move in residency training from the current temporal model to a competency-based model, as embodied in the ACGME's milestones framework, was the basis for new language proposed by the Section on Medical Schools, to include pathways "based on competency evaluation." Your Reference Committee believes the proposed edits strengthen the original resolution and urges adoption as amended.

(16) RESOLUTION 316 - RESTORATION OF ACADEMIC FREEDOM AND THE AVAILABILITY OF CME AT COMMUNITY HOSPITALS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 316 be adopted in lieu of Resolution 316.

HOD ACTION: Substitute Resolution 316 adopted in lieu of Resolution 316.

THE AVAILABILITY OF CME AT COMMUNITY HOSPITALS

RESOLVED, That our American Medical Association advocate for the availability of accessible, affordable, high-quality continuing medical education for small rural and community hospitals. (Directive to Take Action).

Resolution 316 asks our AMA to 1) advocate for modification of Accreditation Council for Continuing Medical Education (ACCME) guidelines to allow community hospitals to provide accredited continuing medical education (CME) activities, with little or no financial burden to the institution; and 2) petition the ACCME for modification of its guidelines to allow community hospitals to provide accredited CME activities, with little or no financial burden to the institution.

Your Reference Committee heard considerable testimony against adoption of Resolution 316. For example, testimony was heard that allowing for exceptions to ACCME guidelines would constitute a step backwards in quality education for physicians, and that there is no compelling rationale to support an exemption from standards for one hospital while a second institution is held to a higher standard. It was also noted that such a change could undermine the CME system, and that other mechanisms exist to obtain the needed accreditation. Further, the ACCME already understands that it needs to make accreditation more accessible and affordable, and reduce the accompanying administrative effort, without reducing the quality of the CME accreditation process. Similarly, the Council on Medical Education expressed its opposition to the proposed resolution, and noted that our AMA and the ACCME are working together to simplify the process of accreditation, which could reduce costs without compromising the integrity of CME. At the same time, your Reference Committee heard testimony that small, rural hospitals do not have the needed resources to support CME activities. Our AMA should work to ensure the availability of CME to all physicians, regardless of practice location. Accordingly, Your Reference Committee recommends adoption of Substitute Resolution 316 in lieu of the original resolution.

(17) RESOLUTION 317, TRAINING IN REPRODUCTIVE HEALTH TOPICS AS A REQUIREMENT FOR ACCREDITATION OF FAMILY MEDICINE RESIDENCIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 317 be amended by addition of a new second Resolve, to read as follows:

RESOLVED, That our AMA encourage the ACGME to ensure greater clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics. (Directive to Take Action).

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 317 be adopted as amended.

HOD ACTION: Resolution 317 adopted as amended.

Resolution 317 asks our AMA to work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy.

Your Reference Committee heard strong testimony in favor of Resolution 317. Testimony was heard that women's health and contraception are key parts of the scope of practice of family practitioners. Also, it was noted that the ACGME is moving content areas such as reproductive health services from the program requirements and including these in more detail in the ACGME's Frequently Asked Questions (FAQs) documentation. This will allow the Family Medicine Residency Review Committee of the ACGME to more rapidly respond to changing clinical and educational environments by revising the FAQs, rather than waiting for the next opportunity to revise the program requirements. At the same time, the ACGME needs to assure physicians, and the public, that such critical content areas will continue to be covered in residency education, even if those areas are not in the program requirements, but in FAQs. This was the rationale behind the addition of the new second Resolve. Your Reference Committee recommends adoption as thereby amended.

(18) RESOLUTION 310 - MEDICAL FACILITY REGULATIONS FOR STUDENTS SHADOWING PHYSICIANS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that AMA Policy D-295.941, Facilitating Access to Health Care Facilities for Training, be amended by addition, to read as follows:

D-295.941 Facilitating Access to Health Care Facilities for Training
Our AMA will continue to work with the Association of American Medical Colleges and other national organizations to expedite, wherever possible, the standardization of requirements in regards to training on HIPAA, drug screening, and health requirements for premedical and medical students, and resident and fellow physicians who are being educated in hospitals and other health care settings. (Res. 811, I-07)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the amended Policy D-295.941, Facilitating Access to Health Care Facilities for Training be adopted in lieu of Resolution 310.

HOD ACTION: Resolution 310 referred.

Resolution 310 asks our AMA develop standard criteria for students to shadow physicians in medical facilities.

Your Reference Committee heard mixed testimony on Resolution 310. Reaffirmation of current AMA policy, with the noted edit, expands this policy to include premedical students, as requested in the resolution. Accordingly, your Reference Committee recommends that the amended Policy D-295.941, Facilitating Access to Health Care Facilities for Training, be reaffirmed in lieu of Resolution 310.

(19) RESOLUTION 318, SEEKING CONTINUING MEDICAL EDUCATION CREDITS FOR MEDICAL RESERVE CORPS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 318 not be adopted.

HOD ACTION: Resolution 318 not adopted.

Resolution 318 asks our AMA to 1) encourage the Medical Reserve Corps to apply for recognition by the ACCME as an accredited provider of CME and 2) encourage careful consideration by the Accreditation Council for Continuing Medical Education of any application presented to it by the Medical Reserve Corps.

Your Reference Committee heard very limited testimony on Resolution 318. As our AMA does not involve itself in the application of other organizations to the ACCME, your Reference Committee recommends that Resolution 318 not be adopted.

REPORT OF REFERENCE COMMITTEE D**(1) BOARD OF TRUSTEES REPORT 10 – PREVENTING DEATHS AND INJURIES FROM DISTRACTED WALKING****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 10 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 10 adopted and the remainder of the report filed.

Policy D-10.992, adopted at the 2012 Annual Meeting, asks that our American Medical Association (AMA): (1) as a champion of public health, will include distracted walking as one of the preventable hazards in its published and distributed materials on lifestyle medicine; (2) will utilize established channels of communication with internal and external media to increase public awareness of the hazards caused by distracted walking; (3) will write to appropriate federal and state agencies encouraging them to reevaluate the safety of the roads and intersections for the walking public in their respective jurisdictions; and (4) will report back at the 2013 Annual Meeting summarizing actions which are likely to make walking safer for people.

This report reviews current data regarding the prevalence of pedestrian injury in the U.S. as related to the safety of roads and intersections and provides an overview of national efforts to reduce such injury. It also summarizes the current policies and efforts of the AMA with regard to injury prevention and road safety. The report recommends that our AMA (1) recognize distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (2) encourage research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it. It further recommends that AMA Policy D-10.922 be rescinded.

Your Reference Committee received limited but supportive testimony on this report, and agrees with the report's recommendations.

(2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 – SUNSET REVIEW OF 2003 HOUSE POLICIES**RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 1 adopted and the remainder of the report filed.

In this report, the Council on Science and Public Health (CSAPH) presents its recommendations on the disposition of the House policies from 2003 that were assigned to it. The CSAPH's recommendations on policies are presented in the Appendix of the report.

Your Reference Committee received testimony from one speaker who asked that AMA Policy H-5.983 "Pregnancy Termination" be rescinded rather than amended. Your Reference Committee concurs with testimony emphasizing the need to retain policy on this issue, as recommended by the CSAPH. Your Reference Committee agrees that the demographics of abortion providers are changing across the nation, which may require that our AMA revisit its position on this subject. Your Reference Committee encourages delegates to introduce a resolution on this topic for future deliberation.

(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 – IS OBESITY A DISEASE?

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 3 adopted and the remainder of the report filed.

This report examines the definitions of obesity and disease, the limitations of those definitions, and arguments both for and against the classification of obesity as a disease. The possible implications for provider reimbursement, public policy, and patient stigma were also considered. Of central interest is the potential impact of classifying obesity as a disease on improving patient care and health outcomes. The Council on Science and Public Health (CSAPH) recommends that AMA Policies H-150.953 and H-440.866 be reaffirmed and that Policy D-440.971 be rescinded.

Your Reference Committee received significant testimony on the topic of obesity as a disease, and commends the Council on Science and Public Health for their efforts to address this sensitive issue. Your Reference Committee acknowledges the challenges raised in the report, such as the lack of a single, clear, authoritative, and widely-accepted definition of disease, as well as the limitations of the BMI as a metric. Recognizing that the information brought forth is important and useful, your Reference Committee recommends that the recommendations in CSAPH Report 3 be adopted.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 6 – ELECTRONIC GAMES AND HEALTH PROMOTION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 6 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 6 adopted and the remainder of the report filed.

Policy D-170.993, “Electronic Games and Health Promotion,” directs our AMA to review and report on health-related use of electronic games, types of games that are available, and games that could be recommended by physicians for targeted patient populations. This report focuses on research related to the positive use of electronic games for health improvement in the public and patient populations. With this report, the Council on Science and Public Health (CSAPH) recommends that Policy D-170.993 be rescinded.

Your Reference Committee received limited supportive testimony, and concurs with the Council’s recommendation.

(5) RESOLUTION 402 – CLARIFYING AMA TOBACCO POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 402 be adopted.

HOD ACTION: Resolution 402 adopted.

Resolution 402 asks that our American Medical Association revise policies H-495.989, D-495.999, H-495.988, and H-490.914 to explicitly define “tobacco products” as “including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco”.

Your Reference Committee received only supportive testimony for this resolution. This included testimony to further expand the proposed definition of tobacco products to include cigars and electronic cigarette/nicotine delivery devices. There was additional testimony indicating that there is not sufficient evidence on the harmful effects of nicotine and therefore it was recommended that references to nicotine delivery devices should not be added. Your Reference Committee feels that the language in the original resolution is adequate.

(6) RESOLUTION 413 – HEALTH RISKS OF SITTING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 413 be adopted.

HOD ACTION: Resolution 413 adopted.

Resolution 413 asks that our American Medical Association recognize that there are potential risks of prolonged sitting and encourage efforts by employers, employees, and others to make available alternatives such as standing work stations and isometric balls, and encourage educational efforts regarding ways to minimize this risk. (New HOD Policy)

Your Reference Committee received limited but favorable testimony for the resolution. Your Reference Committee is aware of the potential health problems associated with prolonged sitting, particularly in work settings. It was also noted that prolonged standing can also lead to poor health outcomes. Your Reference Committee is supportive of this resolution and recommends adoption.

(7) RESOLUTION 416 – PUBLIC EDUCATION ON DISTRACTED DRIVING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 416 be adopted.

HOD ACTION: Resolution 416 adopted.

Resolution 416 asks that our American Medical Association support public education efforts regarding the dangers of distracted driving, particularly activities that take drivers’ eyes off the road.

Your Reference Committee received limited but supportive testimony on this resolution. Your Reference Committee recognizes the hazards of distracted driving, which can include visual, manual, and cognitive distractions. While the AMA already has policy that supports a ban on hand-held devices while driving, this resolution could be a step further to address other forms of distraction as well as the importance of public education on the dangers. Your Reference Committee recommends that Resolution 416 be adopted.

(8) RESOLUTION 420 - RECOGNITION OF OBESITY AS A DISEASE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 420 be adopted.

HOD ACTION: Resolution 420 adopted.

Resolution 420 asks that the AMA recognize obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

Your Reference Committee heard significant, mixed testimony on this issue, which addressed the implications on employers, employees, life insurance coverage, disability, workmen's compensation, weight bias, insurer responsibility, physician reimbursement, and ICD-9 coding. While your Reference Committee recognizes the challenges expressed in CSAPH Report 3, they felt that those reasons did not justify rejection of the notion of obesity as a disease. After lengthy discussion, your Reference Committee concluded that the ramifications of obesity warrant a paradigm shift in the way the medical community tackles this complicated issue. Without detracting from the recommendations of CSAPH Report 3, your Reference Committee recommends that Resolution 420 be adopted.

(9) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 – HEALTH EFFECTS OF THE GULF OIL SPILL

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Science and Public Health Report 5 be amended by addition to read as follows:

That Policy D-135.980, “Gulf Oil Spill Health Risks: Update on AMA Involvement” be amended to read as follows.

Our AMA will encourage the National Institute of Environmental Health Sciences and the Natural Resource Damage Assessment program to: (1) continue to monitor health effects (including mental health effects) and public health surveillance activities related to the Gulf oil spill, and provide relevant information and resources as they become available; and

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Science and Public Health Report 5 adopted as amended and the remainder of the report filed.

At the 2010 Interim Meeting, the Council on Science and Public Health (CSAPH) developed a brief report on contemporary views regarding health risks associated with the Gulf oil spill and summarized relevant AMA activities. AMA Policy D-135.980, “Gulf Oil Spill Health Risks: Update on AMA Involvement,” directs the CSAPH to report back at the 2013 Annual Meeting on the results of studies examining the health effects of the Gulf oil spill.

Your Reference Committee received limited but favorable testimony of the report and recommendations, which included an amendment to add “including mental health effects”. Your Reference Committee supports continued monitoring of the possible physical and mental health effects of the Gulf oil spill with an evidence-based approach; this includes appropriate reporting to allow the public to better assess their exposure. Your Reference Committee recommends that the report be adopted as amended given it fulfills the request for a report as asked in AMA Policy D-135.980.

(10) RESOLUTION 403 – PERMITTING SUNSCREEN IN SCHOOLS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve in resolution 403 be amended by addition to read as follows:

RESOLVED, That our American Medical Association support the exemption of sunscreen from over-the-counter medication possession bans in schools and encourage all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve in Resolution 403 be deleted.

~~RESOLVED, That our AMA encourage schools to allow teachers to provide students with sunscreen, without requiring the teacher to assist in application. (New HOD Policy).~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 403 be adopted as amended.

HOD ACTION: Resolution 403 adopted as amended.

Resolution 403 asks that our American Medical Association (1) support the exemption of sunscreen from over-the-counter medication possession bans in schools and encourage all schools to allow students to bring and possess sunscreen at school without restriction and (2) encourage schools to allow teachers to provide students with the sunscreen, without requiring the teacher to assist in application.

Your Reference Committee received testimony in favor of the first resolve. Your Reference Committee added the additional language to clarify that students should not be required to have a physician note to bring sunscreen to their school. While your Reference Committee agreed with the intent of the second resolve, the Committee was persuaded by testimony expressing concern for the possibility of sensitization, and the legal liability of schools for students who manifest allergic or dermatologic reactions to sunscreen products provided by the school. Therefore, your Reference Committee recommends adoption of Resolution 403 as amended.

(11) RESOLUTION 404 – POVERTY SCREENING AS A CLINICAL TOOL FOR IMPROVING HEALTH OUTCOMES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 404 be amended by deletion of the first resolve.

~~RESOLVE, That our American Medical Association support the development of standardized, validated questionnaires to screen for social and economic risk factors with high sensitivity and specificity (New HOD Policy); and be it further~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 404 be amended by addition and deletion of the second resolve to read as follows:

RESOLVED, That our AMA encourage the use of questionnaires to screening for social and economic risk factors in order to improve care plans, and direct patients to appropriate resources. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 404 be adopted as amended.

HOD ACTION: Resolution 404 adopted as amended.

Resolution 404 asks that our American Medical Association (1) support the development of standardized, validated questionnaires to screen for social and economic risk factors with high sensitivity and specificity and (2) encourage the use of questionnaires to screen for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.

Your Reference Committee received mixed testimony on this issue. Opposing testimony did not support the development of another screening tool. It was stated that every good health history and physical examination should include the gathering of information regarding the patient's socioeconomic risk factors, to include financial well-being. Several testified that they did not understand what this resolution was asking physicians to do differently and expressed concern that additional screenings could have unintended consequences which could lead to discrimination in obtaining health care. Discussion of the definition of "poverty" as well as the availability of existing social determinant questionnaires for physicians led to uncertainty regarding the need for a questionnaire which specifically addresses poverty. Due to the confusion, testimony also called for referral. However, there was also substantial testimony in support of the use of existing questionnaires which assist physicians in identifying poverty in a clinical practice. Testimony indicated that it has been well documented that individuals identified with low socioeconomic status (SES) have been found to have poorer health outcomes than those individuals with higher SES. Testimony also included the success of asking a single question ("Do you (ever) have difficulty making ends meet at the end of the month?") as being a good predictor of poverty (sensitivity of 98%; specificity 60%). This question combined with two follow-up questions regarding food insecurity ("In the past year, was there any day when you or anyone in your family went hungry because you did not have enough money for food?") and recent homelessness ("In the last month, have you slept outside, in a shelter, or in a place not meant for sleeping?") have been proven predictors or indicators of poverty. For these reasons, your Reference Committee recommends that Resolution 404 be adopted as amended.

(12) RESOLUTION 405 – THE HEALTH COSTS OF HYDRAULIC FRACTURING

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 405 be adopted.

HOD ACTION: Substitute Resolution 405 adopted.

THE HEALTH RISKS OF HYDRAULIC FRACTURING

RESOLVED, That our AMA encourage appropriate agencies and organizations to study the potential human and environmental health risks and impacts of hydraulic fracturing. (New HOD Policy)

Resolution 405 asks that our American Medical Association (1) support the idea of disease registries for long term monitoring and mitigation of health effects potentially related to hydraulic fracturing and (2) encourage other interested parties to study the potential health risks and impacts of hydraulic fracturing and the estimated health costs to states, insurers, employers and the health care system.

Your Reference Committee received overwhelming testimony supporting the need for public health monitoring programs to identify human and environmental impacts of hydraulic fracturing. Your Reference Committee agrees with testimony that more research is needed regarding occupational and public health risks (eg, oncogenic, teratogenic) of this expanding technology. Estimation of associated health costs, however, is deemed premature pending the results of health risk assessments. While testimony supported ongoing surveillance programs, absent any well-defined symptom complex associated with hydraulic fracturing to date, little support was heard for the

establishment of disease registries. Your Reference Committee believes the substitute resolution appropriately captures the testimony as well as the intent of the resolution.

(13) RESOLUTION 408 – ENHANCED EDUCATION FOR ABRUPT CESSATION OF SMOKING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 408 be amended by deletion of the first and third resolves.

~~RESOLVED, That our American Medical Association inform physicians and the public health community about the documented long-term efficacy of non-pharmaceutical abrupt-cessation smoking cessation protocols (Directive to Take Action); and be it further~~

~~RESOLVED, That our AMA encourage research and evaluation on promising smoking cessation protocols that promote abrupt cessation of smoking without reliance on pharmaceuticals (New HOD Policy); and be it further~~

~~RESOLVED, That our AMA petition The Joint Commission to amend their requirement on smokers being discharged from hospitals to recognize smoking cessation protocols with documented efficacy, not reliant on pharmaceuticals, as smoking cessation options. (Directive to Take Action).~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 408 be adopted as amended.

HOD ACTION: Resolution 408 adopted as amended.

Resolution 408 asks that our American Medical (1) inform physicians and the public health community about the documented long-term efficacy of non-pharmaceutical abrupt-cessation smoking cessation protocols, (2) research and evaluation on promising smoking cessation protocols that promote abrupt cessation of smoking without reliance on pharmaceuticals, and (3) petition The Joint Commission to amend their requirement on smokers being discharged from hospitals to recognize smoking cessation protocols with documented efficacy, not reliant on pharmaceuticals, as smoking cessation options.

Your Reference Committee received testimony from the author with a friendly amendment striking the first and third resolves in the resolution due to lack of interest in funding effective protocols by major industries. Testimony was supportive of this amendment which also addressed concerns raised regarding the effectiveness of abrupt cessation versus pharmaceutical interventions and counseling. It was noted that the AMA endorsed the 2008 U.S. Public Health Service Guidelines for Treating Tobacco Use and Dependence, which concluded that clinical interventions significantly increase long-term quit rates over cold-turkey quit rates. Also, AMA policy supports evidence-based clinical guidelines for cessation from the Agency for Healthcare Research and Quality (AHRQ), which does not include abrupt cessation. The Joint Commission's Tobacco Cessation Performance Measure Set (2012) mandates comprehensive evidence-based tobacco-dependence treatment during hospitalization and on discharge; abrupt cessation was not included in the evidence-based measures. Your Reference Committee recognizes the difficulties in quitting smoking and that chosen methods of cessation are different for each person. In an effort to acknowledge the importance of tobacco cessation and education, your Reference Committee recommends that Resolution 408 be adopted as amended.

- (14) RESOLUTION 409 – BANNING MARKETING AND SALE OF “HIGH-ENERGY/STIMULANT DRINKS” TO CHILDREN/ADOLESCENTS UNDER THE AGE OF 18

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 409 be amended by deletion in the first resolve to read as follows:

RESOLVED, That our American Medical Association support a ~~temporary~~ ban on the marketing of “high stimulant/caffeine drinks” to children/adolescents under the age of 18 (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 409 be amended by deletion of the second resolve.

~~RESOLVED, That the temporary ban on marketing for children/ adolescents under age 18 be kept in place until such time as the scientific evidence regarding the possible adverse medical affects that stimulant drinks may have on children and adolescents is determined. (New HOD Policy)~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 409 be adopted as amended.

HOD ACTION: Resolution 409 adopted as amended.

Resolution 409 asks that our American Medical Association (1) support a temporary ban on the marketing of “high stimulant/ caffeine drinks” to children/ adolescents under the age of 18 and (2) that the temporary ban on marketing for children/adolescents under age 18 be kept in place until such time as the scientific evidence regarding the possible adverse medical effects that stimulant drinks may have on children and adolescents is determined.

Your Reference Committee received favorable testimony for this resolution. Testimony acknowledged the increasing number of health events presenting in emergency departments as a result of energy drink consumption, particularly by youth. It was noted that our AMA already has policy in support of a ban on marketing “beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks” (D-60.973) to youth, and felt this resolution was in line with current policy. Your Reference Committee is very concerned about the potential effects of marketing such products to an impressionable, young audience, and therefore amended the language in the first resolve to take a stronger position with the removal of the word “temporary”. The second resolve was deleted to avoid confusion and redundancy. Your Reference Committee recommends that Resolution 409 be adopted as amended.

- (15) RESOLUTION 410 – PHYSICIANS AND THE PUBLIC HEALTH ISSUES OF GUN SAFETY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 410 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association request that the U.S. Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths ~~by one half by the year 2020, and that such report and~~

~~campaign be completed and presented to the 2013 Interim Meeting.~~ (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 410 be adopted as amended.

HOD ACTION: Resolution 410 adopted as amended.

Resolution 410 asks that our American Medical Association request that the U.S. Surgeon General develop a report and campaign aimed at reducing gun-related deaths by one half by the year 2020, and that such a report and campaign be completed and presented to the 2013 Interim Meeting.

Your Reference Committee received mixed testimony on this resolution. Your Reference Committee acknowledged the serious problem of gun-related injuries and deaths, especially in light of recent traumatic events across the country reported in the media. It was noted that national efforts are needed to address this multifactorial issue, which could be enhanced by the reinstatement of CDC funding for gun violence research pending the President's budget proposal. Your Reference Committee agrees that this resolution is timely, given that a report and campaign from the Surgeon General could lead the charge for change. However, putting parameters on such a report in terms of the number of reduced deaths (by 2020) as well as completing it before our AMA's next meeting (I-13) did not seem appropriate. Therefore your Reference Committee has amended the resolution to remove benchmarks and dates.

(16) RESOLUTION 411 – CHEERLEADING AS A SPORT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 411 be adopted:

HOD ACTION: Substitute Resolution 411 referred.

PROMOTION OF CHEERLEADER SAFETY

RESOLVED, That our AMA strongly encourage schools to provide appropriate athletic and medical resources as necessary to prevent and treat injury, as well as training for coaches on reducing risk associated with potentially dangerous cheerleading activities. (New HOD Policy).

Resolution 411 asks that our American Medical Association (1) support the designation of cheerleading as a sport and (2) support requiring cheerleading coaches to undergo training on reducing risk with potentially dangerous cheerleading activities.

Your Reference Committee received mixed testimony on this resolution. Supportive testimony recognized that the designation as "sport" could require that school districts provide the same benefits to cheerleading teams that are available to other sport teams. However, opposing testimony stated that such a designation would include Title IX requirements, which could be problematic. Your Reference Committee was reticent to adopt policy that could put additional pressure on school districts. Also, your Reference Committee was not comfortable with the use of the word "requiring", given its potential implications. It was noted that the issue of coach training, which impacts cheerleader safety, seems to be the driver of this resolution. Therefore, your Reference Committee recommended striking the first resolve and amending the second resolve to create a Substitute Resolution 411 in an effort to emphasize the need for proper training and resources for coaches that would directly benefit cheerleaders.

(17) RESOLUTION 412 – STRATEGIES TO INCREASE DIABETES PREVENTION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 412 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association organize a series of activities for the public (in collaboration with health care workers and community organizations ~~that contribute to the care of diabetic patients) such as a city-wide walk or exercise demonstration and healthy cooking tips during its 2014 Annual Meeting~~ to bring awareness to the severity of diabetes and measures to decrease its incidence. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 412 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that that the title of Resolution 412 be changed to read as follows:

STRATEGIES TO INCREASE DIABETES AWARENESS

HOD ACTION: Resolution 412 adopted as amended with a change in title.

Resolution 412 asks that our American Medical Association organize a series of activities for the public (in collaboration with health care workers and community organizations that contribute to the care of diabetic patients) including a city-wide walk or exercise demonstration and healthy cooking tips during its 2014 Annual Meeting to bring awareness of the severity of diabetes and measures to decrease its incidence.

Your Reference Committee received favorable testimony for this resolution, as well as support for the AMA's plan to focus on improving health outcomes related to diabetes. Your Reference Committee is aware of the importance of diabetes prevention and control, and expressed that such public efforts would align with the AMA's new strategic focus. However your Reference Committee felt it best that the resolution be worded more broadly to not exclude other possible activities, while at the same time being cognizant of the fiscal note. Therefore your Reference Committee recommends that Resolution 412 and its title be adopted as amended.

(18) RESOLUTION 414 – MONITORING RADIATION FOR FUKUSHIMA IN SEAFOOD

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 414 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association call for the United States government to continue to monitor and fully report the radioactivity levels of edible Pacific Ocean species sold in the United States ~~that could reasonably have been exposed to radiation from the ongoing 2011 Fukushima disaster, with information about any potential health implications of consuming 31 such foods.~~ (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 414 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 414 be changed to read as follows:

MONITORING FOR RADIATION IN SEAFOOD

HOD ACTION: Resolution 414 adopted as amended with a change in title.

Resolution 414 asks that our American Medical Association call for the United States government to continue to monitor and fully report the radioactivity levels of edible Pacific Ocean species sold in the United States that could reasonably have been exposed to radiation from the ongoing Fukushima disaster, with information about potential health implications of consuming such foods.

Your Reference Committee heard testimony only from the sponsor of the resolution. Your Reference Committee agrees with the need to monitor possible contamination of seafood due to the Fukushima nuclear power plant disaster of 2011, which may still have an impact upon the U.S. food supply and the health of Americans. Your Reference Committee also feels that the U.S. government should have an active monitoring program to ensure the safety of the food supply regardless of radiation exposure source. The title of the resolution was changed to more accurately reflect the intent of the resolution.

(19) RESOLUTION 415 – PREVENTION OF FALLS FROM WINDOWS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 415 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the use of window guards and devices that prevent ~~windows from opening enough to allow a child to fall through~~ children from falling through windows. (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 415 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that that the title of Resolution 415 be changed to read as follows:

PREVENTION OF FALLS THROUGH WINDOWS

HOD ACTION: Resolution 415 adopted as amended with a change in title.

Resolution 415 asks that our American Medical Association support the use of window guards and devices that prevent windows from opening enough to allow a child to fall through and (2) support public education regarding the risks of children falling through windows.

Your Reference Committee received testimony in support of the proposed amendments. Your Reference Committee is supportive of removable devices that prevent children from falling out of windows, while at the same allowing people to access windows in cases of emergency.

(20) RESOLUTION 419 – PROMOTING CELIAC DISEASE SCREENING USAGE AND STANDARDS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 419 be amended by deletion in the first resolve to read as follows:

RESOLVED, That our American Medical Association recognize undiagnosed celiac disease as a ~~major~~ public health problem (New HOD Policy); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 419 be amended by deletion of the third and fourth resolves.

~~RESOLVED, That our AMA recognize the mortality or morbidity reduction benefit of screening high-risk patients for celiac disease and supports the use of screening tests as a tool to detect celiac disease (New HOD Policy); and be it further~~

~~RESOLVED, That our AMA encourage the inclusion of these medical screening standards on the US Preventive Services Task Force list of approved preventive services. (New HOD Policy)~~

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 419 be adopted as amended.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 419 be changed to read:

CELIAC DISEASE SCREENING

HOD ACTION: Resolution 419 adopted as amended with a change in title.

Resolution 419 asks that our American Medical Association (1) recognize undiagnosed celiac disease as a major public health problem, (2) support the formal establishment of evidence-based celiac disease screening recommendations and high-risk population definitions for general and pediatric populations by appropriate stakeholders, (3) recognize the mortality or morbidity reduction benefit of screening high-risk patients for celiac disease and supports the use of screening tests as a tool to detect celiac disease, and (4) encourage the inclusion of these medical screening standards on the US Preventive Services Task Force list of approved preventive services.

Your Reference Committee received testimony in support of our AMA acknowledging celiac disease and returning to the original language of the resolution. The author testified to strike the third and fourth resolves of the original language, which your Reference Committee supports. Testimony indicated that guidelines from the American College of Gastroenterology were published in May 2013 (*Am J Gastroenterology* 2013; 108:656-676). Your Reference Committee recommends adoption of the first and second resolves, but recommends removing the word “major” from the first resolve as the Reference Committee felt it overstated the urgency of the problem.

(21) RESOLUTION 422 - ADOLESCENT PREGNANCY AND NON-GRADUATION FROM HIGH SCHOOL

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 422 be adopted:

RESOLVED, That our American Medical Association (AMA) actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school. (Directive to Take Action)

HOD ACTION: Substitute Resolution 422 adopted.

Resolution 422 asks that our American Medical Association (AMA) provide e-information regarding the socioeconomic limitations of non high-school completion due to adolescent pregnancy in efforts to educate adolescents about such consequences.

Your Reference Committee heard favorable testimony on Resolution 422. Testimony indicated that nearly one-third of teen girls who have dropped out of high school cite early pregnancy or parenthood as the main reason and that U.S. teen births accounted for 18.4% of all non-marital births. In addition to utilizing our AMA website, it was recommended that other social media resources, such as Facebook and Twitter, be used for dissemination. For these reasons, your Reference Committee recommends adoption of Resolution 422 as amended.

(22) RESOLUTION 423 - ADDRESSING VIOLENCE PREVENTION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that AMA Policies H-515.966 and H-515.982 be reaffirmed in lieu of Resolution 423.

HOD ACTION: AMA Policies H-515.966 and H-515.982 reaffirmed in lieu of Resolution 423.

Resolution 423 asks the AMA to (1) be the primary advocate for physicians to address violence prevention and response when it interferes with their patient-physician relationship through the establishment of a clearinghouse with resources, model legislation, educational opportunities, links to external websites, and patient education that is culturally sensitive and linguistically appropriate; and (2) advocate for the implementation of the Occupational Safety and Health Administration (OSHA) workplace safety programs within healthcare organizations to improve the safety of physicians' workplaces.

Your Reference Committee heard testimony only from the sponsor of this resolution. While your Reference Committee concurs with the spirit of the resolution and acknowledges the importance of protecting physicians and other healthcare personnel from violence in the workplace, testimony was not compelling to support AMA leadership in the establishment of an informational clearinghouse for physicians on this topic. Your Reference Committee also questioned the need for action as requested in the second resolve since healthcare organizations would be expected to implement applicable OSHA standards and regulations. Rather than adopt this resolution, your Reference Committee feels that existing AMA policy adequately addresses the concerns raised in this resolution.

Policies recommended for reaffirmation:

H-515.966 Violence and Abuse Prevention in the Healthcare Workplace

Our AMA encourages all healthcare facilities to adopt policies to reduce and prevent all forms of workplace violence and abuse and to develop policies to manage reported occurrences of workplace violence and abuse and will advocate that training courses on workplace violence prevention and reduction

be more widely available. (Res. 424, I-98; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: BOT Rep. 2, I-12)

H-515.982 Violent Acts Against Physicians

Our AMA (1) condemns acts of violence against physicians involved in the legal practice of medicine; (2) will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity; (3) will continue to monitor state legislative efforts on increased criminal penalties for assaults against health care providers; and (4) will continue to work with interested state and national medical specialty societies through all appropriate avenues, including state legislatures, when issues related to workplace violence inside and outside of the emergency department arise. (Res. 605, A-92; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 608, A-12; Modified: BOT Rep. 2, I-12)

(23) RESOLUTION 401 – TORNADO AND STORM SAFETY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 401 be referred.

HOD ACTION: Resolution 401 referred.

Resolution 401 asks that our American Medical Association adopt policy that: 1) manufacturing standards be improved to require every new manufactured home produced in the United States to contain a “safe room” with clear labeling indicating its location; 2) local ordinances across the United States require that manufactured homes be properly anchored; 3) incentives be offered to owners of existing homes to promote the installation of a “safe room” or other storm shelter for those homes; and 4) programs providing discounted weather alert radios be developed and promoted.

Your Reference Committee received mixed testimony for the specific actions called for in this resolution. Your Reference Committee heard uniform support for AMA efforts to improve awareness of measures to protect public health and safety in a tornado or other severe wind storm. Testimony cited uncertainty regarding the precise structural engineering and manufacturing standards and building codes that could be implemented and promoted to achieve this goal, particularly since not all regions of the United States are at equal risk. Your Reference Committee agrees that safe rooms and storm shelters are important safety considerations in residential structures, but is unsure of their effectiveness or feasibility in manufactured homes. Your Reference Committee prefers referral for more in-depth study and analysis to inform a comprehensive approach to personal and public health preparedness for tornados.

(24) BOARD OF TRUSTEES REPORT 18 – ANNUAL UPDATE ON ACTIVITIES AND PROGRESS IN TOBACCO CONTROL: MARCH 2012 THROUGH FEBRUARY 2013

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 18 be filed.

HOD ACTION: Board of Trustees Report 18 filed.

This report summarizes American Medical Association (AMA) activities and progress in tobacco control from March 2012 through February 2013 and is written in response to AMA Policy D-490.983, “Annual Tobacco Report.”

Your Reference Committee heard testimony from a single delegate who lauded this timely and ongoing informational report. Testimony requested that our AMA recognize the year 2014 as the 50th anniversary of Luther L. Terry's Surgeon General's report on smoking. In lieu of adding a formal recommendation to this report, your

Reference Committee requests that AMA staff and the Board of Trustees consider ways to publicly commemorate this event with a report back in the 2014 Annual Update in Tobacco Control Report to the House of Delegates.

REPORT OF REFERENCE COMMITTEE E

- (1) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 –
NANOTECHNOLOGY SAFETY AND REGULATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 2 be adopted and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 2 adopted and the remainder of the report filed.

Council on Science and Public Health Report 2 offers a brief overview of the current uses of nanotechnology, potential effects on human health and the environment, and regulation of nanomaterials. It recommends that our American Medical Association (a) recognize the benefits and potential risks of nanotechnology; (b) support responsible regulation of nanomaterial products and applications to protect the public's health and the environment; and (c) encourage continued study on the health and environmental effects of exposure to nanomaterials.

Limited but supportive testimony was heard on the Council's report. Your Reference Committee believes the report is well written and recommends adoption of its recommendation.

- (2) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 – SAFETY OF
X-RAY SECURITY SCANNERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 4 be adopted and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 4 adopted and the remainder of the report filed.

Council on Science and Public Health Report 2 briefly reviews the safety concerns associated with x-ray backscatter security scanners. Its recommendation states that our American Medical Association (a) believes that as of June 2013, no data exist to suggest that individuals, including those who are especially sensitive to ionizing radiation, should avoid backscatter security scanners due to associated health risks; and (b) supports the adoption of routine inspection, maintenance, calibration, survey, and officer training procedures meant to ensure that backscatter security scanners operate as intended.

Virtual supportive testimony thanked the Council for a well-done report, and noted that even though concern about medical exposure to radiation exists, the report found that exposure from backscatter scanners is exceedingly small. A Council member also noted that the backscatter units will be removed from all airports by June 2013. Very limited but supportive on-site testimony was heard on the Council's report. Your Reference Committee recommends adoption of the report's recommendation.

- (3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 7 – GENETIC DISCRIMINATION AND THE GENETIC INFORMATION NONDISCRIMINATION ACT
RESOLUTION 511 – GENETIC INFORMATION NON-DISCRIMINATION IN INSURANCE COVERAGE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 7 be adopted in lieu of Resolution 511 and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 7 adopted in lieu of Resolution 511 and the remainder of the report filed.

Council on Science and Public Health Report 7 examines genetic discrimination and the Genetic Information Nondiscrimination Act (GINA), and identifies gaps in protection and necessary steps toward strengthening protections. It recommends that our American Medical Association (1) strongly opposes discrimination based on an individual's genetic information; (2) will pursue and support legislation intended to provide robust and comprehensive protections against genetic discrimination and misuse of genetic information; and (3) supports education for health care providers and patients on the protections against genetic discrimination currently afforded by federal and state laws.

Resolution 511 asks that our American Medical Association oppose discrimination based on genetic information in decision-making for not only health insurance, but also long-term care, disability, and life insurance policies.

Both virtually and on-site, your Reference Committee received limited but supportive testimony on both the Council's report and Resolution 511, noting the importance of protections that will lessen patients' fears of undergoing genetic testing. Testimony also was supportive of educating health care providers and patients on protections against genetic discrimination. A question was raised about whether Recommendation 2 in Council's report was intended to cover discrimination in the life, long-term care, and disability markets, as specifically noted in Resolution 511. Your Reference Committee believes that the Council thoughtfully developed its recommendations to include all instances of genetic discrimination, which were specifically addressed in the body of the Council's report. Your Reference Committee therefore believes that adoption of the recommendations in the Council report achieves the intent of Resolution 511; the sponsor of 511 agreed.

- (4) RESOLUTION 503 – SUPPORT FOR MEDICAID REIMBURSEMENT OF NEONATAL MALE CIRCUMCISION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 503 be adopted.

HOD ACTION: Resolution 503 adopted.

Resolution 503 asks that our American Medical Association 1) encourage state Medicaid reimbursement of neonatal male circumcision; and 2) amend Policy H-60.945 by insertion and deletion to read as follows:

Our AMA: (1) encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision; (2) supports the general principles of the ~~1999~~ 2012 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: ~~“Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision. In circumstances in which there are potential benefits and risks, yet the procedure is not essential to the child's current well being, parents should determine what is in the best interest of the child. To make an informed choice, parents of all male infants should be given accurate and unbiased information and be provided the opportunity to discuss this decision. If a decision for circumcision is made, procedural~~

~~analgesia should be provided;~~ “Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure’s benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV.” and (3) urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions. (CSA Rep. 10, I-99; Reaffirmed: CSAPH Rep. 1, A-09)

Overwhelmingly, virtual and onsite testimony supported Resolution 503. Virtual testimony expressed concern about whether the cost benefit of spending public tax dollars could be justified. As underscored by on-site testimony, your Reference Committee believes that the science supports the benefits of circumcision, and therefore, that the resolution should be adopted.

(5) RESOLUTION 505 – MEDICAL EXEMPTIONS FROM VACCINES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 505 be adopted.

HOD ACTION: Resolution 505 adopted.

Resolution 505 asks that our American Medical Association encourage physicians to follow medical contraindications to vaccines when parents seek a note for a medical exemption from vaccines to attend school.

Limited but supportive testimony was heard for this resolution, highlighting the importance of vaccination for public health. Your Reference Committee agrees with using evidence-based contraindications for medical exemption and recommends adoption of this resolution.

(6) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 8 – NATIONAL DRUG SHORTAGES: UPDATE
RESOLUTION 508 – TO ADDRESS NATIONAL SHORTAGES OF ANTI-TUBERCULOSIS MEDICATIONS
RESOLUTION 510 – ADDRESSING DRUG SHORTAGES
RESOLUTION 517 – DECLINING AVAILABILITY OF INEXPENSIVE GENERIC MEDICATIONS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 8 be amended by substitution to read as follows:

That Policy-H-100.956(6,7) be amended addition and deletion to read as follows:

6. The Council on Science and Public Health ~~will~~ should continue to evaluate the drug shortage issue and report back on progress made in addressing drug shortages as appropriate. ~~at the 2013 Annual Meeting of the House of Delegates.~~
(Modify Current HOD Policy)

7. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors, including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. The Council should monitor and

evaluate the forthcoming report on drug shortages from the Government Accountability Office and report back on its findings.

8. Our AMA advocate for government stockpiling of oral and intravenous parenteral drug shortage products, or for removal of government policy price controls to mitigate against an unfair manufacturing free market place.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 8 be adopted as amended in lieu of Resolutions 508, 510, and 517 and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 8 adopted as amended in lieu of Resolutions 508, 510, and 517 with referral of recommendation #8, and the remainder of the report filed.

Council on Science and Public Health Report 8 evaluates the drug shortage issue and provides an update on progress made in addressing drug shortages since the Council previously reported at I-12. The report's recommendation states:

That AMA Policy H-100.956(6) be amended to read as follows:

6. The AMA should develop a webpage resource dedicated to drug shortages and the Council on Science and Public Health will should continue to evaluate the drug shortage issue and report back on progress made in addressing drug shortages as appropriate. ~~at the 2013 Annual Meeting of the House of Delegates.~~

Resolution 508 asks that our American Medical Association urge the Food and Drug Administration to 1) place anti-tuberculosis medications and diagnostic agents including isoniazid, rifampin, ethionamide, rifabutin, amikacin, capreomycin, kanamycin, streptomycin and tubersol on the FDA list of medically necessary products and; 2) utilize the tentative approval process of the President's Emergency Plan for AIDS Relief (PEPFAR) to enable expedited review and approval of high quality medical products made in foreign countries and work with other federal agencies to develop mechanisms to allow the purchase and domestic use of these products when domestic stockouts or shortages occur; and 3) consult with the Centers for Disease Control and Prevention, the Office of the Global AIDS Coordinator (OGAC) and its Supply Chain Management System, the Global Drug Facility (GDF) and others to develop integrated structures that can effectively forecast demand and assure a continuous and high quality domestic and global supply of anti-TB medications, and; 4) work with other key stakeholders to develop incentives and other mechanisms to accelerate the development and approval of new drugs to halt the global TB pandemic.

Resolution 510 asks that our American Medical Association (1) educate its members and the public about the economic and health aspects of drug shortages via material on the web; (2) compile and make available examples of "failure to supply" contractual provisions; (3) work with the Food and Drug Administration in its continued efforts to decrease drug shortages by tracking the impact of any "failure to supply" clauses on drug costs, drug supply, and drug shortages; (4) work with legislators to propose laws addressing the economics of the drug shortage that may act as restraints on trade well outside the jurisdiction of the Food and Drug Administration (FDA) such as mandating multiple supply chains, stockpiling of drugs, or other means to decrease shortages in the event that legal and contractual solutions fail as evidenced by continued or worsening drug shortages as tracked by the FDA; and (5) advocate that any legislation that addresses the economics of the drug shortage such as mandating multiple supply chains, stockpiling of drugs, or other means to decrease shortages include both a sunset provision and a monitoring period to assure their effectiveness.

Resolution 517 asks that our American Medical Association perform a study to determine the cause of shortages and increase in pricing of otherwise inexpensive generic medications, and, based on these findings, develop solutions with both governmental and non-governmental organizations that will keep generic drugs readily available and affordable for our patients as an effective alternative treatment.

Testimony expressed strong support for the Council report and the ongoing work of the Council in helping to monitor the issue of drug shortages and keeping the House informed. The FDA reported significant reductions in the number of new drug shortages as well as an increase in the number of shortages that have been prevented in 2012 compared with 2011. An updated status report for 2013 will be forthcoming, as is a new strategic plan from the Agency to address drug shortages. Testimony also noted that AMA already has developed a dedicated webpage on drug shortages. Resolutions 510 and 517 focus on certain economic issues that may be influencing trends in drug shortages, including contracting practices between manufacturers and group purchasers/distributors. Your Reference Committee is skeptical that these proprietary contracting practices could be subject to scrutiny and systematic evaluation by our AMA. Furthermore, your Reference Committee is aware that, as directed by provisions in the 2012 Food and Drug Administration Safety and Innovation Act (FADSI), the Government Accountability Office (GAO) is currently working on a comprehensive root cause analysis of the causes of drug shortages, including the entire range of economic factors; this report is scheduled for completion in January 2014. Therefore, it seems advisable for the AMA to allow the GAO to complete its work and evaluate its findings.

While your Reference Committee is sensitive to the issues raised in Resolution 508 regarding the availability of medications to manage tuberculosis, it is not aware that the FDA maintains a list of medically necessary products, and is uncertain about the feasibility of using the President's Emergency Plan for AID Relief (PEPFAR), which is a global program, as a mechanism to import drugs from foreign sources that might be in short supply in the U.S. That authority is vested with the FDA, which is not part of the interagency collaboration comprising PEPFAR. While the remaining elements of Resolution 508 may have some merit, your Reference Committee generally does not support a process whereby AMA policy on drug shortages begins addressing individual products. Amendments were offered to require an updated report from the Council at each meeting of the HOD in the near term, and to have our AMA call for an end to recent FDA regulatory actions that may affect the ability of drug manufacturers to market products, and policies that limit reimbursement for injectable drugs under Medicare Part B. Your Reference Committee notes that previous reports from the Council have addressed several issues surrounding drug shortages. Your Reference Committee believes that current AMA policy is comprehensive and, as amended, provides sufficient guidance for addressing ongoing shortages that may come to the AMA's attention.

Given all of these considerations, your Reference Committee recommends adopting an amended Council report in lieu of Resolutions 508, 510, and 517.

(7) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 9 - PHARMACY COMPOUNDING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 9 be amended by substitution to read as follows:

That Policy-H-120.945 be amended by addition and deletion to read as follows:

Our AMA: 1. recognizes that traditional compounding pharmacies must be subject to state board of pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications; ~~2. recognizes the accreditation program of the Pharmacy Compounding Accreditation Board (PCABTM) and the PCABTM Seal of Accreditation as a means to identify compounding pharmacies that adhere to quality and practice standards, including those set forth in the USP-NF, for the preparation of individualized medications for specific patients;~~ 3. encourages all state boards of pharmacy to reference sterile compounding quality standards, including but not limited to those contained in United States Pharmacopeia Chapter <797>, as the standard for sterile compounding in their state require compounding pharmacies in their states to obtain the PCABTM Seal of Accreditation or, alternatively, and to

satisfy other relevant comparable standards that have been promulgated by the state in its laws and regulations governing pharmacy practice; ~~and~~ 3. supports the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce be recognized as compounding manufacturers subject to FDA oversight and regulation; 4. supports the view that allowances must be made for the conduct of compounding practices that can realistically supply compounded products to meet anticipated clinical needs, including urgent and emergency care scenarios, in a safe manner; and, 5. in the absence of new federal legislation affecting the oversight of compounding pharmacies, continues to encourage state boards of pharmacy and the National Association of Boards of Pharmacy (NABP), ~~the umbrella organization for state boards of pharmacy,~~ to work with the United States Food and Drug Administration (FDA) to identify and take appropriate enforcement action against entities that are illegally manufacturing medications under the guise of pharmacy compounding. (BOT Action in response to referred for decision Res. 521, A-06) (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 9 be adopted as amended and the remainder of the report filed.

HOD ACTION: Council on Science and Public Health Report 9 adopted as amended and the remainder of the report filed.

Council on Science and Public Health Report 9 reviews pharmacy compounding and current oversight mechanisms. Its recommendation states:

That Policy H-120.945, “AMA Action on Non FDA-Approved Compounded Medications,” be amended to read as follows:

Our AMA: 1. recognizes that traditional compounding pharmacies must be subject to state board of pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications; 2. recognizes the accreditation program of the Pharmacy Compounding Accreditation Board (PCABTM) and the PCABTM Seal of Accreditation as a means to identify compounding pharmacies that adhere to quality and practice standards, including those set forth in the USP-NF, for the preparation of individualized medications for specific patients; 3. encourages all state boards of pharmacy to require compounding pharmacies in their states to obtain the PCABTM Seal of Accreditation or, alternatively, to satisfy comparable standards that have been promulgated by the state in its laws and regulations governing pharmacy practice; ~~and~~ 4. supports the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce be recognized as compounding manufacturers subject to FDA oversight and regulation; 5. supports the view that allowances should be made for the conduct of compounding practices that can realistically supply compounded products needed to manage urgent and emergency care scenarios in a safe manner; and, ~~4~~6. in the absence of new federal legislation affecting the oversight of compounding pharmacies, continues to encourage state boards of pharmacy and the National Association of Boards of Pharmacy (NABP), the umbrella organization for state boards of pharmacy, to work with the United States Food and Drug Administration (FDA) to identify and take appropriate enforcement action against entities that are illegally manufacturing medications under the guise of pharmacy compounding. (BOT Action in response to referred for decision Res. 521, A-06) (Modify Current HOD Policy)

The Council on Science and Public Health noted that it initiated this report in response to widespread concerns about the safety of contemporary pharmacy compounding practices, and the extent to which use of such products is deeply embedded in the U.S. health care system. While traditional compounding pharmacies licensed and regulated by states continue to provide important patient-specific services, the overall practice of pharmacy compounding has evolved into an industrial-scale national business. Accordingly, a need exists to create appropriate and effective oversight of pharmacy compounding practices, close loopholes that allowed the recent fungal meningitis outbreak to occur, and have in place compounding practices that can realistically supply compounded products to meet anticipated clinical needs, as well as urgent and emergency care scenarios, as appropriate. The Council's recommended language is intended to provide our AMA the necessary direction and flexibility to respond in an appropriate manner to legislative initiatives. Considerable testimony was offered by the ophthalmology community noting extensive routine use of compounded products for macular degeneration and certain emergency conditions where timely access is critical.

In addition, the Council is aware that the National Association of Boards of Pharmacy (NABP) recently adopted a new policy position related to pharmacy compounding of sterile products. The Council believes the new NABP Policy encouraging boards of pharmacy to reference sterile compounding quality standards, including but not limited to those contained in USP Chapter <797>, should be the standard for sterile compounding in their state. It seems clear that FDA is the agency that will need to regulate facilities that are manufacturing bulk compounded products in the absence of a patient specific prescription for interstate commerce. Additionally, the FDA noted that in its recent inspection of high risk sterile compounding pharmacies among the facilities that had demonstrable problems, several were accredited by the Pharmacy Compounding Accreditation Board. The suggested amendments to AMA policy are made in consideration of the overall testimony.

(8) RESOLUTION 502 – ACCOUNTING FOR SOCIOECONOMIC STATUS IN CLINICAL AND PUBLIC HEALTH RESEARCH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 502 be amended by addition and deletion on lines 19-21 to read as follows:

RESOLVED, That our American Medical Association encourage study of the literature regarding the inclusion of Socioeconomic Status (SES) data in such clinical and public health research so as to recommend identify appropriate minimum standards for the inclusion of such data in research studies for each. ~~(Directive to Take Action)~~ (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 502 be adopted as amended.

HOD ACTION: Resolution 502 adopted as amended.

Resolution 502 asks that our American Medical Association study the literature regarding the inclusion of Socioeconomic Status data in such clinical and public health research so as to recommend appropriate minimum standards for each.

In the virtual reference committee, your Reference Committee received limited, mixed testimony on Resolution 502, with some underscoring the importance of developing guidelines for inclusion of socioeconomic status (SES) in research studies, and others noting that current policy largely covers the AMA's support for inclusion of SES in research. Your Reference Committee agrees that SES is an important factor that should be included in clinical research, but questions whether the AMA is the appropriate group to recommend minimum standards for SES inclusion in research. The AMA's focus is on the delivery of care informed by quality research, and your Reference Committee believes that groups with a strong focus on clinical and public health research methodology itself would be better suited to study and identify minimum standards for inclusion of SES in research. On-site, the Medical

Student Section testified that it was pleased with the preliminary recommendation of the Reference Committee. Your Reference Committee therefore recommends adoption of the amended resolution.

(9) RESOLUTION 504 – SKIN CANCER SURVEILLANCE THROUGH HAIRDRESSER AND BARBER EDUCATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 504 be adopted.

HOD ACTION: Substitute Resolution 504 adopted.

SKIN CANCER SURVEILLANCE THROUGH LAY PROFESSIONAL EDUCATION

RESOLVED, That our American Medical Association support mechanisms for the education of lay professionals, such as hairdressers and barbers, on self skin examination to encourage early skin cancer referrals to qualified health care professionals. (New HOD Policy)

Resolution 504 asks that our American Medical Association (1) encourage the American Academy of Dermatology to develop studies to further examine the potential role of hair professionals in skin cancer identification; and (2) encourage the American Academy of Dermatology to investigate mechanisms for referral of identified individuals to qualified health care providers.

Virtual testimony both supported and opposed Resolution 504. Some saw the referral of clients by hairdressers and barbers as a helpful mechanism to aid in skin cancer screening, while others were concerned about the lack of medical training among hair professionals. Additionally, a question was raised about whether a study is needed when it appears that client referral is already occurring, including by massage therapists and manicurists/pedicurists. On-site, your Reference Committee received preferred language from the Dermatology Section Council and others supporting the education of lay professionals on the fundamentals of self skin exams, so that they may be more likely to notice troublesome skin lesions in clients and recommend that they see a health care professional. Your Reference Committee believes this wording to be supportable, and recommends adoption of the substitute language.

(10) RESOLUTION 506 – IMMUNIZATION EXEMPTIONS FOR PHYSICIANS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 506 be amended by addition and deletion on page 2, line 6 to read as follows:

RESOLVED, That our American Medical Association review and address existing inconsistencies in ~~its policy~~ policies regarding immunization exemptions ~~for physicians and patients~~. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 506 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 506 be changed to read as follows:

IMMUNIZATION EXEMPTIONS

HOD ACTION: Resolution 506 adopted as amended with a change in title.

Resolution 506 asks that our American Medical Association review and address existing inconsistencies in policy regarding immunization exemptions for physicians and patients.

Limited but supportive virtual and on-site testimony underscored the importance of immunizations for public health. Your Reference Committee agrees, and acknowledges that there are some inconsistencies in AMA policy regarding religious and philosophical exemptions, with some policies seemingly opposed to such exemptions, and others, including ethical opinion, supportive of religious and philosophical exemptions for physicians. Your Reference Committee believes that the inconsistencies would benefit from both a scientific and an ethical examination. Our Speaker noted the existence of a new policy reconciliation process, and perhaps the examination of the immunization policies could be addressed by such a mechanism. Finally, your Reference Committee recommends a small amendment, deleting the phrase “for physicians and patients” so that the entirety of the AMA’s immunization policy base is considered; it recommends a change in title for the same reason.

(11) RESOLUTION 507 – SUPPORT OF OVER-THE-COUNTER SALES OF ORAL CONTRACEPTIVES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 507 be adopted.

HOD ACTION: Substitute Resolution 507 adopted.**OVER THE COUNTER ACCESS TO ORAL CONTRACEPTIVES**

RESOLVED, That our American Medical Association recommend to the U.S. Food and Drug Administration that manufacturers of oral contraceptives be encouraged to submit the required application and supporting evidence for the Agency to consider approving a switch in status from prescription to over-the-counter for such products (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the continued study of issues relevant to over-the-counter access for oral contraceptives. (New HOD Policy)

Resolution 507 asks that our American Medical Association support over-the-counter access to oral contraceptives.

In order for a prescription drug product to be switched to over-the-counter (OTC) status, a manufacturer must submit an application including data demonstrating that consumers can use such products safely and effectively in an OTC environment without the aid of a health care provider. Your Reference Committee received mixed testimony on Resolution 507, with some believing that too many contraindications exist to make over-the-counter (OTC) access to oral contraceptives safe for patients. Others believe that the science supports a move to OTC access, and that it’s an important step in preventing unplanned pregnancy. Switching a drug from prescription to OTC status also carries reimbursement and cost considerations for patients. The fact that supportive testimony was offered by the American Congress of Obstetricians and Gynecologists (ACOG) was important in garnering the support of others. Your Reference Committee also is aware of an ACOG Committee Opinion released in December 2012 that supports OTC access. Rather than adopt a philosophical statement or continue to debate the potential pros and cons of OTC access, your Reference Committee believes that it is appropriate for the AMA to recommend that the necessary regulatory pathway be engaged to evaluate this action. During the course of that process, continued study of relevant issues may be instructive.

(12) RESOLUTION 514 – REVISED BLOOD DONOR DEFERRAL CRITERIA

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 514 be adopted:

BLOOD DONOR DEFERRAL CRITERIA

RESOLVED, That our American Medical Association support the use of rational, scientifically-based blood and tissue donation deferral periods that are fairly and consistently applied to donors according to their level of risk (New HOD Policy); and be it further

RESOLVED, That our AMA oppose the current lifetime deferral on blood and tissue donations from men who have sex with men. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Policies H-50.974 and D-50.997 be rescinded.

HOD ACTION: Substitute Resolution 514 adopted and Policies H-50.974 and D-50.997 rescinded.

Resolution 514 asks that our American Medical Association oppose the current lifetime deferral on blood donations from men who have sex with men, and express support for the use of rational, scientifically-based deferral periods that are fairly and consistently applied to donors according to their level of risk rather than being solely based on sexual orientation.

Your Reference Committee received mixed testimony on Resolution 514. While some support the AMA's current policy of a five-year deferral for men who have sex with men (MSM), others noted that deferral policies should be based on risk rather than being set for a certain length of time since a person's sexual orientation does not necessarily indicate a level of risky sexual behavior. Blood banking organizations have argued for changing the MSM deferral period to one that is based on risk. The Council on Science and Public Health studied the topic in 2008 and concluded that the lifetime deferral should be reconsidered. Additionally, the Council on Ethical and Judicial Affairs studied in a 2011 informational report the societal and ethical consequences of the MSM deferral period, concluding that the current lifetime deferral of MSM blood donors is ethically problematic in that it does not clearly treat comparable risks to blood safety in a consistent manner. Your Reference Committee also believes that deferral periods should be scientifically-based, and recommends substitute language to that effect. Further, your Reference Committee believes that the scientific and ethical analyses suggest that the lifetime deferral for men who have sex with men is not necessary and is discriminatory, and therefore recommends opposing it. It also recommends that Policy H-50.947, supporting a five-year deferral, be rescinded since it is inconsistent with the proposed substitute resolution, and that D-50.997 be rescinded since it has already been accomplished.

Policies recommended for rescission:

H-50.974 Revision of the Lifetime Deferral for Blood Donation of the Men Who Have Sex with Men (MSM) Population

Our AMA recognizes that based on existing scientific evidence and risk assessment models, a shift to a 5-year deferral policy for blood donation from men who have sex with men (MSM) is supportable. (CSAPH Rep. 5, A-08)

D-50.997 Societal and Ethical Consequences of a Five-Year Blood Donation Deferral Policy for Men Who Have Had Sex With Men

Our AMA, working with relevant organizations and agencies, will analyze the societal and ethical consequences of a shift to a 5-year deferral policy for blood donation from men who have sex with men, with report back at the 2011 Annual Meeting. (Res. 2, A-10)

(13) RESOLUTION 515 – TARGETED TUBERCULOSIS TESTING OF SCHOOL CHILDREN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 515 be amended by addition and deletion on lines 17-20 to read as follows:

RESOLVED, That our American Medical Association support ~~efforts to replace universal tuberculosis testing of school aged children with~~ use of a tuberculosis (TB) risk assessment questionnaire in U.S. school aged children when appropriate, with follow-up and support TB testing of school aged children based on the results of that TB risk assessment. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 515 be adopted as amended.

HOD ACTION: Resolution 515 adopted as amended.

Resolution 515 asks that our American Medical Association support efforts to replace universal tuberculosis testing of school aged children with a TB risk assessment questionnaire, and support TB testing of school aged children based on the results of that TB risk assessment.

Virtual testimony was mostly supportive, and on-site testimony was overwhelmingly supportive, stating that targeted tuberculosis (TB) testing of school children is consistent with the policies of the CDC, United States Preventive Services Task Force, American Academy of Pediatrics, American Academy of Family Physicians, American Thoracic Society, and the Infectious Diseases Society of America. Other testimony expressed doubt that targeted testing would be effective in geographical areas with high TB infection rates, such as areas populated by large numbers of immigrants from countries with prevalent TB. Your Reference Committee agrees that universal testing may not be necessary in many areas, and supports the policies of groups that recommend targeted testing. However, it recommends amending the resolution to include the term “when appropriate” to express support for universal testing in geographical areas needing it. The resolution sponsors appreciated the Reference Committee’s recommendation for clarifying amendments.

(14) RESOLUTION 516 – EARLY TREATMENT AND PARTNER SERVICES FOR HIV

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 516 be amended by addition on lines 24-25 to read as follows:

RESOLVED, That our American Medical Association support programs raising physician awareness of the benefits of early treatment of HIV and of “treatment as prevention,” and the need for linkage of newly HIV-positive persons to clinical care and partner services. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 516 be adopted as amended.

HOD ACTION: Resolution 516 adopted as amended.

Resolution 516 asks that our American Medical Association support programs raising physician awareness of the benefits of early treatment and of “treatment as prevention,” and the need for linkage of newly positive persons to clinical care and partner services.

Virtual testimony was mostly supportive of the resolution, with some calling for reaffirmation of existing policy on expedited partner services. Your Reference Committee notes that current policy on expedited partner therapy addresses gonorrheal and chlamydial infections, not HIV. On-site testimony was overwhelmingly supportive of the resolution. Your Reference Committee believes that the resolution should be adopted, and recommends minor amendments to ensure that the policy stands on its own and is consistent with the title.

(15) RESOLUTION 519 – GENOME ANALYSIS AND VARIANT IDENTIFICATION**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 519 be amended by addition and deletion on page 1, lines 31-32 to read as follows:

RESOLVED, That our American Medical Association encourage payers, regulators and providers to make ~~the~~ clinical variant data and their interpretation publicly available through a system that assures patient and provider privacy protection (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage laboratories to place all clinical variants and the clinical data that was used to assess the clinical significance of these results, into the public domain which would allow appropriate interpretation and surveillance for these variations that can impact the public’s health. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 519 be adopted as amended.

HOD ACTION: Resolution 519 adopted as amended.

Resolution 519 asks that our American Medical Association (1) encourage payers, regulators and providers to make the clinical data and their interpretation publicly available through a system that assures patient and provider protection; and (2) encourage laboratories to place all clinical variants and the clinical data that was used to assess the clinical significance of these results, into the public domain which would allow appropriate interpretation and surveillance for these variations that can impact the public’s health.

Overwhelmingly supportive testimony was heard, noting the importance of sharing genomic variant data, which will improve physicians’ ability to interpret genetic test results. Testimony highlighted the existence of a National Institutes of Health (NIH)-funded project to develop a large public database for the submission of such data. Some concern was expressed about patient and physician privacy, and a suggestion was made for referral to study that concern. However, your Reference Committee is aware that genomic variant databases are in existence on a small scale, and are already operating using strict privacy controls. Additionally, the NIH project will treat privacy as an important component. Your Reference Committee believes the practice of personalized medicine will benefit from support of this resolution, and recommends adoption with minor amendments for clarity.

(16) RESOLUTION 520 – STUDY THE SAFETY OF BIOSIMILAR MEDICATIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 520 be adopted.

HOD ACTION: Substitute Resolution 520 adopted.

UPDATING AMA POLICY ON BIOSIMILARS

RESOLVED, That our American Medical Association revisit the topic of biosimilars and study emerging issues that are relevant for such products under the current abbreviated pathway for approval. (Directive to Take Action)

Resolution 520 asks that our American Medical Association study the safety of biosimilars, including the safety of following traditional Food and Drug Administration pathways for generic drug approval.

The Council previously developed a report on biosimilars at Interim 2011. As the approval of the first biosimilar product in the United States becomes closer to reality, several issues have emerged that demand attention including the remodeling of pharmacy practice acts, naming conventions, which products might be deemed interchangeable, and what notification requirements should be in place for prescribers to facilitate post-marketing surveillance. Therefore, your Reference Committee agrees with the need to conduct a study, and has offered a substitute resolution that is aligned with the current regulatory environment.

(17) RESOLUTION 522 – THE NEXT TRANSFORMATIVE PROJECT: IN SUPPORT OF THE BRAIN INITIATIVE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 522 be amended by deletion on lines 20-24 to read as follows:

RESOLVED, That our AMA support the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process (New HOD Policy); and be it further

RESOLVED, That our AMA encourage appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the ~~Brain Research through Advancing Innovative Neurotechnologies (BRAIN)~~ initiative. (New HOD Policy) ; ~~and be it further~~

~~RESOLVED, That our AMA evaluate the role of our organization in ensuring the proper execution of the BRAIN initiative.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 522 be adopted as amended.

HOD ACTION: Resolution 522 adopted as amended.

Resolution 522 asks that our American Medical Association (1) support the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain

to better understand normal and disease process; (2) encourage appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative; and (3) evaluate the role of our organization in ensuring the proper execution of the BRAIN initiative.

Testimony was mostly positive, noting the pressing need to develop better research information and medical innovations to understand and treat neurologic disorders. Some concern was expressed about the budget implications, and others suggested deleting the third resolve since our AMA has no role in ensuring the execution of the BRAIN initiative. Your Reference Committee concurs with the preponderance of testimony supporting the concept of the initiative, and offers amendments to delete the third resolve and simplify the language in the second resolve.

(18) RESOLUTION 512 – CANNABIS DECRIMINALIZATION, REGULATION, AND TAXATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 512 be referred.

HOD ACTION: Resolution 512 referred.

Resolution 512 asks that our American Medical Association urge federal agencies to: 1) reschedule medical cannabis in order to encourage research leading to responsible regulation; 2) decriminalize medical use of cannabis; 3) build an appropriate public health regulatory framework for cannabis use; and 4) facilitate dissemination of information about risks and benefits of cannabis use.

Virtual testimony reflected contemporary issues that have been widely discussed about the intersection of medicinal and recreational cannabis use, the most appropriate Schedule for cannabis under the Controlled Substances Act and existing AMA policy on the topic. Your Reference Committee is aware that the Council on Science and Public Health is currently working on a global report related to federal drug policies, the so-called “war on drugs”, and the intersection of illicit and prescription drug misuse and abuse, currently planned for I-13. On-site testimony from the Council noted that it would accept referral. Given the controversial nature of this resolution, your Reference Committee believes it should be considered within the context of the Council’s forthcoming report, and therefore recommends referral.

(19) RESOLUTION 509 – INCREASE AWARENESS OF HAPTENATION AND HYPERSENSITIVITY DISORDERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 509 be referred for decision.

HOD ACTION: Resolution 509 referred for decision.

Resolution 509 asks that our American Medical Association use its communication vehicles to make physicians aware of the process of haptenation and sensitization and their multiple ramifications; to help physicians teach patients methods to avoid exposure to haptens; to help physicians include chemical sensitivity in the differential diagnosis; and to help physicians take a history focused on exposures to toxins and symptoms related to known toxins and testing.

Limited supportive testimony, with no clear opposition, was received. The sponsoring delegation noted that the Council on Science and Public Health studied this topic 22 years ago, and believes that referral is called for to update the Council’s report. However, the Council noted that it prefers the Board of Trustees to weigh in on the request for the Council to study this topic, so that the Board can evaluate the topic’s relevance to the AMA’s Strategic Priorities. Your Reference Committee concurs, and recommends referral for decision.

(20) RESOLUTION 513 – MEDICATION COLLECTION “TAKE BACK” PROGRAMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 513 be referred for decision.

HOD ACTION: Resolution 513 referred for decision.

Resolution 513 asks that our American Medical Association support medication collection or “take back” programs, funded in whole or part by the pharmaceutical industry, that help keep unused medications out of the environment and out of the hands of potential overdose victims or drug abusers.

Testimony was mixed, both supporting the potential for pharmaceutical “take back” programs to reduce environmental contamination and the supplies of controlled substances subject to diversion, and noting relevant existing AMA policy that supports efforts to safely dispose of unused medications. Some programs currently exist at the community level to facilitate take back at community pharmacies, and the Drug Enforcement Administration holds periodic national take back days for controlled substances. No disagreement existed about the need to reduce environmental exposure to prescription and nonprescription drugs, but no consensus was apparent on how to structure or pay for a uniform national approach to medication take back. Current AMA policy already supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications. Your Reference Committee believes that this issue could benefit from more structured review and decision-making, and therefore recommends referral for decision.

(21) RESOLUTION 518 – FDA RECOMMENDATION ON SCHEDULING OF HYDROCODONE COMBINATION PRODUCTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 518 not be adopted.

Resolved, That our AMA issue a public statement to the U.S. Food and Drug Administration, urging the FDA to maintain hydrocodone combination products as Schedule III of the Controlled Substances Act. (Directive to Take Action)

HOD ACTION: Substitute Resolution 518 adopted.

Resolution 518 asks that our American Medical Association issue a public statement to the Commissioner of the FDA, urging her to issue a scientifically-based recommendation for changing hydrocodone combination products from Schedule III to Schedule II of the Controlled Substances Act.

Testimony acknowledged the ongoing high utilization rate and nonmedical use of hydrocodone-containing products in the U.S. and the need to effectively address the prescription drug abuse problem in this country. Overall, hydrocodone-containing products are among the most commonly dispensed prescription drug products in the U.S. Your Reference Committee is aware that the AMA has expressed concern about the relative degree of access to Schedule II opioid analgesics in long-term care facilities and the fact that hydrocodone combination products are the only remaining Schedule III product that is approved for treating severe pain. Considerable testimony addressed the need to have a sufficiently potent opioid analgesic that could be prescribed over the phone, and concerns about patient access and unintended consequences were prevalent. In contrast, hydrocodone, in and of itself, is a Schedule II opioid reflecting its high potential for misuse and addiction. The Committee agrees that the scheduling of hydrocodone should be scientifically based. The FDA convened an Advisory Committee to discuss the public health benefits and risks of hydrocodone combination products, and the potential impacts of rescheduling these products from Schedule III to II. Your Reference Committee believes a prudent course of action is to allow the FDA to complete its scientific and medical evaluation and rescheduling recommendation, and to support this process. Therefore, a recommendation to not adopt is offered.

REPORT OF REFERENCE COMMITTEE F

(1) BOARD OF TRUSTEES REPORT 2 - AMA 2014 DUES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 2 adopted and the remainder of the Report filed.

Board of Trustees Report 2 recommends no changes to our AMA membership dues levels for 2014. The Report further notes that our AMA last raised its dues in 1994.

Regular Members	\$420
Physicians in Their Second Year of Practice.....	\$315
Physicians in Military Service.....	\$280
Physicians in Their First Year of Practice	\$210
Semi-Retired Physicians.....	\$210
Fully retired Physicians	\$84
Physicians in Residency Training.....	\$45
Medical Students	\$20

Your Reference Committee received limited online testimony in response to Board of Trustees Report 2, but noted a suggestion for a potential membership dues decrease. While your Reference Committee is sensitive to all of the financial burdens on physicians, including the cost of professional membership dues, we believe that our AMA has acted in the financial interests of physicians by not increasing our membership dues for the past 19 years. On site testimony consisted mainly of questions that were addressed by the Board of Trustees.

(2) BOARD OF TRUSTEES REPORT 30 - FUTURE OF THE INTERIM MEETING OF THE HOUSE OF DELEGATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 30 be adopted and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 30 not adopted.

Board of Trustees Report 30 responds to unresolved questions about the future of the Interim Meeting that have been discussed in the House of Delegates (HOD) for several years, and which have resulted in a policy calling for a pilot project to combine the HOD and the National Advocacy Conference. As called for by the policy, the Board of Trustees surveyed members of the HOD and assembled a task force to review available options and suggest appropriate implementation steps.

The survey results suggest that a majority of medical society executives believe our AMA’s policymaking activity could be carried out in a single annual meeting; less than half the delegates responding to the survey agreed. At the same time, current Federation practice indicates that few Federation members sponsor more than one meeting annually.

Based on the survey results, the Task Force on the Interim Meeting concluded that there is a disconnect between members of the House of Delegates and their sponsoring societies and that AMA’s policymaking activities could be accomplished in a single annual meeting with additional opportunities for AMA’s elected leaders (councils and sections) and a forum at the National Advocacy Conference to include members of the House of Delegates.

The Board of Trustees agreed with the Task Force's recommendations and this report recommends that our AMA bylaws be amended to call for the discontinuation of the Interim Meeting of the House of Delegates.

Your Reference Committee extends its appreciation to the Task Force and to the Board of Trustees for its careful research and its thorough and thoughtful report. Your Reference Committee received extensive and passionate testimony on this issue. Despite compelling testimony on both sides, your Reference Committee heard a preponderance of support from larger delegations favoring adoption.

While this is a difficult decision with strongly held views on both sides, we need to achieve consensus and take decisive action on this matter at this time.

(3) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON
COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in the Report of the House of Delegates Committee on Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Report of the House of Delegates Committee on Compensation of the Officers adopted and the remainder of the Report filed.

The Report of the House of Delegates Committee on Compensation of the Officers presents the history of recent changes and provides two recommendations:

1. That there be no changes to the Officers' compensation for the period beginning July 1, 2013 through June 30, 2014; and
2. That the travel policy and the Board travel and expense standing rules be amended by addition as follows:

Transportation

Air: AMA policy on reimbursement for domestic air travel for members of the Board is that our AMA will reimburse for coach fare only. The Presidents (President, Immediate Past President and President Elect) will each have access to an individual \$2,500 term allowance (July 1 to June 30) to use for upgrades as each deems appropriate, typically when traveling on an airline with non-preferred status. The unused portion of the allowance is not subject to carry forward or use by any other Officer and remains the property of our AMA. In rare instances, it is recognized that short notice assignments may require up to first class travel because of the lack of availability of coach seating, and this will be authorized when necessary by the Board Chair, prior to travel. Business Class airfare is authorized for foreign travel on AMA business. (Also, see Rule IV-Invitations, B-Foreign, for policy on foreign travel.)

Your Reference Committee received limited, but supportive online and on site testimony. Your Reference Committee wishes to extend its appreciation to the House of Delegates Committee on Compensation of the Officers for its thorough report.

(4) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG
RANGE PLANNING AND DEVELOPMENT REPORT 2 - GOVERNANCE
POLICY CONSOLIDATION: LODGING, MEETING VENUES AND
SOCIAL FUNCTIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 2 adopted and the remainder of the Report filed.

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 2 recommends that Policies D-600.975, G-630.130, and G-630.141 be consolidated into Policy G-630.140 as follows:

G-630.140 Lodging, Meeting Venues and Social Functions

AMA policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold meetings or pay member, officer or employee dues in any club, restaurant, or other institution that has exclusionary policies based on gender, race, color, religion, national origin, gender identity, or sexual orientation.
5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.

Your Reference Committee received no online or on site testimony that objected to this joint report, which was written in response to a House of Delegates directive to consolidate three similar policies.

- (5) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 4 - AMA POLICIES ON WOMEN PHYSICIANS FOR SUNSET AND CONSOLIDATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 4 be adopted and the remainder of the Report be filed.

HOD ACTION: Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 4 adopted and the remainder of the Report filed.

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 4 presents recommendations for sunset, retention, and consolidation of current Policies related to women physicians. The councils collaborated with the Women Physicians Congress and the Council on Medical Education to prepare this report.

Your Reference Committee expresses its appreciation to not only the Council on Constitution and Bylaws and the Council on Long Range Planning and Development, but also to the Women Physicians Congress for their diligent efforts to ensure that our AMA's Policy Database is up-to-date and provides clear guidance on policies related to women physicians.

Your Reference Committee received no online objections to this report and acknowledges receiving a proposed amendment to this report on site, but believes that the scope of the proposed amendment changes rather than consolidates current policy; therefore, a resolution should be submitted at a future House of Delegates meeting.

(6) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - PROPOSAL FOR A WOMEN PHYSICIANS SECTION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

Council on Long Range Planning and Development Report 1 comes in response to a letter of application from the Women Physicians Congress (WPC) requesting a change in status from a Board of Trustees advisory committee to a section with representation in our AMA House of Delegates.

The Council on Long Range Planning and Development recommends that our AMA transition the Women Physicians Congress to the Women Physicians Section, as a delineated section, and that appropriate bylaws language be developed to recognize the Women Physicians Section.

Your Reference Committee extends its appreciation to the Council on Long Range Planning and Development for its extensive work in reviewing the women physicians' application for section status. Online and on site testimony was supportive and clearly favors the formation of a Women Physicians Section.

(7) RESOLUTION 602 - MOCK RESIDENCY INTERVIEW PROGRAM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 602 be adopted.

HOD ACTION: Resolution 602 adopted.

Resolution 602 calls upon our AMA to promote the International Medical Graduates Section's Mock Residency Interview Program to any AMA member who is in the process of applying for a medical residency position, and to promote the program as one of the benefits of AMA membership.

Your Reference Committee received supportive online and on site testimony in response to Resolution 602.

In 2012, the International Medical Graduates Section and the Resident and Fellow Section created a pilot program offering mock residency interviews to AMA members who are ECFMG-certified and awaiting residency acceptance. The program was created in response to international medical graduates' concerns over lack of one-on-one opportunities to practice for their interviews.

Experienced volunteers conducted one-on-one interviews with participating international medical graduate members, who were paired by AMA staff. Twenty-eight interviews were conducted between December 2012 and January 2013 via Skype™, telephone, or in person. An electronic survey was completed by participants, and all but two people rated the pilot as excellent or good. All promotional materials and marketing of this program has been by electronic means. AMA staff time has been the only investment.

(8) BOARD OF TRUSTEES REPORT 8 - VIRTUAL REFERENCE COMMITTEES IN THE HOUSE OF DELEGATES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that recommendation 1 in Board of Trustees Report 8 be amended by addition and deletion on page 6, lines 14-16 to read as follows:

- Comments submitted to a virtual reference committee should be used to prepare a preliminary summary report that reflects the comments received up to that point ~~and that characterizes the recommendations that would follow in the absence of further discussion;~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 8 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Board of Trustees Report 8 adopted as amended and the remainder of the Report filed.

Board of Trustees Report 8 provides an evaluation of the virtual reference committee process currently being piloted in the House of Delegates. The Board of Trustees report summarizes the overall experience with the virtual process and recommends continued use to include ongoing experimentation with alternative procedures and enhancements over time.

Your Reference Committee received only positive online testimony in support of Board of Trustees Report 8, which highlighted the fact that a virtual deliberative process increases opportunity for input, thereby engaging more member physicians in our AMA. Additionally, it helps to streamline the on site reference committee and House of Delegates meetings, providing opportunities to focus on key topics and issues of greatest importance to our profession. Online testimony further indicated that the virtual process is becoming more efficient as implementation issues have been and continue to be resolved. Some suggestions heard that the Speakers may wish to include are improving technology and user access, and adding a like / dislike option.

Prior to deciding upon a recommendation of adoption of Board of Trustees Report 8, your Reference Committee considered constructive, online testimony indicating that the pilot virtual process should continue for three more meetings; however, we believe that ongoing advances in technology and ideas for adaptation will cause our deliberative processes to evolve beyond any specific timeline. Your Reference Committee further believes that the Speakers have shown a propensity to accept suggestions and recommendations to improve and/or correct real or perceived issues, and we anticipate they will continue to address any future concerns.

On site testimony presented to your Reference Committee indicated that while many accept the continued use of the online process to receive testimony from a broader segment of AMA members, the creation and presentation of a preliminary reference committee report creates questions about bylaws compliance, perceptions of prejudicial positions based on minimal testimony, and concerns about reference committees presenting opinion versus a compilation of testimony. Therefore, your Reference Committee believes that the amendment reflected in this report, and proffered during the on site hearing, provides for the continued use of technology while addressing the concerns outlined here.

- (9) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - AMA POLICY DIRECTIVES WHICH ARE OBSOLETE, DUPLICATIVE OR ACCOMPLISHED

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 be amended on page 3, line 23 to retain Policy D-180.998.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 adopted as amended and the remainder of the report filed.

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 1 presents recommendations for sunsetting existing House of Delegates directives that are obsolete, duplicative, or accomplished. This report is distinct from the sunset reports submitted by each council.

Your Reference Committee received limited online testimony that supported this report. Your Reference Committee heard on site testimony recommending retention of Policy D-180.998, "Insurance Parity for Mental Health and Psychiatry," because the intent of the directive has not been accomplished despite the passage of the Emergency Economic Stability Act of 2008.

Your Reference Committee wishes to express its appreciation to the Council on Constitution and Bylaws and the Council on Long Range Planning and Development for their diligent efforts to ensure that our AMA's Policy Database does not include duplicative, conflicting, or inconsistent directives.

- (10) COUNCIL ON CONSTITUTION AND BYLAWS / COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 3 - CCB-CLRPD SUNSET REVIEW OF 2003 HOUSE POLICIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 be amended on page 4, the last item, to retain Policy H-520.996.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 adopted as amended and the remainder of the Report filed.

Council on Constitution and Bylaws / Council on Long Range Planning and Development Report 3 presents a review of Policies adopted in 2003 with a goal of sunseting those that have been accomplished or are obsolete.

Your Reference Committee received no online objections to this report. Your Reference Committee heard on site testimony objecting to the deletion of Policy H-520.996, “Arms Reduction”. Nuclear weapons are still proliferating throughout the world and continue to be acquired by nations not bound to existing arms reductions treaties.

Your Reference Committee expresses its appreciation to the Council on Constitution and Bylaws and the Council on Long Range Planning and Development for their thorough and thoughtful recommendations, which provide valuable guidance and add clarity to our AMA Policy Database.

(11) RESOLUTION 609 - REAL PRIMARY PREVENTION AS A NEW FACE OF OUR AMA

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 609 be amended by addition and deletion to read as follows:

~~RESOLVED, That our Board of Trustees be asked to consider whether our American Medical Association’s strategic plan adequately addresses public health and primary prevention and report back to the House of Delegates at the 2013 Interim Meeting. [avoiding a perception our AMA has exited the public health space] (New HOD Policy); and be it further~~

~~RESOLVED, That our AMA place the primary prevention of the following eight behavioral issues (alcohol and other drugs, violence and abuse, accidents and injuries, obesity, tobacco use, teen pregnancy, sexually transmitted illness, and suicide) at the forefront of its activities. (New HOD Policy)~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 609 be adopted as amended.

HOD ACTION: Resolution 609 adopted as amended.

Resolution 609 calls upon our AMA to ask the Board of Trustees to consider whether our American Medical Association’s strategic plan adequately addresses public health and primary prevention—avoiding a perception our AMA has exited the public health space. Additionally, this resolution calls upon our AMA to place the primary prevention of eight behavioral issues (alcohol and other drugs, violence and abuse, accidents and injuries, obesity, tobacco use, teen pregnancy, sexually transmitted illness, and suicide) at the forefront of its activities.

While your Reference Committee heard supportive testimony for our AMA’s strategic initiative to improve health outcomes in Type 2 diabetes and cardiovascular disease, testimony also indicated that more emphasis needs to be placed on primary prevention of disease, and especially the behavioral determinants of health.

Your Reference Committee recognizes that there is ample Policy stipulating that strategic planning is our AMA Board of Trustees’ responsibility. Therefore, your Reference Committee deleted the second Resolve as they believed it was overly prescriptive.

(12) BOARD OF TRUSTEES REPORT 11 - DESIGNATION OF SPECIALTY SOCIETIES FOR REPRESENTATION IN THE HOUSE OF DELEGATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 11 be referred.

HOD ACTION: Board of Trustees Report 11 referred.

Board of Trustees Report 11 outlines the continuing difficulties by which specialty society representation in the House of Delegates is determined, and the Board of Trustees provide the following recommendations:

1. That the current specialty delegation allocation ballot system be discontinued and that specialty society delegate allocation be determined in the same manner as state medical society delegate allocation based on membership numbers allowing one delegate per 1000 AMA members.
2. That the membership data used to determine the delegate allocation be the data that the specialty societies are required to submit every five years to determine their representation in the House of Delegates.
3. That this system is implemented beginning with the delegate allocation process for 2014.
4. That organizations that do not meet the five-year review criteria be allowed a one-year grace period to meet the requirements and that their delegation is frozen until the end of the grace period
5. That this system of delegate allocation continues to be monitored and evaluated for improvements.

Your Reference Committee heard testimony supportive of the Board the Trustees recommendation that the balloting system for specialty delegation allocation should be discontinued. Your Reference Committee also heard testimony that data reflecting the immediate impact of the proposed process change is needed in the report. Specific concerns included that implementation of the recommendations may lead to a dramatic increase in the size of the House of Delegates, and may also result in an unintended increase in the number of AMA members represented by more than one specialty society.

(13) RESOLUTION 606 - AMA TO DEVELOP CONFLICT OF INTEREST DISCLOSURE FOR CANDIDATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 606 be referred.

HOD ACTION: Resolution 606 referred.

Resolution 606 calls upon our AMA to develop a conflict of interest declaration form to be completed each year by elected officers and those delegates appointed to office or running as candidates, and these conflict of interest disclosures be available to members, especially members of our AMA House of Delegates, for review.

Your Reference Committee received supportive online and on site testimony in response to Resolution 606.

Despite a lack of House of Delegates policy, your Reference Committee was informed that our AMA currently utilizes conflict of interest disclosure statements. Your Reference Committee favors referral of Resolution 606 in order to receive a report back as soon as possible detailing for the House of Delegates what documentation and procedures currently exist, to whom the procedures apply, and to receive information and recommendations regarding access to such documentation.

- (14) RESOLUTION 610 - FAIR ACCESS TO SCIENCE AND TECHNOLOGY RESEARCH ACT FOR IMPROVED ACCESS TO MEDICAL RESEARCH

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 610 be referred.

HOD ACTION: Resolution 610 referred.

Resolution 610 calls upon our AMA to urge its members and physicians across the country to support initiatives about open access to research literature.

Your Reference Committee received testimony from our AMA Board of Trustees indicating that research articles published in *JAMA* are available without charge six months after publication on The JAMA Network web site. Additionally, research articles in our nine specialty journals are free 12 months after publication, as those journals tend to be published only 12 times a year.

The Harvard Library memorandum cited in Resolution 610 is directed toward two commercial publishers, not scholarly journal publishers such as our AMA. Your Reference Committee believes that referral of Resolution 610 for a report back would serve to better inform the House of Delegates on our AMA's publishing initiatives and to provide more information about the Fair Access to Science and Technology Research (FASTR) Act.

- (15) RESOLUTION 603 - POTENTIAL CONFLICTS OF DATES IF THE AMA INTERIM MEETINGS ARE COMBINED WITH THE NATIONAL ADVOCACY CONFERENCE AND NATIONAL SPECIALTY ANNUAL MEETINGS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 603 be referred for decision.

HOD ACTION: Resolution 603 referred for decision.

Resolution 603 calls upon our AMA to conduct a survey to ascertain the dates of future national specialty meetings, and to make every effort to avoid future conflicting dates.

Your Reference Committee received limited testimony in response to Resolution 603, which included a request from the authors for referral to the Board of Trustees, as any potential action would be contingent upon our AMA House of Delegates' handling of Board of Trustees Report 30.

- (16) RESOLUTION 604 - CONFLICT IN DATES BETWEEN AMA INTERIM MEETINGS AND SPECIALTY ANNUAL MEETINGS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 604 be referred for decision.

HOD ACTION: Resolution 604 referred for decision.

Resolution 604 calls upon our AMA to conduct another survey to ascertain future conflicts of the Interim Meeting and the annual meetings of specialty societies, and to make every effort to avoid future conflicting dates.

Your Reference Committee received limited testimony in response to Resolution 604, which included a request from the authors for referral to the Board of Trustees, as any potential action would be contingent upon our AMA House of Delegates' handling of Board of Trustees Report 30.

(17) RESOLUTION 608 - PRESIDENTIAL MEDAL OF FREEDOM

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 608 be referred for decision.

HOD ACTION: Resolution 608 referred for decision.

Resolution 608 calls upon our AMA to write a letter of support to President Obama on behalf of Dr. R. Adams Cowley to posthumously receive the Presidential Medal of Freedom.

The Presidential Medal of Freedom is the nation's highest civilian honor and is given by the President at his discretion. On average, a President gives 11 awards per year based on very broad criteria. There have been 21 physician recipients of the Presidential Medal of Freedom since its inception in the 1940's. William H. Foege, MD, MPH was the latest physician to receive the award in 2012.

Your Reference Committee received no online testimony in response to Resolution 608, and limited on site testimony of which the most compelling statements indicated that decisions regarding awards are not the business of our AMA House of Delegates. Your Reference Committee recommends referral for decision to allow the Board of Trustees the opportunity to determine if the proposed action is consistent with our AMA's current initiatives, and to act accordingly.

(18) RESOLUTION 601 - ADVANCE DIRECTIVE COUNSELING AND PHYSICIAN BILLING FOR INVOLVED SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 601 not be adopted.

HOD ACTION: Resolution 601 not adopted.

Resolution 601 calls upon our AMA to urge the Current Procedural Terminology (CPT) Editorial Panel to research and pursue development of a CPT® Code representing end-of-life and advanced care directives planning allowing licensed physicians, who are also acting as the patients' treating physicians, the ability to bill public and private payers for the service.

Your Reference Committee received limited online testimony favoring adoption of Resolution 601. The appropriate mechanism for bringing forth such issues is clearly described in current Policy H-70.919, "Use of CPT Editorial Panel Process," which establishes the independent CPT Editorial Panel process as the proper mechanism for addressing issues of this nature. Anyone desiring a change to the CPT code set must submit a code change application to the independent CPT Editorial Panel. The application needs to be completed in accordance with established deadlines and procedures, which are outlined on our AMA web site. This is the only pathway for achieving a change to the CPT code set. On site testimony stressed that CPT-related matters are not within the purview of our AMA House of Delegates. Therefore, your Reference Committee recommends that Resolution 601 not be adopted.

- (19) RESOLUTION 605 - REVISION OF THE AMA CURRENT PROCEDURAL TERMINOLOGY TO REFLECT EHR-EMR DOCUMENTATION AND WORK PROCESSES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 605 not be adopted.

HOD ACTION: Resolution 605 not adopted.

Resolution 605 calls upon our AMA to request the Current Procedural Terminology (CPT) Editorial Panel review the CPT coding guidelines with the aim of developing a new model of payment that reflects 21st century EHR technology. Additionally, this resolution calls upon our AMA to request that the CPT Editorial Panel consider the need for immediate revisions to the current CPT practice performance reporting process aimed at preparing the infrastructure for new models of paying for the delivery care.

As was the case with Resolution 601, CPT-related matters are not within the purview of our AMA House of Delegates. The appropriate mechanism for bringing forth such issues is clearly described in current Policy H-70.919, "Use of CPT Editorial Panel Process," which establishes the independent CPT Editorial Panel process as the proper mechanism for addressing issues of this nature. Anyone desiring a change to the CPT code set must submit a code change application to the independent CPT Editorial Panel. The application needs to be completed in accordance with established deadlines and procedures, which are outlined on our AMA web site. This is the only pathway for achieving a change to the CPT code set. Therefore, your Reference Committee recommends that Resolution 605 not be adopted.

- (20) BOARD OF TRUSTEES REPORT 1 - AUDITOR'S REPORT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Board of Trustees Report 1 be filed.

HOD ACTION: Board of Trustees Report 1 filed.

Board of Trustees Report 1 serves to introduce the Association's 2011 and 2012 Consolidated Financial Statements along with an Independent Auditor's report, which are featured in a separate booklet, titled "2012 Annual Report" that was distributed with the Handbook materials.

Your Reference Committee received an informative presentation of our AMA's financials that reflected 2012 operating income was \$16.6 million, marking the 13th consecutive year our AMA has achieved positive operating results. Additionally, it was announced that our AMA membership had increased by more than three percent, marking the second year in a row of membership growth.

Your Reference Committee extends its appreciation to our AMA Board of Trustees and staff for their ongoing efforts to maintain our AMA's solid financial position and commends them for the continued gains in our AMA membership.

REPORT OF REFERENCE COMMITTEE G**(1) BOARD OF TRUSTEES REPORT 13 - MEDICARE/MEDICAID
COVERAGE OF MULTI-USE TECHNOLOGY PLATFORMS****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 13 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 13 adopted and the remainder of the report filed.

Board of Trustees Report 13 recommends that third party payers investigate the possibility of reimbursing patients for using common consumer electronic devices as assistive devices for bona fide health care needs.

There was mixed testimony on this item. Some speakers suggested that our AMA should not be taking any position with respect to coverage for consumer electronic devices, given the lack of in-house expertise in this area. Other speakers noted that this type of technology is evolving rapidly, and coverage decisions by health insurers will influence the market for these products. Your Reference Committee agrees with testimony indicating that the Board's recommendation that third party payers investigate the possibility of reimbursing patients for consumer electronic devices strikes an appropriate balance that acknowledges the growth of this type of technology, without committing our AMA to take an active role in supporting their use. Accordingly, your Reference Committee recommends adoption of Board of Trustees Report 13.

**(2) BOARD OF TRUSTEES REPORT 17 - DATA OWNERSHIP AND ACCESS
TO CLINICAL DATA IN HEALTH INFORMATION EXCHANGES****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 17 be adopted and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 17 adopted and the remainder of the report filed.

Board of Trustees Report 17 recommends that our AMA support full transparency in health information exchange (HIE) policies and procedures, and continue its efforts to educate physicians on the subject of HIEs, with particular attention to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE.

There was supportive testimony on this item. Your Reference Committee believes that the recommendations of Board of Trustees Report 17 provide a good framework for the AMA to respond to issues physicians will face as they weigh whether or not to participate in health information exchanges, and recommends its adoption. Your Reference Committee appreciates that the Board of Trustees reissued the report to include an appendix of relevant policies, which will enable the report to serve as a valuable resource on this issue moving forward.

**(3) BOARD OF TRUSTEES REPORT 21 - EXAM ROOM COMPUTING AND
PATIENT-PHYSICIAN INTERACTIONS****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 21 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 21 adopted and the remainder of the report filed.

Board of Trustees Report 21 recommends that our AMA make physicians aware of tips and resources for effectively using computers and electronic health records (EHRs) in patient-physician interactions, encourage physicians to incorporate questions regarding use of computers and EHRs in patient-satisfaction surveys.

Board of Trustees Report 21 provides a thorough overview of the literature regarding the impact of computers in the exam room on the physician patient relationship, and highlights several suggestions for ensuring physicians continue to communicate effectively with their patients when using technology. Your Reference Committee recommends that the recommendations in the report be adopted.

(4) BOARD OF TRUSTEES REPORT 23 - INNOVATION TO IMPROVE USABILITY AND DECREASE COSTS OF ELECTRONIC HEALTH RECORD SYSTEMS FOR PHYSICIANS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 23 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 23 adopted and the remainder of the report filed.

Board of Trustees Report 23 recommends that our AMA advocate for the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator to support collaboration between and among proprietary and open-source electronic health record (EHR) developers to help drive innovation in the marketplace; continue to advocate for research and physician education on EHR adoption and design best practices that can improve the quality, safety, and efficiency of health care; and continue to survey physician use and issues with various EHRs through its partnership with AmericanEHR Partners.

There was mixed testimony on Board of Trustees Report 23. While testimony raised concerns with rescinding Policy H-478.992, "Open Source Code Electronic Medical Records," your Reference Committee agrees with the Board of Trustees that the intent of the policy – to make open source EHRs available to the physician community – has been realized. Also, a speaker testified that the report did not go far enough. However, your Reference Committee believes that the report fulfilled the directive espoused in H-478.992. Your Reference Committee notes that other resolutions in this Reference Committee represent better vehicles to address the diversity of EHR issues raised in testimony.

At this point, the total cost of ownership for open source and proprietary EHRs has become roughly equivalent given the availability of low- or even no-cost proprietary products largely because of technologic advances. Your Reference Committee recognizes that the interest in standardization is an important issue affecting both usability and patient safety, and applauds our AMA for its advocacy efforts in these arenas. Moving forward, your Reference Committee believes that AMA advocacy efforts should focus on both proprietary and open-source EHR developers to advance best practices, adoption and interoperability and help physicians improve the quality of care they provide to their patients. Accordingly, your Reference Committee recommends adoption of Board of Trustees Report 23.

(5) BOARD OF TRUSTEES REPORT 26 - SECURITY OF TELEMEDICINE COMMUNICATION

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 26 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 26 adopted and the remainder of the report filed.

Board of Trustees Report 26 recommends that our AMA collaborate with the American Telemedicine Association to develop physician and patient specific content on the use of telemedicine services.

Your Reference Committee commends the Board of Trustees on this thorough report that highlights ongoing challenges associated with using telemedicine as a means of delivering health care, and describes resources to assist physicians interested in delivering telemedicine services. Your Reference Committee agrees with supportive testimony on this report, and recommends its adoption.

(6) COUNCIL ON MEDICAL SERVICE REPORT 4 - CMS SUNSET REVIEW OF 2003 HOUSE POLICIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Council on Medical Service Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 4 adopted and the remainder of the report filed.

Council on Medical Service Report 4 contains recommendations to retain or rescind 2003 AMA socioeconomic policies.

Your Reference Committee commends the Council for its recommendations to update the AMA Policy Database and recommends adoption of Council on Medical Service Report 4.

(7) RESOLUTION 702 - PATIENT PROTECTION AND THE AFFORDABLE CARE ACT, ACCOUNTABLE CARE ORGANIZATIONS, PUBLIC HEALTH AND ORGANIZED MEDICINE
RESOLUTION 703 - POPULATION BASED PRACTICES IN ACCOUNTABLE CARE ORGANIZATIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 702 be adopted in lieu of Resolution 703.

HOD ACTION: Resolution 702 adopted in lieu of Resolution 703.

Resolution 702 asks that our AMA recommend that state and local medical societies encourage accountable care organizations (ACOs) to make sure that data needed by Public Health to protect the community against disease are available; recommend that ACO leadership work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health; and encourage state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

Resolution 703 asks that our AMA recommend that accountable care organization (ACO) developers be physicians with the skills to promote and evaluate population-based approaches to care delivery, and encourage that clinical and community ACO quality data become part of the information provided to all purchasers of health insurance through the health insurance exchange program.

Resolutions 702 and 703 emphasize the importance of ensuring that public health efforts are supported and promoted within an ACO framework. Your Reference Committee is supportive of the intent of these resolutions, and notes that they are generally consistent with policy that supports working cooperatively with public health officials (e.g., Policy H-440.965). There was supportive testimony on Resolution 702, and your Reference Committee believes that the resolution effectively expresses our AMA's commitment to preserving and promoting public health activities in the context of ACOs. A concern was raised that the first resolve of Resolution 702 could lead to unintended consequences related to the collection and use of patient data from ACOs, but your Reference Committee notes that HIPAA protections apply to ACOs.

Your Reference Committee agrees with testimony that the first resolve of Resolution 703 would limit flexibility by defining the specific skills that physician leaders of ACOs should possess. Testimony suggesting more general language advocating that physicians with population health backgrounds be included in the leadership of all ACOs raised similar concerns. Our AMA has made it a priority to advocate for flexibility in ACO implementation guidelines, to ensure that ACOs can be designed in a way that best reflects the needs of the local community, and to ensure that physicians interested in creating ACOs do not face unnecessary barriers. Regarding the second resolve of Resolution 703, testimony expressed concern that the resolve is too vague with respect to the specific types of data that should be reported and how it should be used. Your Reference Committee notes that health insurance exchanges are required to provide cost and quality information about plans offered on the exchange. To the extent that individual plans include ACOs in their networks, our AMA would support the use of quality data reporting, as long as the data is accurate and reliable, and physicians have the ability to review and modify specific data (Policy H-406.991). In light of the concerns related to Resolution 703, your Reference Committee recommends adopting resolution 702 in lieu of Resolution 703.

(8) RESOLUTION 704 - GUIDELINES FOR MOBILE MEDICAL APPLICATIONS AND DEVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 704 be adopted.

HOD ACTION: Resolution 704 adopted.

Resolution 704 asks that our AMA prepare a report on the appropriate indications, guidelines and certification processes necessary to assure the efficacy and safety of mobile medical applications and devices developed for smartphones and other personal electronic devices that may be used by physicians, allied health professionals, caregivers and patients.

The issue of regulating mobile medical applications and devices is an emerging issue that has been receiving increased attention in the context of broader discussions related to medical technology and telemedicine. Your Reference Committee is aware that the Food and Drug Administration (FDA) is expected to issue further guidance with regard to mobile medical applications and devices in October 2013, and thinks the guidance will provide useful information as our AMA considers establishing related policy. Your Reference Committee believes Resolution 704 is timely, and recommends that it be adopted.

(9) RESOLUTION 706 - GOVERNMENT INTERFERENCE IN THE PRACTICE OF MEDICINE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 706 be adopted.

HOD ACTION: Resolution 706 adopted.

Resolution 706 asks that our AMA endorse several principles developed by the American College of Physicians (ACP) concerning the roles of federal and state governments in health care and the patient-physician relationship.

There was supportive testimony on this resolution, which is consistent with several policies (e.g., H-373.995, H-5.989, D-315.989 and H-275.937) that were identified on the virtual reference committee forum. In addition, your Reference Committee is aware that our AMA's Advocacy Resource Center (ARC) launched a campaign in 2012 entitled, "Keeping politics out of the exam room: protecting the physician-patient relationship" to assist states confronting legislation that encroaches on the patient-physician relationship. More information about the ARC campaign is available under the Public Health Improvement Campaign section of the ARC web site: www.ama-assn.org/go/arc.

Your Reference Committee reviewed the document from the ACP that includes the principles outlined in Resolution 706, and commends ACP on its thorough and organized approach to these important issues. A concern was raised about whether the fourth resolve, which addresses laws that mandate treatments and procedures, could be misinterpreted, especially in the context of Council on Ethical and Judicial Affairs Report 1, "Physician Exercise of Conscience," which is also before the House at this meeting in the Reference Committee on Amendments to Constitution and Bylaws. Your Reference Committee believes that the primary intent of the principles identified in Resolution 706 is to preserve physician autonomy and the primacy of the patient-physician relationship, and is confident that this emphasis would be clear in subsequent advocacy efforts. Your Reference Committee recommends that Resolution 706 be adopted.

(10) RESOLUTION 709 - IMPROVING ACCESS TO PHYSICIANS WITH THE SPECIAL SKILLS REQUIRED IN GERIATRIC CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 709 be adopted.

HOD ACTION: Resolution 709 adopted.

Resolution 709 asks that our AMA explore and advocate for policies that best improve access to, and the availability of, high-quality geriatric care for older adults in the post-acute and long term care continuum.

There was supportive testimony on this resolution, which is consistent with policies that support increased training in geriatric medicine in medical school, and for all physicians who care for older adults (e.g., Policies H-295.918, H-295.981). Accordingly, your Reference Committee recommends that Resolution 709 be adopted.

(11) RESOLUTION 710 - THIRD-PARTY PAYER POLICIES ON OPIOID USE DISORDER PHARMACOTHERAPY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 710 be adopted.

HOD ACTION: Resolution 710 adopted.

Resolution 710 asks that our AMA oppose restrictions that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder.

There was generally supportive testimony on this resolution. A concern was raised that methods for treating addiction and chronic pain are being reevaluated, and the resolution potentially limits policy options that could balance patient safety and patient access to necessary therapies. Your Reference Committee appreciates this concern, but concurs with testimony that preserving the patient-physician relationship and eliminating unwarranted interference by third parties is critically important. Issues related to the risks associated with the use and abuse of controlled substances need to be addressed in ways that do not interfere with a physician's ability to exercise professional judgment. Accordingly, your Reference Committee recommends that Resolution 710 be adopted.

(12) RESOLUTION 713 - VALUE OF GROUP MEDICAL APPOINTMENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 713 be adopted.

HOD ACTION: Resolution 713 adopted.

Resolution 713 asks that our AMA promote education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.

There was supportive testimony on Resolution 713. Testimony recognized the potential value of group medical appointments as part of a comprehensive care plan for the conditions outlined in the resolution, but also for patient preventive care. Testimony also noted that there sometimes are difficulties in getting paid for group medical appointments. Your Reference Committee is aware that our AMA continues to advocate for separate payment of the relevant CPT codes for group medical appointments, and hopes that this will address payment issues associated with this type of service.

(13) RESOLUTION 714 - MANDATING E-PRESCRIBING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 714 be adopted.

HOD ACTION: Resolution 714 adopted.

Resolution 714 asks that our AMA work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.

There was mixed testimony on Resolution 714. Some testimony raised concerns that this resolution may be too rigid and have unintended consequences. Other testimony recommended reaffirmation of existing policy in lieu of Resolution 714. Speakers noted that existing policy on e-prescribing was dated, and therefore stressed that additional policy as proposed in Resolution 714 was necessary. Your Reference Committee agrees, and believes that Resolution 714 would adequately update AMA policy on e-prescribing. Working with representatives of pharmacies, pharmacy benefit managers, and software vendors could help remove some of the remaining obstacles there are to e-prescribing all medications, including controlled substances. As such, your Reference Committee recommends adoption of Resolution 714.

(14) RESOLUTION 717 - GOVERNMENT INTERFERENCE IN THE PATIENT-PHYSICIAN RELATIONSHIP

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 717 be adopted.

HOD ACTION: Resolution 717 adopted.

Resolution 717 asks that our AMA oppose any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both, and asks the AMA to educate lawmakers and industry experts on several principles endorsed by the American College of Physicians (ACP) related to the potential impact of new policies on the patient-physician relationship.

There was generally supportive testimony on this resolution, which is similar to Resolution 706 and refers to principles developed by ACP regarding the role of governments in the patient-physician relationship. Some concern was expressed that the second resolve is too complicated, and could be confusing to lawmakers and others trying to understand our AMA's position regarding government interference in the practice of medicine. However, your Reference Committee believes that the principles are appropriate and provide a useful framework for evaluating new and potential policies that could affect the patient-physician relationship. As noted in the discussion of Resolution 706, your Reference Committee reviewed the full document from the ACP that includes the issues outlined in Resolutions 706 and 717, and found that it is highly consistent with AMA policy related to the primacy of the patient-physician relationship and the role of the government in the practice of medicine. Your Reference Committee recommends that Resolution 717 be adopted.

(15) RESOLUTION 718 - HEALTH LITERACY IN HEALTHCARE INSTITUTIONS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 718 be adopted.

HOD ACTION: Resolution 718 adopted.

Resolution 718 asks that our AMA recommend all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit; recommend all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; encourage the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.

There was supportive testimony on this resolution. There were also calls for reaffirming existing policy in lieu of the resolution. Your Reference Committee believes that Resolution 718 represents the next steps the AMA should take to improve health literacy, and accordingly recommends adoption of Resolution 718.

(16) RESOLUTION 727 - ALIGN THE RECOGNITION PERIODS FOR THE BRIDGES TO EXCELLENCE AND THE NATIONAL COMMITTEE ON QUALITY ASSURANCE RECOGNITION PROGRAMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 727 be adopted.

HOD ACTION: Resolution 727 adopted.

Resolution 727 asks that our AMA request the Bridges to Excellence program to align its validation periods for its recognition programs with the validation periods of the National Committee on Quality Assurance recognition programs.

Testimony on this resolution was limited to the sponsor. Your Reference Committee understands the concerns and inconvenience associated with different validation periods for the two programs, and recommends that the resolution be adopted.

(17) RESOLUTION 732 – ERRORS IN ELECTRONIC CLAIMS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 732 be adopted.

HOD ACTION: Resolution 732 adopted.

Resolution 732 asks that our AMA publicize and encourage physicians to make use of AMA resources created to help physicians submit accurate electronic claims, and advocate that at the time of claim confirmation or no later than two business days after receiving an electronic claim, a third-party payer should provide the physician with an exception report notifying the physician of all information that is missing from the claim, any errors in the claim, any attachment that is missing or in error, and any other circumstances which preclude the claim from being a clean claim.

Testimony on this resolution was limited to the sponsor. Your Reference Committee notes that Resolution 732 is consistent with AMA's Health Insurer Code of Conduct, and accordingly recommends its adoption.

(18) BOARD OF TRUSTEES REPORT 9 - PAIN MANAGEMENT AND THE HOSPITAL VALUE-BASED PURCHASING PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the Board of Trustees Report 9 be amended by addition of a third recommendation to read as follows:

3. That our AMA urge the Centers for Medicare and Medicaid Services to suspend the use of HCAHPS measures addressing pain management until their validity as reliable and accurate measures of quality of care in this domain has been determined.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 9 adopted as amended and the remainder of the report filed.

Board of Trustees Report 9 recommends that our AMA urge the Centers for Medicare and Medicaid Services (CMS) to evaluate the relationship between patient satisfaction on the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) survey and hospital performance measures used in the value-based purchasing program, and to reexamine the validity of questions related to pain management used on the HCAHPS survey.

There was generally supportive testimony on this report, although concerns were raised that the recommendations did not go far enough with respect to ensuring the validity of the assessment tools used to assess pain management in the hospital setting. Your Reference Committee agrees with testimony suggesting the addition of a third recommendation that would support suspending the use of the HCAHPS questions on pain management pending a thorough review of their validity. Additional testimony noted that the report focused on pain management issues in the inpatient setting, which was consistent with the scope of the referred resolution that generated the report. Your Reference Committee believes the Board has done a thorough job of addressing the issues associated with measuring patient experience with pain management in the hospital setting, and recommends that the recommendations in Board of Trustees Report 9 be adopted as amended.

(19) BOARD OF TRUSTEES REPORT 22 - PROFESSIONALISM IN
TELEMEDICINE AND TELEHEALTH

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 in Board of Trustees Report 22 be amended by addition and deletion to read as follows:

2. That H-480.974 Evolving Impact of Telemedicine be amended by addition and deletion to read as follows:

Our AMA:

- (1) will evaluate relevant federal legislation related to telemedicine;
- (2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
- (3) urges professional organizations that serve medical specialties ~~specialty societies~~ specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
- (4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
- (4~~5~~) ~~encourages the CPT Editorial Board to develop CPT codes or modifiers for telemedical services~~ development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
- (5~~6~~) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
- (6~~7~~) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and
- (7~~8~~) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. (Modify Current HOD Policy);

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendations in Board of Trustees Report 22 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 22 adopted as amended and the remainder of the report filed.

Board of Trustees Report 22 examines the effect of telemedicine and telehealth on the patient-physician relationship, and recommends reaffirmation or modification of several related AMA policies.

Your Reference Committee heard supportive testimony on this report. There was a suggestion that the report include language specifying that the initial contact for a telehealth/telemedicine interaction should be a physician, but your Reference Committee does not believe that this would be necessary or appropriate in all circumstances, and was unclear about the best way to incorporate this concept into the recommendations of the report. A member of the Board of Trustees requested that Recommendation 2 be amended by making an additional change to Policy H-480.974, original subsection 4, which encourages the creation of CPT codes for telemedicine services. The amended language reflects the appropriate process for CPT code change modifications, which requires that changes to the CPT code set be initiated with a code change application. Your Reference Committee recommends that the recommendations in Board of Trustees Report 22 be adopted as amended.

(20) BOARD OF TRUSTEES REPORT 24 - COST AND BENEFIT ANALYSIS FOR ELECTRONIC HEALTH RECORD IMPLEMENTATION, UNDERSTANDING THE PITFALLS OF EHRS AND PROVIDING STRATEGIES FOR SUCCESS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 3 of Board of Trustees Report 24 be amended by addition to read as follows:

3. That our AMA make available the findings of the AmericanEHR Partners' Survey and report back to the House of Delegates. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 24 be adopted as amended and that the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 24 adopted as amended and the remainder of the report filed.

Board of Trustees Report 24 recommends that our AMA continue to work with AmericanEHR Partners to survey physician use and issues with various EHRs, and make the results of the survey available.

There was mixed testimony on Board of Trustees Report 24. While concerns were raised in testimony that the recommendations of the report do not go far enough, your Reference Committee believes that the report provides compelling information to support the recommendation that our AMA, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs, and work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes. Your Reference Committee also heard testimony in support of reporting back to the House of Delegates on the implementation of the recommendations of this Board report. Accordingly, your Reference Committee recommends adoption of Board of Trustees Report 24 as amended.

(21) COUNCIL ON MEDICAL SERVICE REPORT 1 - WORKSITE HEALTH CLINICS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1(l) of Council on Medical Service Report 1 be amended by addition and deletion to read as follows:

1. Worksite health clinics should allow ~~encourage~~ the involvement of community physicians in clinic operations.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 1(n) of Council on Medical Service Report 1 be amended by addition to read as follows:

- n. Worksite health clinics should be encouraged to use interoperable electronic health records as a means of communicating patient information to and facilitating continuity of care with community physicians, hospitals and other health care facilities.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 1 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 1 provides background on worksite health clinics, outlines issues associated with the structure of worksite health clinics, summarizes relevant AMA policy, and presents policy recommendations to guide the establishment and operation of worksite health clinics.

There was generally supportive testimony on Council on Medical Service Report 1. A question was posed in testimony concerning why community physicians should be involved in worksite health clinic operations, as outlined in Recommendation 1(l). A member of the Council on Medical Service clarified that involving community physicians in worksite health clinic operations could support continuity of care for employees and their families, while giving community physicians the opportunity to further diversify the payer mix of their patients. While your Reference Committee supports the intent of this recommendation, whether or not to participate in worksite clinic operations needs to remain the decision of the community physician. Therefore, your Reference Committee recommends a change of wording to this recommendation to allow for physicians to participate in worksite clinic operations, should they choose to do so.

Testimony also suggested that the wording of Recommendation 1(n), which encourages worksite health clinics to use interoperable electronic health records, could be clarified to stress that their electronic health records systems should be interoperable with physicians, hospitals and other health care facilities at the community level. In addition, a speaker raised an issue with the usage of the term “worksite health clinic” in the report, and suggested that “employer-sponsored medical clinics” be used instead to include all possible clinic structures and designs. However, your Reference Committee notes that the Council outlined the options employers have to design and structure their worksite health clinics in its report, which addresses the concerns raised by the speaker. Furthermore, the term “worksite health clinic” has been frequently used in the literature, including in various reports and journal articles. As the Council’s usage of the term “worksite health clinics” is inclusive of a wide range of clinic designs and structures, your Reference Committee believes that a change in terminology is unnecessary. Your Reference Committee recommends that Council of Medical Service Report 1 be adopted as amended.

(22) COUNCIL ON MEDICAL SERVICE REPORT 2 - VALUE-BASED INSURANCE DESIGN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2[b] of Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

- b. Practicing physicians ~~must~~ should be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Council on Medical Service Report 2 be amended by addition of section [i] to read as follows:

- i. VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972).

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 2 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 2 describes the concept of value-based insurance design (VBID), summarizes evidence related to the effect of VBID on patient outcomes and health care costs, and proposes a set of principles to guide the implementation of VBID initiatives.

There was mixed testimony on Council on Medical Service Report 2. A question was raised about whether VBID would apply to care providers, such as in a tiered network structure. The chair of the Council on Medical Service clarified that, while VBID could be applied to providers, it most commonly relates to the services or treatments being provided. The Council chair also commented that the report references strong AMA policy (Policy H-450.941 and D-285.972) that opposes tiered physician networks that steer patients to certain providers based only on cost of care. Your Reference Committee believes that it is critical that VBID not be used as a vehicle to steer patients to physicians or services based on cost, and agrees with testimony that the principles related to VBID should include a statement that VBID programs must conform to AMA policies related to pay for performance, physician economic profiling, and tiered and narrow networks. Your Reference Committee also agrees with proposed amended language that would strengthen principle 2b. by emphasizing that physicians, including relevant specialists, must be involved in the development of VBID programs.

Testimony noted that VBID programs must reflect a commitment to comparative effectiveness research and to assuring that patients receive adequate and balanced information, such as through a shared decision-making process. Your Reference Committee agrees that these are important points, and believes that they are addressed in the Council's recommendations, particularly regarding the use of high-quality, evidence-based data. In addition, Policy H-373.997 supports the voluntary use of shared decision-making processes as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions. Your Reference Committee believes that the recommendations in Council on Medical Service Report 2 provide a solid framework to guide the implementation of VBID programs, and recommends that they be adopted as amended.

Additional testimony expressed concern about the lack of evidence related to the use of VBID on outcomes and costs, and recommended adding a principle in Recommendation 2 that would limit VBID implementation to pilot projects until more evidence can be gathered about the utility of VBID programs. Testimony also recommended deleting the first recommendation, based on concerns that it places undue emphasis on the potential for VBID to control health care costs. Your Reference Committee appreciates these concerns, but is persuaded by the conclusion of the Council that, "despite the lack of definitive evidence that VBID will consistently result in better health outcomes, lower health care costs, or both, the Council believes that it is important to encourage innovative benefit designs..." (page 5, lines 36-40). Your Reference Committee believes that the principles outlined in the Council's

report, as strengthened by the proposed amendments, provide reasonable guidelines to help shape the development of VBID programs.

(23) COUNCIL ON MEDICAL SERVICE REPORT 6 - DELIVERY REFORM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 6 of Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

6. That our AMA amend Policy H-450.966[6] by addition and deletion to read as follows: “The AMA ... (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. ~~(f) Standards and measures shall account for the range of settings and providers practitioners involved in health care delivery.~~ (eg) Standards and measures shall recognize the informational needs of patients and physicians. ~~(fh) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations.~~ (gi) Standards and measures shall recognize the importance and implications of patient choice and preference. ~~(hj) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured.~~ (ik) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.” (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 6 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 6 recommends amending existing policies and creating new policies that will strengthen existing body of AMA policy related to delivery reform.

There was generally supportive testimony on Council on Medical Service Report 6. Testimony raised a concern over the use of the term “provider” in Recommendation 6 of the Council report, which recommends amending Policy H-450.966. Therefore, an amendment was offered in testimony that suggested changing “providers” to “practitioners” in the proposed new subpart 6(f) of Policy H-450.966, to more appropriately reflect the intent of the provision. Your Reference Committee agrees with the amendment, and accordingly recommends that Council on Medical Service Report 6 be adopted as amended.

(24) RESOLUTION 705 - ENHANCING ACCOMMODATIONS FOR PEOPLE WITH DISABILITIES IN PRIMARY CARE MEDICAL HOMES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 705 be adopted.

HOD ACTION: Substitute Resolution 705 adopted.

ENHANCING ACCOMMODATIONS FOR PEOPLE WITH DISABILITIES

RESOLVED, That our AMA encourage physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines. (New HOD Policy)

Resolution 705 asks that our AMA include in its policies regarding Primary Care Medical Homes (PCMHs) in the ambulatory care setting reasonable accommodations for people with disabilities in physicians' offices, such as wheelchair accessibility and accessible exam tables, to allow improved access to primary care services.

There was mixed testimony on this resolution. Some comments suggested that focusing on accessibility only in PCMHs was too limiting, and that all physicians should facilitate access to care for all patients. However, others raised concerns about the practicality of making all physician offices accessible, especially older practices in urban areas where space may be limited. Your Reference Committee believes that all physicians should strive to make their offices accessible to patients with disabilities, and recommends the substitute language to establish our AMA support for this.

(25) RESOLUTION 711 - DEVELOPMENT OF MODELS/GUIDELINES FOR MEDICAL TEAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 711 be amended by addition and deletion on lines 11 – 14 to read as follows:

RESOLVED, That our AMA propose acceptable models that value the expertise of the physician and models that could be used by ~~such~~ medical teams that address including specific issues such as patient safety, the nature of physician authority within the teams, ~~any role of physicians in a non-physician led team,~~ and the ethical and legal issues of the team model. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 711 be adopted as amended.

HOD ACTION: Resolution 711 adopted as amended.

Resolution 711 asks that our AMA study and report back on the definition of leadership in physician-led medical teams, and propose potential models that could be used by such teams.

The chair of the Council on Medical Education offered supportive testimony on this resolution, and noted that the Board of Trustees has appointed a task force to define and clarify terms related to health care teams, which is consistent with the first resolve of Resolution 711. Additional testimony expressed concern that narrowly defining terms and models for team-based care could end up limiting flexibility and interfering with efforts to provide improved care more efficiently. Your Reference Committee acknowledges that the concept of team-based care is

evolving, and believes that this resolution will complement our AMA's ongoing work in this area by identifying issues that merit further consideration. Several speakers emphasized the importance of continuing to promote physician-led teams, and the amended language reflects testimony suggesting that the original language be modified to eliminate language that could imply AMA support for non-physician led teams.

(26) RESOLUTION 712 - PATIENT ACCESS TO INDEPENDENT APPEAL AND GRIEVANCE PROCEDURES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 712 be amended by deletion to read as follows:

RESOLVED, That our current American Medical Association policy be amended by addition as follows: H-320.952 (External Grievance Review Procedures) to read: "Our AMA establishes an External Grievance procedure for all health plans including those under the Affordable Care Act (ACA) with the following basic components: (1) It should apply to all health carriers and Accountable Care Organizations..." ~~and policy H-165.839 (Health Insurance Exchange Authority and Operation) to read: "Our American Medical Association adopts the following principles for the operation of health insurance exchanges and Accountable Care Organizations: ...F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of the state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices...."~~ to reflect the new landscape under the PPACA. (Modify Current HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 712 be adopted as amended.

HOD ACTION: Resolution 712 adopted as amended.

Resolution 712 asks that Policy H-320.952 (External Grievance Review Procedures) be amended to read, "Our AMA establishes an External Grievance procedure for all health plans including those under the Patient Protection and Affordable Care Act (PPACA) with the following basic components: (1) It should apply to all health carriers and Accountable Care Organizations..." and policy H-165.839 (Health Insurance Exchange Authority and Operation) to read: "Our American Medical Association adopts the following principles for the operation of health insurance exchanges and Accountable Care Organizations: ...F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of the state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices...."

The policy amendments included in Resolution 712 are intended to address new insurance coverage and care delivery models that have emerged as a result of the ACA, particularly ACOs. Your Reference Committee agrees that the proposed amendments to Policy H-320.952 appropriately strengthen our existing policy and increase its relevancy in the current environment. However, Policy H-165.839 specifically addresses health insurance exchanges and their operation and authority. The principles in this policy are unique to insurance exchanges, and it would not make sense to apply them to ACOs. Your Reference Committee believes that the intent of the resolution is accomplished by the modification called for in the first part of Resolution 712, and accordingly recommends that it be adopted as amended.

(27) RESOLUTION 715 - UTILIZATION OF EMR AND THE PRACTICE OF “CUTTING AND PASTING” OR CLONING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 715 be adopted.

HOD ACTION: Substitute Resolution 715 adopted.

RESOLVED, that our AMA develop guidelines in conjunction with the Centers for Medicare and 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 (New HOD Policy); and be it further

RESOLVED, that our AMA study the impact of EHR clinical documentation tools and shortcuts on patient safety, quality of care and safe harbor laws. (Directive to Take Action)

Resolution 715 asks that our AMA continue its efforts to educate the Centers for Medicare and Medicaid Services (CMS) on the appropriate use of templates and cutting and pasting in EMRs when the services have actually been provided; take steps to disabuse Federal Enforcement officials of the perception that increased medical costs are the result of fraudulent activity; develop standards or guidelines on the appropriate use of templates and cutting and pasting that will facilitate accurate documentation resulting in better care; and take steps to persuade CMS and federal enforcement authorities that compliance with these developed standards or guidelines results in a presumption that that the EMR is accurate and not the result of fraud, waste, or abuse.

There was mixed testimony on Resolution 715. Testimony in support of the resolution noted that additional guidance on the use of tools and shortcuts in EHRs would be beneficial to physicians. A speaker questioned whether “copy and paste” should be used instead of “cut and paste” in the resolution. Your Reference Committee notes that “cut and paste” is the terminology that has been used in the EHR arena, including in AMA testimony and letters to Congress and the Administration.

There were also calls for referral of Resolution 715. Some commenters raised concerns that the use of templates and cutting and pasting can negatively impact patient care and safety. In addition, speakers noted that the applicability of safe harbor laws to the use of EHR clinical documentation tools and shortcuts needs to be clarified. Your Reference Committee believes that these critical issues raised in testimony merit further study.

Concerning the third resolve of the resolution, there was general support, as well as calls for referral. Consistent with the intent of the third resolve, as well as AMA advocacy efforts, your Reference Committee believes that our AMA should work in conjunction with the Centers for Medicare and Medicaid Services to provide clear and direct guidance to physicians concerning the permissible use of EHR clinical documentation for the purposes of coding and billing.

(28) RESOLUTION 716 - CRIMINALIZATION OF GOOD FAITH ERRORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 716 be adopted.

HOD ACTION: Substitute Resolution 716 adopted.

RESOLVED, That our American Medical Association amend Policy H-160.954 by addition and deletion to read as follows: “(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making

and medical records documentation, exercised in good faith, does not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

Resolution 716 asks that our AMA oppose the criminalization of good faith errors in medical judgment and medical record keeping, and adopt a policy that in the absence of fraud, errors in the preparation of medical records should not be criminalized.

There was supportive testimony on Resolution 716. Your Reference Committee believes that the intent of Resolution 716 could be achieved through modifying existing Policy H-160.954, and therefore recommends adoption of Substitute Resolution 716.

(29) RESOLUTION 719 - PRESCRIPTION MANAGEMENT - CHANGING THE RENEWAL LENGTH TO IMPROVE PRACTICE EFFICIENCY AND QUALITY OF CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 719 be adopted.

HOD ACTION: Substitute Resolution 719 adopted.

RESOLVED, That Policy H-120.952 be amended by addition to read as follows:

H-120.952 Restriction on Prescription Refills

1. Our AMA opposes restrictions on the legitimate, clinically appropriate refill of patient prescriptions including, but not limited to: (A) restricting refill hours to less than usual pharmacy hours; (B) restricting refills to limited pharmacies rather than all participating pharmacies; (C) restricting refills for chronic medications to a less than 90-day supply; and (D) restricting the date of refill.
2. Our AMA will encourage relevant organizations, including but not limited to insurance companies and professional pharmacy organizations, to develop a plan to implement prescription refill schedule strategies so that patients requiring multiple prescription medications may reduce the need for multiple renewal requests and travel barriers for prescription acquisition.

Resolution 719 asks that our AMA work with the State Boards of Pharmacy and the state legislatures to extend the validity of state non-controlled substance prescription renewal length to 13 months.

There was testimony in support of efforts to develop flexible prescription refill strategies that would promote continuity of care and increase the efficiency of the prescription renewal process. Your Reference Committee notes that the whereas clauses of the resolution highlight administrative and other hassles associated with providing prescription renewals for multiple prescriptions at different times throughout the year. It is unclear how extending the prescription renewal period to 13 months alone will address the issues that the sponsors raise. Your Reference Committee notes that Policy H-120.952[2], which was adopted at the 2012 Interim Meeting and posted on the virtual reference committee forum, encourages insurers to develop broad strategies to minimize the hassle associated with multiple prescription renewals. Your Reference Committee believes that a broad-based approach to coordinating prescription renewals would be more effective than simply extending the prescription renewal period. The recommended substitute language would amend Policy H-120.952 to acknowledge the importance of reducing the need for multiple renewal requests, in addition to travel barriers associated with filling prescriptions at multiple times.

(30) RESOLUTION 720 - STANDARDS FOR ELECTRONIC MEDICAL RECORDS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 720 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association request that the Centers for Medicare & Medicaid Services (CMS) study support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 720 be adopted as amended.

HOD ACTION: Resolution 720 adopted as amended.

Resolution 720 asks that our AMA request that the Centers for Medicare and Medicaid Services (CMS) study the effect of electronic medical records (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices, and request that CMS develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

Your Reference Committee received mixed testimony on Resolution 720, as well as a call for reaffirming existing policy in lieu of the resolution. In particular, your Reference Committee heard testimony concerned with the Centers for Medicare and Medicaid Services conducting the study as called for in the resolution. As such, your Reference Committee believes that CMS should support an external, independent evaluation of the effect of EMR implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices. Such an evaluation would be in line with AMA advocacy efforts in support of an external, independent evaluation that assesses Stage 1 of the Medicare/Medicaid meaningful use EHR program, including its impact on the productivity of physician practices. Therefore, your Reference Committee recommends that Resolution 720 be adopted as amended.

(31) RESOLUTION 721 - EHR STANDARDIZATION
RESOLUTION 723 - BARRIERS TO ELECTRONIC HEALTH RECORD CONNECTIVITY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 721 be adopted in lieu of Resolutions 721 and 723.

PROMOTING ELECTRONIC HEALTH RECORD CONNECTIVITY

RESOLVED, That our American Medical Association seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery. (Directive to Take Action)

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost

effective use and sharing of electronic health records across all settings of care delivery.

HOD ACTION: Substitute Resolution 721 adopted as amended in lieu of Resolutions 721 and 723.

Resolution 721 asks that our AMA seek legislation or regulation to require all electronic health records (EHR) vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery.

Resolution 723 asks that our AMA work with the Centers for Medicare and Medicaid Services (CMS) to compel and /or incentivize health systems to work with physician practices to achieve interconnectivity of electronic health records through interfaces.

Testimony was generally supportive of the intent of Resolutions 721 and 723. Your Reference Committee recognizes that Resolutions 721 and 723 have the same goal – to enable the EHR systems of independent physician practices to connect and be interoperable with the EHR systems of the hospitals and health systems in their community. Your Reference Committee notes that AMA policy supports incentives rather than penalties to support compliance with the EHR incentive program. Your Reference Committee believes that appropriate incentives in the EHR marketplace will drive innovation in vendor EHR product offerings, with the goal of creating sustainable information exchange environments. Incentives can also encourage hospitals and health systems to share information more broadly.

There was general support for Substitute Resolution 721 in the live hearing. Testimony noted that interoperability of electronic health records systems may not be feasible in the immediate future for all stakeholders. Your Reference Committee notes that existing AMA policy on EHRs affirms the implementation of an interoperable health information technology infrastructure as an overarching goal, and realizes additional steps must be taken to ensure that interoperability of EHR systems can become a reality for all stakeholders. Your Reference Committee also intended for the language of Substitute Resolution 721 to include imaging systems as part of EHR interoperability, and therefore does not believe additional language proposed in testimony is necessary. An amendment was offered during the live hearing to Resolution 723; however, your Reference Committee recommends adoption of Substitute Resolution 721 in lieu of Resolution 723.

(32) RESOLUTION 722 - CLARIFYING EMTALA SPECIALTY ON-CALL REQUIREMENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 722 be amended by addition and deletion to read as follows:

RESOLVED, That the American Medical Association ~~provide~~ provide compile and make available to the physician community various ~~models~~ examples of on-call solutions ~~that intended to avoid undue risks of Emergency Medical Treatment and Active Labor Act liability without~~ that intended to avoid undue risks of Emergency Medical Treatment and Active Labor Act liability without subjecting physicians to unrealistic and unduly burdensome on-call demands, ~~and expectations~~ and to educate AMA physician members regarding these options and how best to pursue them.
(Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 722 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 722 be changed to read as follows:

ON CALL COVERAGE MODELS

HOD ACTION: Resolution 722 adopted as amended with a change in title.

Resolution 722 asks that our AMA provide to the physician community various models of on-call solutions that avoid undue risks of EMTALA liability without subjecting physicians to unrealistic and unduly burdensome on-call demands and expectations and educate AMA physician members regarding these options and how best to pursue them.

Testimony on this resolution raised multiple issues related to EMTALA and the different rules and requirements that hospitals impose in order to comply with their interpretation of their obligations under EMTALA. Our AMA has several policies related specifically to problems with EMTALA and calling for AMA advocacy to address these problems (e.g., Policies H-130.950, D-130.976, H-130.948, D-130.989). Several speakers called for referral, so that the Board could conduct an in-depth study of EMTALA-related policies and procedures. Your Reference Committee notes, however, that the scope of the original resolution is relatively limited, and calls for our AMA to provide examples of on-call coverage arrangements. Your Reference Committee interprets the intent of this resolution to be a call for the development of a resource that could be used to gather ideas and suggestions about effective ways of managing on-call coverage that help ensure patient access to care, and equitable arrangements for physicians. Your Reference Committee believes this could be a valuable information resource, and recommends adoption of amended language, which is intended to clarify that our AMA will not be providing guidance or advice specifically related to compliance with EMTALA, since this would imply our AMA was acting in a legal capacity.

(33) RESOLUTION 730 - DIABETIC DOCUMENTATION REQUIREMENTS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 730 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association Board of Trustees consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers ~~limitation~~ on diabetic patients to procure procurement of blood glucose monitoring medically necessary durable medical equipment and supplies (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 730 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA Board of Trustees consider a legal challenge, if appropriate, to the authority and policy of CMS and other insurers to practice medicine through their guidelines, and place excessive time and financial burdens without reimbursement ~~place burdens~~ on a physician ~~office~~ assisting diabetic patients seeking reimbursement for ~~diabetic monitoring~~ supplies needed to treat their Diabetes. (Directive to Take Action)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 730 be adopted as amended.

HOD ACTION: Resolution 730 adopted as amended

Resolution 730 asks that our AMA consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing limitation on diabetic patients' procurement of blood glucose monitoring supplies and burdens on a physician office assisting diabetic patients seeking reimbursement for diabetic monitoring supplies.

Testimony on this resolution was limited but supportive. The sponsor proposed the amended language to highlight the need for patient-focused and physician-focused advocacy on this issue. Your Reference Committee is aware that our AMA has been advocating with CMS on this issue, and recommends that Resolution 730 be adopted as amended.

(34) RESOLUTION 731 – MEDICAL STAFF-HOSPITAL COMPACTS**RECOMMENDATION A:**

Mr. Speaker, your Reference Committee recommends that Resolution 731 be amended by addition of a second resolve to read as follows:

RESOLVED, That our AMA publicize to medical staffs the pitfalls of medical staff-hospital compacts and modify as needed the Physician's Guide to Medical Staff Organization Bylaws. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 731 be adopted as amended.

HOD ACTION: Resolution 731 adopted as amended

Resolution 731 asks that our AMA recommend that organized medical staffs and physicians use medical staff bylaws instead of compacts or similar agreements to establish agreements with hospitals governing bodies or administrations.

Your Reference Committee heard supportive testimony on this resolution. The sponsor of Resolution 731 noted that the resolution has been vetted by AMA's Healthcare Law Advisory Panel. Testimony also noted that such compacts could conflict with medical staff bylaws and physician employment contracts, which has the potential to be detrimental to physicians. An amendment was offered during the live hearing that called for the AMA to publicize to medical staffs the pitfalls of medical staff-hospital compacts and modify the Physician's Guide to Medical Staff Organization Bylaws as needed to account for such compacts. Accordingly, your Reference Committee recommends that Resolution 731 be adopted as amended.

**(35) RESOLUTION 726 – EXCLUSION OF PRIMARY CARE PHYSICIANS IN LONG TERM CARE FROM ACCOUNTABLE CARE ORGANIZATIONS
RESOLUTION 733 – PHYSICIAN PARTICIPATION IN MULTIPLE ACCOUNTABLE CARE ORGANIZATIONS****RECOMMENDATION:**

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 726 be adopted in lieu of Resolution 726 and 733:

PHYSICIAN PARTICIPATION IN MULTIPLE MEDICARE ACCOUNTABLE CARE ORGANIZATIONS

RESOLVED, That our AMA continue to work with the Centers for Medicare and Medicaid Services to address accountable care organization (ACO) rules that preclude physician participation in multiple Medicare ACOs. (Directive to Take Action)

HOD ACTION: Substitute Resolution 726 adopted in lieu of Resolutions 726 and 733.

Resolution 726 asks that our AMA support legislative and/or regulatory action that would allow long term care providers and medical directors of nursing homes to practice in multiple accountable care organizations (ACO).

Resolution 733 asks that our AMA advocate that physicians be permitted to participate fully in multiple accountable care organizations (ACOs).

Resolutions 726 and 733 both relate to Medicare rules that limit a physician's ability to participate in more than one ACO. There was supportive testimony on Resolution 726, which asks our AMA to pursue changes that would allow long-term care physicians to participate in multiple ACOs, since such physicians often work with several hospital systems or groups. Resolution 733 is more broad than 726, and asks that our AMA advocate that all physicians be permitted to participate in multiple ACOs. There was testimony calling for referral of Resolution 733, which reflected concerns that patient attribution issues could become increasingly complex if physicians were allowed unrestricted participation in multiple ACOs. Your Reference Committee recognizes this, but also believes it is important to preserve flexibility in the organization and operation of ACOs, and to ensure that Centers for Medicare and Medicaid Services (CMS) rules accommodate a wide range of practice, specialty and community circumstances, such as rural physicians practicing in watershed areas between competing ACOs. Your Reference Committee notes that our AMA has been working with CMS to address concerns about policies that limit physician participation to a single ACO, and after meeting with our AMA and several other medical societies, CMS has agreed to review and consider modifying its current policy. Your Reference Committee recommends adoption of the substitute language, which is consistent with our AMA's ongoing advocacy efforts in this area.

(36) RESOLUTION 707 - PEDIATRIC MEDICAL ORDERS BETWEEN STATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be referred.

HOD ACTION: Resolution 707 referred

Resolution 707 asks that our AMA advocate so that board certified physicians currently licensed and registered to practice medicine in any state can execute conventional medical orders for patients who are moving out of state for a transitional period of no more than sixty days.

Your Reference Committee received mixed testimony on Resolution 707. Testimony raised concerns that Resolution 707 could be construed as support for the national licensure of physicians. Testimony also stressed that physicians should facilitate the transition of care for their patients before their patients move out of state. In addition, there was testimony that highlighted that Resolution 707 could negatively impact physicians who entered practice before board certification was commonplace. A speaker also noted that the resolution could expose the physician of record to additional liability. Finally, testimony questioned whether the resolution could also be applicable to adults, as well as to children without special needs. Your Reference Committee appreciates the intent of the sponsor to improve the coordination of care for special needs children who move out of state. However, your Reference Committee agrees with testimony that this resolution could have unintended consequences, and therefore recommends referral of Resolution 707.

(37) RESOLUTION 708 - MENTAL HEALTH SERVICES FOR SCHOOL-AGED CHILDREN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 708 be referred.

HOD ACTION: Resolution 708 referred.

Resolution 708 asks that our AMA work to develop school-based programs that assure at-risk children/adolescents access to appropriate mental health screening and treatment services.

There was mixed testimony on Resolution 708. Your Reference Committee recognizes the concerns raised in testimony that more needs to be done to ensure that children and adolescents receive necessary mental health screening and services to prevent future tragedies like Sandy Hook and Columbine. Testimony also questioned whether schools had the resources necessary to develop and implement the school-based mental health programs as called for in Resolution 708. There were also calls for referral, to ensure that the AMA can be appropriately engaged on this issue moving forward. Your Reference Committee agrees and recommends referral of Resolution 708.

(38) RESOLUTION 728 - DATA TRANSITION COSTS WHEN SWITCHING ELECTRONIC MEDICAL RECORDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 728 be referred.

HOD ACTION: Resolution 728 referred.

Resolution 728 asks that our AMA work with the Office of the National Coordinator for Health Information Technology (ONC) and other interested parties to make electronic medical record (EMR)-to-EMR medical record data transition capabilities a requirement of ONC's EMR product certification, and seek legislative action requiring this of EMR vendors if necessary.

Your Reference Committee heard mixed testimony on this resolution. Speakers noted that this resolution addresses a complicated and emerging issue, and directly relates to the issues of EHR interoperability and health information exchanges. As such, your Reference Committee recommends referral of Resolution 728.

(39) RESOLUTION 701 - IMPLEMENTATION AND FUNDING OF CHILDCARE SERVICES FOR PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 701 not be adopted.

HOD ACTION: Resolution 701 not adopted.

Resolution 701 asks that our AMA encourage primary care and emergency department settings, where feasible, to offer inexpensive or free childcare services to patients.

There was mixed testimony on Resolution 701. Testimony raised concerns regarding the feasibility of providing inexpensive or free childcare services to patients. Testimony also noted that the provision of childcare services has the potential to expose physicians to additional liability. In addition, without funding for the provision of inexpensive or free childcare services to patients, your Reference Committee is concerned that this resolution could

amount to another unfunded mandate on physician practices, which Policy H-270.962 vigorously opposes. Therefore, your Reference Committee recommends that Resolution 701 not be adopted.

(40) RESOLUTION 724 - DEFECTIVE ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies D-478.995, D-478.996 and H-480.971 be reaffirmed in lieu of Resolution 724.

HOD ACTION: Policies D-478.995, D-478.996 and H-480.971 reaffirmed in lieu of Resolution 724.

Resolution 724 asks that our AMA work with the Centers for Medicare and Medicaid Services (CMS) or seek federal legislation to require the Office of Inspector General to verify that the electronic health records certified by the Office of the National Coordinator for Health Information Technology and offered for sale to physicians meet certain standards and requirements.

Your Reference Committee agrees with the intent of Resolution 724, but notes that existing AMA policy has already enabled the AMA to advocate in support of improved EHR functionality, usability and interoperability. The sponsor of Resolution 724 was supportive of reaffirming existing policy in lieu of the resolution. As such, your Reference Committee recommends that the three policies that were identified on the virtual reference committee forum be reaffirmed in lieu of Resolution 724.

D-478.995 National Health Information Technology

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems. (Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12)

D-478.996 Information Technology Standards and Costs

Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems. (Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12)

H-480.971 The Computer-Based Patient Record

The following steps will allow the AMA to act as a source of physician input to the revolutionary developments in computer-based medical information applications, as a coordinator, and as an educational resource for physicians. The AMA will: (1) Provide leadership on these absolutely critical and rapidly accelerating issues and activities. (2) Work, in cooperation with state and specialty associations, to bring computer education and information to physicians. (3) Work to define the characteristics of an optimal medical record system; the goal being to define the content, format and functionality of medical record systems, and aid physicians in evaluating systems for office practice computerization. (4) Focus on the CPR aspect of human-computer interaction (the physician data input step) and work with software vendors on the design of facile interfaces. (5) Provide guidance on the use of computer diagnosis and therapeutic support systems. (6) Continue to be involved in national forums on issues of electronic medical data control, access, security, and confidentiality. (7) Continue to work to ensure that issues of patient confidentiality and security of data are continually addressed with implementation resolved prior to the implementation and use of a computer-based patient record. (BOT Rep. 29, A-96; Reaffirmation A-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation I-08; Reaffirmation A-09)

- (41) RESOLUTION 725 - ELECTRONIC HEALTH RECORD PENALTIES: TAXATION WITHOUT REPRESENTATION?

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-478.991 be reaffirmed in lieu of Resolution 725.

HOD ACTION: Policy H-478.991 reaffirmed in lieu of Resolution 725.

Resolution 725 asks that our AMA work to have all federal penalties tied to the use of electronic health records revoked as yet another form of unfair financial penalty for physicians.

There was mixed testimony on this resolution. While there was testimony in support of Resolution 725, other commenters had concerns with its wording and direction. The sponsor of Resolution 725 was supportive of reaffirming existing policy in lieu of the resolution. Your Reference Committee believes that Policy H-478.991 addresses the intent of this resolution, and therefore recommends that it be reaffirmed in lieu of Resolution 725.

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; and (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. (Sub. Res. 202, A-09; Reaf I-09; Reaf A-10; Reaf I-10; Reaf in lieu of Res. 237, A-12; Reaf in lieu of Res. 218, I-12; Reaf in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12)

- (42) RESOLUTION 729 - COORDINATION OF BENEFITS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policy H-190.969 be reaffirmed in lieu of Resolution 729.

HOD ACTION: Policy H-190.969 reaffirmed in lieu of Resolution 729.

Resolution 729 asks that our AMA support regulation or legislation that would require insurance carriers to perform coordination of benefits in timely fashion in order to lessen the burden on a provider's practice.

There was limited yet supportive testimony on Resolution 729. A member of the Board of Trustees highlighted that the AMA has been active on this issue through the “Heal the Claims Process” campaign. Your Reference Committee notes that the campaign was the result of existing AMA policy, and believes that Policy H-190.969 addresses the intent of Resolution 729. Therefore, your Reference Committee recommends that Policy H-190.969 be reaffirmed in lieu of Resolution 729.

H-190.969 Delay in Payments Due to Disputes in Coordination of Benefits

Our AMA: (1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries’ claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced; (2) includes the “birthday rule” and the “employer first rule” in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims; (3) urges state medical associations to advocate for the inclusion of the “employer first rule” and “birthday rule” in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits; (4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays; (5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation; (6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and (7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services. (CMS Rep. 8, I-98; Reaffirmation I-04)