MEMORIAL RESOLUTIONS
Adopted Unanimously

Charles Everett Koop, MD
Introduced by New York

Whereas, Charles Everett Koop, MD was appointed as US Surgeon General in 1981 by President Ronald Reagan and served in that capacity until 1989 becoming a household name and often regarded as one of the most influential Surgeon Generals in US history; and

Whereas, Dr. Koop earned his MD degree from Cornell Medical College in 1941 and a Doctor of Science degree in Medicine from the University of Pennsylvania in 1947; and

Whereas, From 1946-1981, Dr. Koop served as the Surgeon-in-Chief at Children's Hospital of Philadelphia where he established the nation's first neonatal surgical intensive care unit in 1956 and also helped establish the Pediatric Surgery Fellowship Training Program; and

Whereas, Dr. Koop performed ground-breaking surgical procedures on conjoined twins, inventing techniques, which today are commonly used for infant surgery, and first gained international recognition in 1957 when he successfully separated two female infants conjoined at the pelvis and then again in 1974 by the separation of twins conjoined at the spine; and

Whereas, During his tenure as Surgeon General, Dr. Koop issued emphatic warnings about the dangers of smoking, and almost single-handedly encouraged Washington to take a more aggressive stand against AIDS; and

Whereas, Dr. Koop began campaigning against smoking after studying the research into its link to cancer, heart disease, stroke and multiple other diseases; and

Whereas, In taking on the tobacco lobby, he also angered powerful politicians from tobacco growing states; and

Whereas, When his anti-smoking public education campaign "A Smoke-Free Society by the Year 2000" was not totally embraced by the Reagan Administration; he embarked upon a national speaking tour in 1984; and

Whereas, When Dr. Koop took office, 33% of Americans smoked, compared to 26% when he left in 1989; and

Whereas, By 1987, 40 states had restricted smoking in public places, 33 had prohibited it on public conveyances, and 17 had banned it in offices and other work sites; and

Whereas, More than 800 local anti-smoking ordinances had been passed, and the federal government had restricted smoking in 680 federal buildings; and

Whereas, During his tenure, in 1984 Congress passed legislation providing for new health warning labels on cigarette packs and also requiring advertising to include these warnings. (These labels remain unchanged today.); and

Whereas, In 1986, a report was issued which linked secondhand smoke to cancer causing disease. Over the next year, federal, state and local governments, as well as private businesses, began to restrict smoking in public and quasi-public places like restaurants and airports; and

Whereas, In his 1988 Report of the Surgeon General, he identified that nicotine has an addictiveness similar to that of heroin or cocaine; and

Whereas, Dr. Koop played a major role in educating Americans about AIDS, particularly in identifying HIV, the virus that causes the disease, and in developing a blood test to detect it; and

Whereas, As the epidemic worsened, in 1986 President Reagan asked Dr. Koop to prepare a special report, which he did even knowing that it would be unpopular with many in the administration, with conservatives in Congress and with church groups opposed to homosexuality; and

Whereas, The report concluded that the best protection against AIDS was abstinence and monogamy, and that condoms were a necessary precaution, while also advocating for sex education in schools, possibly as early as the 3rd grade; and

Whereas, When President Reagan asked Dr. Koop to study the health risks that abortion posed to women, knowing what the president and his supporters would expect, he reported back that "I regret Mr. President, that in spite of a diligent review on the part of many in the Public Health Service and in the private sector, the scientific studies do not provide conclusive data about the health effects of abortion on women." Dr. Koop's religion was central to his opposition to abortion but that never interfered with his reporting of the scientific facts; and

Whereas, Charles Everett Koop, MD passed away on February 25, 2013 at the age of 96; therefore be it

RESOLVED, That our American Medical Association expression respect for Charles Everett Koop, MD, and remember his objectivity in considering the public health aspects while discharging any political and moral elements of others, thereby elevating the visibility, importance and effectiveness of the office of the US Surgeon General.

Narinder K. Sherma, MD
Introduced by Michigan

Whereas, on November 16, 2012, a longtime member of the American Medical Association and active delegate, Doctor Narinder K. Sherma, unexpectedly passed away; and

Whereas, Doctor Sherma served as a member of the AMA House of Delegates for 10 years, diligently attending and actively participating in all the meetings in order to advocate the interests and wishes of the physicians in his state; and

Whereas, Doctor Sherma served as an AMA delegate to the OMSS on behalf of several different hospitals; and

Whereas, Doctor Sherma served as an active member on several of his state committees and as a Board Member on the Michigan State Medical Society's Board of Directors; therefore be it

RESOLVED, That our American Medical Association recognize the lifelong service of Doctor Narinder K. Sherma to his community, patients, profession and organized medicine; and be it further

RESOLVED, That our AMA convey this resolution and its deepest sympathy to the surviving family members of Doctor Narinder K. Sherma.

B. David Wilson, MD
Introduced by Michigan

Whereas, on February 10, 2013, a longtime advocate for allergy and asthma prevention and awareness, Doctor B. David Wilson, passed away; and

Whereas, Doctor Wilson devoted his life to assisting those who suffer from asthma and allergies and helping educate the caregivers by practicing as an allergist for 32 years and serving as the co-chair on the Michigan Asthma Strategic Planning Initiative Task Force; and

Whereas, Doctor Wilson served as the President of the Michigan Allergy and Asthma Society (1977-78) and the Michigan State Medical Society (1995-96) and as a member of the American Medical Association House of Delegates for 18 years; therefore be it

RESOLVED, That our American Medical Association recognize the lifelong service of Doctor B. David Wilson to his community, patients, and profession; and be it further

RESOLVED, That our AMA convey this resolution and its deepest sympathy to the surviving family members of Doctor B. David Wilson.

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Items considered on the reaffirmation calendar do not appear in the reference committee reports and were handled as part of the Committee on Rules and Credentials Supplementary Report on Sunday, June 16. The following resolutions were handled on the reaffirmation calendar: 201, 202, 213, 214, 220, 223, 224, 312, 314, 406, 407, 417, 418 and 501.

1. DISCRIMINATION AGAINST PATIENTS BY MEDICAL STUDENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-295.865

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

2. INVESTIGATING THE POSSIBILITY OF A UNIFIED LIVING DONOR KIDNEY REGISTRY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association support the study of how to develop a unified, nationwide living kidney donor registry and advocate for public and private funding of such studies to reach the long term goal of establishing a unified registry.

3. ORGAN DONATION EDUCATION IN DRIVER TRAINING PROGRAMS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: POLICY H-370.984 AMENDED BY ADDITION IN LIEU OF RESOLUTION 3

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.

4. CONFORMING BIRTH CERTIFICATE POLICIES TO CURRENT MEDICAL STANDARDS FOR TRANSGENDER PATIENTS
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-65.967

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 physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care.

5. CONFORMING BIRTH CERTIFICATE POLICIES TO CURRENT MEDICAL STANDARDS FOR TRANSGENDER PATIENTS
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

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 physician that the individual has undergone gender transition according to applicable medical standards of care; and be it further

RESOLVED That our AMA support eliminating any government requirement that an individual have undergone surgery in order to change the sex designation on birth certificates; and be it further

RESOLVED, That our AMA support that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventative care.

6. MAINTAINING PUBLIC SAFETY AND TRUST IN MEDICINE
Introduced by New York

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: POLICY H-175.992 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association address the inappropriate testimonials and dissemination of dubious or inappropriate medical information through the public media including television, radio and print media.

7. RESIDENTS' RIGHTS TO MAKE POTENTIALLY UNSAFE CHOICES IN LONG-TERM CARE
Introduced by Illinois

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: OPINION E-8.08 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support the freedom of residents in long-term care to choose potentially unsafe treatment options including the right to eat with severe dysphagia and the right to fall without restraints, after signing informed consent and waiver of liability.

8. PHYSICIANS AND PHYSICIANS-IN-TRAINING AS EXAMPLES FOR THEIR PATIENTS TO PROMOTE WELLNESS AND HEALTHY LIFESTYLES
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-405.959

RESOLVED, That our American Medical Association establish a program that recognizes physicians and physicians-in-training who model wellness and healthy lifestyles in their practice and communities or establish programs that contribute to the wellness of their patients and/or community; and be it further

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

9. RESTRICTIVE COVENANTS
Introduced by Minnesota

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association conduct an in-depth review of and update to existing AMA policy on restrictive covenants in physician contracts, which is contained in Opinion 9.02 of the Code of Medical Ethics.

101. AFFORDABLE ACCESS FOR LOW INCOME INDIVIDUALS
Introduced by Washington

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-165.848, H-165.855 AND D-165.955 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association adopt a new policy that all individuals under 400% of the Federal Poverty Level (FPL) should be eligible for refundable tax credits in order to provide premium assistance for coverage of a qualified health plan; and be it further

RESOLVED, That our AMA adopt a new policy 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%.

102. PATIENT SATISFACTION SURVEYS AND QUALITY PARAMETERS AS CRITERIA FOR PHYSICIAN PAYMENT
Introduced by Ohio

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy D-385.958

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 payment; and be it further

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

103. MANAGED CARE CONTRACT PAYMENT SHOULD BE ABOVE MEDICARE FEES
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy D-400.990

RESOLVED, That our American Medical Association seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.

104. COST-SAVING PUBLIC COVERAGE FOR RENAL TRANSPLANT PATIENTS
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-370.963

RESOLVED, That our American Medical Association support private and public mechanisms that would extend insurance coverage for evidence-based treatment of renal transplant care for the life of the transplanted organ; and be it further

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.

105. REDUCING THE COST OF PRESCRIPTION DRUGS TO LOW INCOME SENIORS
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-110.990 AND H-330.902 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association 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.

106. TRANSITIONAL REINSURANCE FEES UNDER THE AFFORDABLE CARE ACT
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy D-165.939

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, be taken from administrative and medical management costs.

107. MEDICARE'S NON-EXISTENT RELATIONSHIP TO USUAL, CUSTOMARY AND REASONABLE FEES
Introduced by New York

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy H-385.923

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.

108. VACCINES FOR CHILDREN PROGRAM AND THE NEW CPT CODES FOR IMMUNIZATION ADMINISTRATION
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-440.937

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 immunize eligible patients and to be paid fairly for their participation in the Vaccines for Children Program.

109. COMPREHENSIVE DENTAL COVERAGE (INCLUDING DENTAL IMPLANTS) FOR CHILDREN WITH OROFACIAL CLEFTING
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-185.967

RESOLVED, That our American Medical Association advocate for appropriate funding for comprehensive dental coverage (including dental implants) for children with orofacial clefting.

110. LANGUAGE AND HEARING IMPAIRED INTERPRETER SERVICES
Introduced by Illinois and Texas

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-160.924, H-285.985 AND D-385.978 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services and other public and private entities to require the payment of interpreter services by all public and private payers.

111. MEDICARE LONG-TERM CARE PRIOR HOSPITALIZATION REQUIREMENT
Introduced by Illinois

Resolution 111 was considered with Resolution 117. See Resolution 117.

RESOLVED, That our American Medical Association 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.

112. UNFAIR MEDICARE PAYMENT PRACTICE
Introduced by Florida

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association seek legislation to fairly compensate proceduacross 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.

113. MAKING MEDICARE PRICE STANDARDIZATION ACCURATE
Introduced by Iowa

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: POLICIES H-400.966, H-400.984, H-400.988 AND D-450.964 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That the American Medical Association 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.

114. ONCOFERTILITY AND FERTILITY PRESERVATION TREATMENT
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-185.990

RESOLVED, That our American Medical Association support 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; and be it further

RESOLVED, That our AMA 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.

115. MEDICATION NON-ADHERENCE AND ERRORS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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.

116. EXTENDING MEDICAID PAYMENT INCREASES TO PRIMARY CARE PHYSICIANS TO INCLUDE OBSTETRICIAN/GYNECOLOGISTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate for the extension of Medicaid reimbursement rate increases to primary care physicians to include obstetrician/gynecologists.

117. OBSERVATION STATUS AND MEDICARE PART A QUALIFICATION
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 111
See Policy D-280.988

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.

118. PAP TESTING GUIDELINES: HEDIS VERSUS USPSTF
Introduced by Michigan

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association 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.

119. PLACE OF SERVICE CODE FOR OBSERVATION SERVICES
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association conduct a study that examines 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; and be it further

RESOLVED, That our AMA consult with the American Hospital Association and other stakeholders in this study on place of service code for observation services; and be it further

RESOLVED, That based on the findings of the study our AMA and other interested stakeholders petition the Centers for Medicare & Medicaid Services to recognize a new place-of-service code for observation services.

120. PATIENT ACCESS TO ANTI-TUBERCULOSIS MEDICATIONS
Introduced by American Thoracic Society

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-440.840

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.

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
Introduced by New Mexico

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: ADOPTED
See Policy H-60.969

RESOLVED, That American Medical Association Policy H-60.969, Childhood Immunizations, be reaffirmed; and be it further

RESOLVED, That our AMA work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.

122. HEALTH INSURER CODE OF CONDUCT PRINCIPLES
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association (AMA) update the following AMA Health Insurer Code of Conduct Principles, and report back at the 2014 Annual Meeting:

1. Health Insurance Cancellation and Rescission. a. Health insurer decisions to cancel a person's coverage must be subject to independent, outside review. b. Rescission of coverage should not be permitted for innocent mistakes on applications, nor after significant delay. c. Health insurers must not cancel policies of patients who become injured or severely ill after the policy is issued. d. Paying employees or contractors bonuses or rewards for rescinding the policies of sick consumers, our patients, must be prohibited.

2. Health Insurance Premiums and Spending on Medical Services. a. Health insurers must calculate health insurance premiums fairly, and different products must be priced proportionate to their actuarial value. b. Health insurers must spend the substantial bulk of the premium dollar on direct medical care. c. Health insurer expenditures on profit and on administrative, non-medical costs (salaries and bonuses, advertising, utilization review, etc.) must be transparent to the public, based on a single standard definition and reporting mechanism. d. Clear information on covered benefits, including co-payments, co-insurance and other information affecting patient financial responsibility must be readily available to patients and their physicians. e. Consumers must receive written justification for premium quotes or renewal increases, and be provided with a fair opportunity and forum to seek redress.

3. Access to Medical Care. a. Health insurance benefits, including all medically necessary and emergency care, must be available to all enrollees on a timely and geographically accessible basis at the preferred, in-network rate. b. Provider directories must be easily accessible in paper and electronic formats and clearly and accurately provide consumers with all information relevant to fulfilling the medical needs of themselves and their families. This includes which physicians (including hospital-based physicians), hospitals, and other health care providers are in- network and accepting new patients. c. Directories which include listings for providers who are not freely accessible, such as providers who are in a restricted "tier" or "out of network," must clearly and conspicuously disclose the specific terms of any financial or other access limitations which may apply, such as increased co-payment, co-insurance or other patient financial responsibility.

4. Respectful Relations. a. Health insurers must treat all enrollees, physicians and other trading partners respectfully. b. Health insurers must protect the confidentiality of each enrollee's medical information, and must give appropriate deference to the treating physician's skill and professional judgment. c. Patients must be

confident that the physicians and other health care professionals in the network may talk freely, without fear of retaliation. d. Health insurers must cease such unfair practices with physicians as demanding unreasonable contract terms, improperly applying contractual discounts, unilaterally amending contracts or refusing to acknowledge contract terminations.

5. Medical Necessity. a. Medical care is "necessary" when a prudent physician would provide it to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (i) in accordance with generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site and duration; and (iii) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider. b. All emergency screening and treatment services (as defined by the prudent layperson standard) provided by physicians and hospitals to patients must be covered without regard to prior authorization or the treating physician's or other health care provider's contractual relationship with the payer. c. Health insurers must not use financial incentives that discourage the rendering, recommending, prescribing of, or referral for medically necessary care. d. No care may be denied on the grounds it is not "medically necessary" except by a physician qualified by education, training and expertise to evaluate the specific clinical issues. e. Patients and their physicians must have the right to a transparent appeal process and obtain a free, timely, external review of any adverse benefit decision based on "medical necessity" or a claim the service is "investigational" or "experimental."

6. Benefit Management. a. Clear information on benefit restrictions must be readily available to patients and physicians. b. Decisions based on formularies or other benefit management tools must be consistent with clinically appropriate medical guidelines, and physicians must have a simple, fast way to get exceptions when warranted by their patients' medical needs. c. Adverse changes to formularies or other benefits must not be made during the plan coverage year, and physicians who have stabilized a patient on a particular medication or other treatment regime must not be forced to change those medications or other treatments, nor should these patients be required to incur additional costs based upon such changes. d. Financial incentives must not corrupt benefit decisions, and all financial incentives potentially impacting benefit decisions must be fully disclosed.

7. Administrative Simplification. a. Health insurers must eliminate complexity and confusion from their processes and communications. b. Health insurers must comply with all laws governing the use of electronic transactions, and should participate in efforts to improve these transactions. c. Health insurers must provide clear, timely, and accurate eligibility and benefit information on request. d. Requirements imposed on patients, physicians and other health care providers to obtain approvals and respond to information requests must be minimized and streamlined, and health insurers must maintain sufficient staff and infrastructure to respond promptly.

8. Physician Profiling. a. Physician profiling systems must be focused primarily on improving the provision of quality care—not on reducing the cost of care. b. Profiling systems must use good and relevant data and produce accurate, statistically valid results reflecting matters within the physician's control. c. Profiling systems must be appropriately risk-adjusted to account for patient variation for co-morbidities, severity of illness, racial/ethnic factors, compliance and other mitigating factors. d. Physicians must be given a meaningful opportunity to review their data, challenge the insurers' profiles and be afforded due process to remedy incorrect profiles prior to their publication or use in determining incentives or network placement.

9. Corporate Integrity. a. Health insurers must conduct their business in compliance with the highest levels of corporate citizenship, consistent with their fiduciary obligations to their enrollees. b. Health insurers must comply with the letter and spirit of all laws that protect the clinical and business integrity of their dealings with their enrollees and their dealings with physicians and other health care providers. c. Policies prohibiting conflicts of interest, retaliation against whistleblowers and sharp business practices must be established and aggressively enforced. d. The corporate compliance officer must be adequately funded and staffed, and be given direct and open access to the health insurer's Board of Directors.

10. Claims Processing. a. Health insurers must pay claims accurately and timely, and provide clear and comprehensive explanations of how each claim was handled, including the specific reason for any denial of, or reduction in payment. b. All fee schedules, claim edits and payment policies which may affect payment for a service or a patient's financial responsibility must be disclosed in a reasonably understandable, downloadable format. c. Requests for refunds after payment must occur rarely, and then only within a reasonable time after

making the initial payment. d. Patients and their physicians must have a fair, fast and cost-effective right to appeal any contested claim.

201. SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM
Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-150.933, H-150.937, H-150.944, H-150.953, H-150.960, H-440.902, D-150.981, D-150.983, D-150.987 AND D-440.954 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support modifying federal guidelines for the Supplemental Nutrition Assistance Program (SNAP) to eliminate sugar-sweetened beverages and consumption of high-density caloric foods; and be it further

RESOLVED, That our AMA work actively to modify federal guidelines for SNAP so that they implement dietary education and incentivize increased consumption of fruits and vegetables.

202. INCREASING PUBLIC SERVICE OPPORTUNITIES FOR SPECIALISTS
Introduced by Medical Student Section

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-200.954, H-305.928, D-200.978, D-200.980, D-200.982, D-200.985, D-305.960, D-305.973, D-305.975, D-305.979 AND D-305.993 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association encourage the National Health Service Corps and similar loan repayment programs to expand their scope and encourage the participation of specialists in order to ensure the provision of services in underserved communities; and be it further

RESOLVED, That our AMA work with state and federal governments, medical schools, the AAMC, and other relevant entities to encourage new loan forgiveness programs for specialists treating underserved patient populations; and be it further

RESOLVED, That our AMA urge states who opt-out of the ACA expansion of Medicaid to still comply with the increased reimbursement schedule for specialists treating Medicaid patients.

203. NEEDLE EXCHANGE PROGRAMS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-95.958

RESOLVED, 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.

204. PROGRAMS TO COMBAT FOOD DESERTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-150.978

RESOLVED, 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.

205. PREVENTING PENALTIES FOR PHYSICIANS WHO PROVIDE CARE TO MILITARY PATIENTS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-478.991

RESOLVED, 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.

206. PRESERVATION OF THE PUBLIC HEALTH INFRASTRUCTURE
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-440.997

RESOLVED, 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; and be it further

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; and be it further

RESOLVED, 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.

207. PHYSICIAN EXTENDERS REIMBURSEMENT
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICIES H-330.932, H-360.988 AND D-390.971 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association immediately lobby Congress for an increase in physician payment commensurate with training, experience and responsibility; and be it further

RESOLVED, 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.

208. ALLOW PHYSICIANS TO RECEIVE DUAL USE SUPPLIES FOR IN-OFFICE BLOOD COLLECTION
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-270.955

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

209. EXTRAPOLATION BY MEDICARE RECOVERY AUDIT CONTRACTORS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-320.991

RESOLVED, 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; and be it further

RESOLVED, 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.

210. HIGH FEDERAL TAXES ON GOOD HEALTH INSURANCE PLANS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, 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.

211. CALL FOR ACTION FOR SUPPORT OF CONTINUATION OF CO-OP APPLICATIONS
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-165.882

RESOLVED, 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; and be it further

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.

212. RESTRICTING PRESCRIPTIONS TO MEDICARE BENEFICIARIES
Introduced by New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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.

213. PRESCRIBING CONTROLLED SUBSTANCES IN LONG-TERM CARE
Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-120.969, H-280.958, D-120.971 AND D-360.993 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support allowing nurses to act as physicians' agents in receiving and transcribing verbal orders for controlled substances in long-term care; and be it further

RESOLVED, That our AMA support and introduce federal legislation recommending that nurses be permitted to act as physicians' agents in receiving and transcribing verbal orders to facilitate prescribing of controlled substances in long-term care.

214. GUN CONTROL AND RESEARCH
Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-145.984, H-145.997, H-515.971, H-515.979 AND D-145.999 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support legislation removing Congressional prohibitions against the collection, analysis, and reporting of data by the Centers for Disease Control and Prevention regarding injuries and deaths associated with the use of firearms and encouraging research regarding such injuries.

215. REFORM THE US FARM BILL TO IMPROVE US PUBLIC HEALTH AND FOOD SUSTAINABILITY
Introduced by Minnesota

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-150.932

RESOLVED, That our American Medical Association 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.

216. RECOGNIZING THE DIVERSITY OF PRACTICE MODELS IN THE TRANSITION FROM THE SGR TO A HIGHER PERFORMING MEDICARE PROGRAM
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 216, 217, 232 AND 239
See Policy H-390.844

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; 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; and be it further

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

217. AMA HOD SUPPORT OF THE PHYSICIAN-LED, MULTI-SPECIALTY, INTEGRATED ACCOUNTABLE PRACTICE MODEL AS A MEANS OF REPLACING THE SGR
Introduced by American Medical Group Association

Resolution 217 was considered with Resolution 216. See Resolution 216.

RESOLVED, 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; and be it further

RESOLVED, 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.

218. AMA RESPONSE TO PHARMACY INTRUSION INTO MEDICAL PRACTICE
Introduced by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy D-35.981

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

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 and be it further;

RESOLVED, That if the inappropriate pharmacist prescription verification requirements and inquiry issues are not resolved promptly, our AMA will advocate for legislative and regulatory solutions to prohibit pharmacies and pharmacists from denying medically necessary and legitimate therapeutic treatments to patients.

219. DISCRIMINATION AGAINST DIABETIC TRUCK DRIVERS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association actively pursue striking Federal Law Item 3, Code Section 391.41 from the current DOT laws; and be it further

RESOLVED, That our AMA inform appropriate state authorities of this national change when accomplished in order to ensure state policy changes consistent with this resolution.

220. FIREARM SAFETY
Introduced by Wisconsin

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-145.976, H-145.978, H-145.984, H-145.988, H-145.990, H-145.997, H-515.971, H-515.979 AND D-145.999 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support legislation which would remove Congressional prohibitions against the collection, analysis, and reporting of data by the Centers for Disease Control and Prevention regarding injuries and deaths associated with the use of firearms, and which would encourage the CDC to engage in such research regarding such injuries; and be it further

RESOLVED, That our AMA encourage physicians to access the most accurate and timely data available regarding firearm safety and use that information to educate and counsel their patients about firearm safety; and be it further

RESOLVED, That our AMA support federal legislation that would affirm the rights of physicians to have free and open communication with their patients regarding matters of firearm safety and the use of gun locks in their homes; and be it further

RESOLVED, That our AMA encourage and applaud state, county and specialty medical societies, the charitable foundations associated with those medical societies, and the AMA Alliance and its state and local chapters, when they undertake projects to educate physicians and patients about the use of gun locks and locks on gun cases and projects to facilitate the low-cost distribution of gun locks for use in our nation's homes to minimize the risk of firearm injuries and deaths, especially to children; and be it further

RESOLVED, That our AMA encourage and applaud physicians who are sportsmen and sportswomen to become involved in local firearm safety classes for the general public and to proclaim in such settings that they are physicians so that the public will know of the interest of physicians in such educational activities as a means of promoting injury prevention and the public health.

221. FIREARM SAFETY AND RESEARCH, REDUCTION IN FIREARM VIOLENCE, AND ENHANCING ACCESS TO MENTAL HEALTH CARE
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 221 AND 222
See Policy H-145.975

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 US 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.

222. NATIONAL VIOLENT DEATH REPORTING SYSTEM
Introduced by American College of Preventive Medicine

Resolution 222 was considered with Resolution 221. See Resolution 221.

RESOLVED, 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.

223. PROMOTE MDS AND DOS TO USE PHYSICIAN AND SURGEON DESIGNATIONS
Introduced by Pennsylvania

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-330.992, H-405.969 AND H-405.976 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association promote MDs and DOs to use physician and surgeon to distinguish our professional designation and maintain a clear distinction.

224. REDUCTION OF GUN VIOLENCE
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-145.984, H-145.997, H-515.971, H-515.979 AND D-145.999 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association support federal and state evidence-based research on firearm injury and the use of state/national firearms injury databases including the National Violent Death Reporting System to inform state/federal health policy.

225. REGULATORY MODERNIZATION
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-270.954

RESOLVED, 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.

226. SUBMITTING RECOMMENDATIONS TO MEDICARE
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-330.887

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services and seek federal legislation, if necessary, to provide that the Center for Medicare and Medicaid Innovation Center

website accept suggestions from physicians to improve health care and/or reduce costs, acknowledge submission by receipt, and 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 and encouraged to participate in further developing the idea if they wish to remain involved.

227. THE FUTURE OF GENITO-URINARY TREATMENT AND RESEARCH
Introduced by American Urological Association, American Association of Clinical Urologists and American Congress of Obstetricians and Gynecologists

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-520.986

RESOLVED, That our American Medical Association 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 mental health care; and be it further

RESOLVED, 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.

228. THE SAFE ACT
Introduced by Charles Rothberg, Delegate, New York

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-190.973

RESOLVED, 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.

229. REQUIRE PHYSICIAN RAC REVIEW AND APPROVAL
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-320.991

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 audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians; and be it further

RESOLVED, That our AMA seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making; and be it further

RESOLVED, That our AMA seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered; and be it further

RESOLVED, That our AMA seek the enactment of fines, 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.

230. RIGHTS OF MEDICARE BENEFICIARIES TO RECEIVE COVERED SERVICES
Introduced by Louisiana

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: REFERRED

RESOLVED, 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; and be it further

RESOLVED, 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.

231. REDEFINING AMA's POSITION ON ACA AND HEALTHCARE REFORM
Introduced by Florida

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-165.938

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 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;
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; and be it further

RESOLVED, That there be a report back at each meeting of the AMA HOD.

232. FEE-FOR-SERVICE
Introduced by Kansas

Resolution 232 was considered with Resolution 216. See Resolution 216.

RESOLVED, That our American Medical Association advocate that physicians should be free to choose the 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); and be it further

RESOLVED, 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; and be it further

RESOLVED, That our AMA work with Congress, CMS, payors and the profession to preserve the fee-for-service payment methodology in public and private insurance programs.

233. STRONG OPPOSITION TO CUTS IN FEDERAL FUNDING FOR THE INDIAN HEALTH SERVICE
Introduced by New Mexico

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policies H-350.976 and H-350.977 and D-350.987

RESOLVED, That American Medical Association Policies H-350.977, Indian Health Service, and H-350.976, Improving Health Care of American Indians, be reaffirmed; and be it further

RESOLVED, 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; and be it further

RESOLVED, That our AMA ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service; and be it further

RESOLVED, 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; and be it further

RESOLVED, 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.

234. FLEXIBILITY IN MEDICARE OPT-OUT AND NEW SAFE HARBOR
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-390.955

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; and be it further

RESOLVED, 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.

235. EXEMPT PHYSICIAN-ADMINISTERED DRUGS FROM MEDICARE SEQUESTRATION
Introduced by American Academy of Neurology, American Association of Clinical Urologists, American College of Gastroenterology, American College of Rheumatology, American Gastroenterological Association and American Society of Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy H-330.888

RESOLVED, 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.

236. ACTION TO ELIMINATE IMPLEMENTATION OF ICD-10
Introduced by American College of Rheumatology

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-70.952

RESOLVED, 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 be it further

RESOLVED, 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; and be it further

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.

237. TRANSPARENCY OF OUR AMERICAN MEDICAL ASSOCIATION'S POLICY CONCERNING THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: POLICY D-165.940 AMENDED BY ADDITION IN LIEU OF RESOLUTION 237

Policy D-165.940 amended by addition to read as follows:

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, coverage and physician-practice impacts of the law, and report back to the House of Delegates at the 2013 Interim Meeting.

238. ELIGIBILITY OF SUGAR-SWEETENED BEVERAGES FOR SNAP
Introduced by Texas

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-150.975

RESOLVED, 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; and be it further

RESOLVED, That our AMA encourage state health agencies to include educational materials about nutrition and healthy 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; and be it further

RESOLVED, That our AMA work to remove SSBs from SNAP.

239. RECOGNIZING THE DIVERSITY OF PRACTICE MODES IN THE TRANSITION FROM THE SGR TO A HIGHER PERFORMING MEDICARE PROGRAM
Introduced by Integrated Physician Practice Section

Resolution 239 was considered with Resolution 216. See Resolution 216.

RESOLVED, 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.

240. AMA SUPPORT FOR STATES IN THEIR DEVELOPMENT OF LEGISLATION TO SUPPORT PHYSICIAN-LED, TEAM BASED CARE
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOUSE ACTION: ADOPTED
See Policy D-35.982

RESOLVED, That our American Medical Association continue to assist states in opposing legislation that would allow for the independent practice of certified registered nurse practitioners; and be it further

RESOLVED, 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 be it further

RESOLVED, That our AMA actively oppose health care teams that are not physician-led.

301. SYSTEMS-BASED PRACTICE EDUCATION FOR MEDICAL STUDENTS AND RESIDENT/FELLOW PHYSICIANS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 301, 303 AND 313
See Policy H-295.864

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; 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; 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.

302. COLLABORATIVE EFFORTS TO REDUCE FEDERAL LOAN INTEREST RATES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-305.984

RESOLVED, That our American Medical Association work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program.

303. INSURANCE EDUCATION FOR MEDICAL STUDENTS
Introduced by Medical Student Section

Resolution 303 was considered with Resolution 301. See Resolution 301.

RESOLVED, That our American Medical Association 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 educational 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.

304. RETAINING PUBLIC SERVICE LOAN FORGIVENESS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-305.928

RESOLVED, That our AMA support the expansion and increase of medical student and physician benefits under Public Service Loan Forgiveness.

305. STUDY ON DECERTIFICATION OF PHYSICIANS PRACTICING WITH A LIMITED LICENSE
Introduced by Washington

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy H-275.978

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

306. EVALUATING THE EFFECT OF ACGME RESIDENT WORK HOURS REFORM
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-310.955

RESOLVED, That our American Medical Association recommend that the Accreditation Council for Graduate Medical Education use, where possible, recommendations from respective specialty societies, and evidence-based approaches to any future revision or introduction of resident duty hour rules.

307. SUPPORT FOR RESIDENTS AND FELLOWS DURING FAMILY AND MEDICAL LEAVE TIME
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-310.908

RESOLVED, That our American Medical Association encourage specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible.

308. BOARD CERTIFICATION / MAINTENANCE OF CERTIFICATION
Introduced by International College of Surgeons

Resolution 308 considered with Council on Medical Education Report 4.
See Council on Medical Education Report 4.

RESOLVED, That our American Medical Association oppose mandatory specialty board recertification by examination; and be it further

RESOLVED, That our AMA recommend that recertification by examination not be a requirement for hospital credentialing.

309. MAINTENANCE OF CERTIFICATION AND LICENSURE VERSUS BOARD CERTIFICATION, CONTINUING MEDICAL EDUCATION AND LIFELONG COMMITMENT TO LEARNING
Introduced by Oklahoma

Resolution 309 considered with Council on Medical Education Report 4.
See Council on Medical Education Report 4.

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA 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 re-certification programs labeled as “voluntary” by the specialty medical boards; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA 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.

310. MEDICAL FACILITY REGULATIONS FOR STUDENTS SHADOWING PHYSICIANS
Introduced by Georgia

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association develop standard criteria for students to shadow physicians in medical facilities.

311. TRANSPARENCY AND ACCOUNTABILITY FOR SPECIALTY BOARDS AND MAINTENANCE OF CERTIFICATION
Introduced by New York

Resolution 311 considered with Council on Medical Education Report 4.
See Council on Medical Education Report 4.

RESOLVED, That our American Medical Association call on the American Board of Medical Specialties (ABMS) and its component specialty boards to increase their transparency and accountability to the physician community; and be it further

RESOLVED, That our AMA call upon the ABMS and its specialty boards to publish detailed reports of revenues and expenses, including compensation to board members and senior staff; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA 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.

312. BASIC LIFE SUPPORT KNOWLEDGE AND SKILLS FOR PHYSICIANS
Introduced by Illinois

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-300.999 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association adopt policy encouraging all physicians to gain basic life support skills through completion of basic life support (BLS) training courses.

313. ADVOCACY TRAINING IN MEDICAL SCHOOLS
Introduced by Michigan

Resolution 313 was considered with Resolution 301. See Resolution 301.

RESOLVED, That our American Medical Association 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.

314. MAINTAINING OPHTHALMOLOGY RESIDENCY POSITIONS
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-200.955, H-305.929, D-305.958 AND D-305.967 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with federal, private, and non-private sources to ensure that adequate opportunities for post graduate ophthalmology training exist to meet the increasing patient demand for ophthalmology services in the United States.

315. OPPOSITION TO MANDATORY MAINTENANCE OF CERTIFICATION
Introduced by New York

Resolution 315 considered with Council on Medical Education Report 4.
See Council on Medical Education Report 4.

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA acknowledge and affirm the professionalism of individual physicians to self-determine the best means and methods for maintenance of their knowledge and skills; and be it further

RESOLVED, That our AMA oppose mandating MOC until such time as evidence- based research demonstrates MOC is linked to improved patient outcomes.

316. THE AVAILABILITY OF CME AT COMMUNITY HOSPITALS
Introduced by Pennsylvania

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-300.983

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

317. TRAINING IN REPRODUCTIVE HEALTH TOPICS AS A REQUIREMENT FOR ACCREDITATION OF FAMILY RESIDENCIES
Introduced by Massachusetts

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-310.954

RESOLVED That our American Medical Association 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; and be it further

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.

318. SEEKING CONTINUING MEDICAL EDUCATION CREDITS FOR MEDICAL RESERVE CORPS TRAINING
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association encourage the Medical Reserve Corps to apply for recognition by the ACCME as an accredited provider of CME; and be it further

RESOLVED, That our AMA encourage careful consideration by the Accreditation Council for Continuing Medical Education of any application presented to it by the Medical Reserve Corps.

319. MAINTENANCE OF CERTIFICATION - PART IV AND OSTEOPATHIC CONTINUOUS CERTIFICATION - COMPONENT 4
Introduced by Young Physicians Section

Resolution 319 considered with Council on Medical Education Report 4.
See Council on Medical Education Report 4.

RESOLVED, That our American Medical Association work with specialty societies, American Board of Medical Specialties (ABMS), and the American Osteopathic Association (AOA) to create, streamline, and integrate activities that satisfy Part IV / Component 4 of maintenance of certification within existing processes already undertaken by physicians; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our 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.

320. SUPPORT FOR QUALITY IN GRADUATE MEDICAL EDUCATION
Introduced by Section on Medical Schools

Reference committee hearing: see report of Reference Committee C.

HOUSE ACTION: ADOPTED
See Policy D-305.967

RESOLVED, That our American Medical Association collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.

401. TORNADO AND STORM SAFETY
Introduced by Indiana

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, 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.

402. CLARIFYING AMA TOBACCO POLICIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policies H-490.914, H-495.988, and H-495.989

RESOLVED, That our American Medical Association revise policies H-495.989, 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.

403. PERMITTING SUNSCREEN IN SCHOOLS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-440.841

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.

404. POVERTY SCREENING AS A CLINICAL TOOL FOR IMPROVING HEALTH OUTCOMES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-160.909

RESOLVED, That our AMA encourage screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.

405. THE HEALTH RISKS OF HYDRAULIC FRACTURING
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-135.931

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

406. ACCEPTANCE OF ENTERTAINMENT TRAUMA
Introduced by International College of Surgeons

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-485.995 AND H-515.974 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work to develop new guidelines and restrictions concerning the production and distribution of TV, radio and movie programs depicting extreme violence, trauma and death; and be it further

RESOLVED, That our AMA work with the appropriate entertainment groups to restrict and reduce the widespread presentation of TV, radio and movie programs depicting extreme violence, trauma and death.

407. TOBACCO HARM REDUCTION
Introduced by American Association of Public Health Physicians

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES H-495.985 AND H-495.988 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association study the Tobacco Harm Reduction-related topics listed below, with a report back at the 2014 Annual Meeting:

1. Does the available scientific literature confirm that the smoke-free products on the American market pose a risk of tobacco-attributable mortality below that of cigarettes, and, if so, by how much?

2. What does the literature show concerning the risk of mouth cancer posed by smoke-free tobacco products, compared to mouth cancer risk among cigarette smokers and in non-users of tobacco products?

408. ENHANCED EDUCATION FOR ABRUPT CESSATION OF SMOKING
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-490.906

RESOLVED, That our American Medical Association encourage research and evaluation on promising smoking cessation protocols that promote abrupt cessation of smoking without reliance on pharmaceuticals.

409. BANNING MARKETING AND SALE OF HIGH-ENERGY/STIMULANT DRINKS TO CHILDREN/ADOLESCENTS UNDER THE AGE OF 18
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-150.976

RESOLVED, That our American Medical Association support a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18.

410. PHYSICIANS AND THE PUBLIC HEALTH ISSUES OF GUN SAFETY
Introduced by New York

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-145.997

RESOLVED, That our American Medical Association request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

411. CHEERLEADING AS A SPORT
Introduced by Illinois

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association support the designation of cheerleading as a sport; and be it further

RESOLVED, That our AMA support requiring cheerleading coaches to undergo training on reducing risk associated with potentially dangerous cheerleading activities.

[Note: The following proposed substitute resolution was also referred.]

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.

412. STRATEGIES TO INCREASE DIABETES AWARENESS
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy D-440.935

RESOLVED, That our American Medical Association organize a series of activities for the public in collaboration with health care workers and community organizations to bring awareness to the severity of diabetes and measures to decrease its incidence.

413. HEALTH RISKS OF SITTING
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-440.843

RESOLVED, 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.

414. MONITORING FOR RADIATION IN SEAFOOD
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy D-135.975

RESOLVED, That our American Medical Association call for the United States government to continue to monitor and fully report the radioactivity levels of edible ocean species sold in the United States.

415. PREVENTION OF FALLS THROUGH WINDOWS
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy H-60.926

RESOLVED, That our American Medical Association support the use of window guards and devices that prevent children from falling through windows; and be it further

RESOLVED, That our AMA support public education regarding the risks of children falling through windows.

416. PUBLIC EDUCATION ON DISTRACTED DRIVING
Introduced by California

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-15.952

RESOLVED, That our American Medical Association support public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road.

417. REAFFIRM SUPPORT OF THE CLEAN AIR ACT
Introduced by Michigan

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-135.984 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association reaffirm support of the Clean Air Act.

418. PROPER PEDIATRIC RESTRAINTS AVAILABLE ON AIRLINE TRANSPORTATION
Introduced by Pennsylvania

Considered on reaffirmation calendar.

HOUSE ACTION: POLICY H-45.989 REAFFIRMED
IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association lobby the appropriate authorities to have five-point restraints available on passenger airplanes for children over the age of two, who are under four feet tall and 80 pounds.

419. CELIAC DISEASE SCREENING
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy H-425.971

RESOLVED, That our American Medical Association recognize undiagnosed celiac disease as a public health problem; and be it further

RESOLVED, That our AMA support the formal establishment of evidence-based celiac disease screening recommendations and high-risk population definitions for general and pediatric populations by appropriate stakeholders.

420. RECOGNITION OF OBESITY AS A DISEASE
Introduced by American Association of Clinical Endocrinologists, American College of Cardiology, The Endocrine Society, American Society for Reproductive Medicine, Society for Cardiovascular Angiography and Interventions, American Urological Association, American College of Surgeons, American College of Gastroenterology, American Society of Anesthesiologists, Connecticut and Texas

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: ADOPTED
See Policy H-440.842

RESOLVED, That our American Medical Association recognize obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

Resolution 421 moved to Reference Committee B. See Resolution 238.

422. ADOLESCENT PREGNANCY AND NON-GRADUATION FROM HIGH SCHOOL
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-60.973

RESOLVED, That our American Medical Association actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school.

423. ADDRESSING VIOLENCE PREVENTION
Introduced by Minority Affairs Section

Reference committee hearing: see report of Reference Committee D.

HOUSE ACTION: POLICIES H-515.966 AND H-515.982 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association 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 be it further

RESOLVED, That our AMA 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.

501. RADIATION EXPOSURE REGISTRY
Introduced by Indiana

Considered on reaffirmation calendar.

HOUSE ACTION: POLICIES D-455.998 AND D-455.999 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association: 1) study the value and practicality of a national radiation exposure registry and that this study be performed in cooperation with appropriate radiological societies and colleges; 2) promote the use of "reduced-radiation" techniques in all X-ray facilities and departments; and 3) promote the most judicious use of imaging possible.

502. ACCOUNTING FOR SOCIOECONOMIC STATUS IN CLINICAL AND PUBLIC HEALTH RESEARCH
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-460.980

RESOLVED, That our American Medical Association encourage study of the inclusion of Socioeconomic Status (SES) data in clinical and public health research identify appropriate minimum standards for the inclusion of such data in research studies.

503. SUPPORT FOR MEDICAID REIMBURSEMENT OF NEONATAL MALE CIRCUMCISION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy H-60.945

RESOLVED, That our American Medical Association encourage state Medicaid reimbursement of neonatal male circumcision; and be it further

RESOLVED, That our AMA 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.

504. SKIN CANCER SURVEILLANCE THROUGH LAY PROFESSIONAL EDUCATION
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-55.980

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.

505. MEDICAL EXEMPTIONS FROM VACCINES
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED
See Policy D-440.947

RESOLVED, 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.

506. IMMUNIZATION EXEMPTIONS
Introduced by Illinois

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
WITH CHANGE IN TITLE
See Policy D-440.936

RESOLVED, That our American Medical Association review and address existing inconsistencies in its policies regarding immunization exemptions.

507. OVER-THE-COUNTER ACCESS TO ORAL CONTRACEPTIVES
Introduced by American College of Obstetricians and Gynecologists

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-75.995

RESOLVED, That our American Medical Association recommend to the US 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; and be it further

RESOLVED, That our AMA encourage the continued study of issues relevant to over-the-counter access for oral contraceptives.

508. TO ADDRESS NATIONAL SHORTAGES OF ANTI-TUBERCULOSIS MEDICATIONS
Introduced by American Thoracic Society

Resolution 508 considered with Council on Science and Public Health Report 8.
See Council on Science and Public Health Report 8.

RESOLVED, 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 structuthat 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.

509. INCREASE AWARENESS OF HAPTENATION AND HYPERSENSITIVITY DISORDERS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, 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 exposuto toxins and symptoms related to known toxins and testing.

510. ADDRESSING DRUG SHORTAGES
Introduced by Michigan

Resolution 510 considered with Council on Science and Public Health Report 8.
See Council on Science and Public Health Report 8.

RESOLVED, That our American Medical Association educate its members and the public about the economic and health aspects of drug shortages via material on the web; and be it further

RESOLVED, That our AMA compile and make available examples of "failure to supply" contractual provisions; and be it further

RESOLVED, That our AMA 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; and be it further

RESOLVED, That our AMA 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 be it further

RESOLVED, That our AMA 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.

511. GENETIC INFORMATION NON-DISCRIMINATION IN INSURANCE COVERAGE
Introduced by Michigan

Resolution 511 considered with Council on Science and Public Health Report 7.
See Council on Science and Public Health Report 7.

RESOLVED, 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.

512. CANNABIS DECRIMINALIZATION, REGULATION AND TAXATION
Introduced by California

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED

RESOLVED, 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.

513. MEDICATION COLLECTION "TAKE BACK" PROGRAMS
Introduced by California

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, 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.

514. BLOOD DONOR DEFERRAL CRITERIA
Introduced by California

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-50.973

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; 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.

515. TARGETED TUBERCULOSIS TESTING OF SCHOOL CHILDREN
Introduced by California

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-440.966

RESOLVED, That our American Medical Association support use of a tuberculosis (TB) risk assessment questionnaire in US school aged children when appropriate, with follow-up TB testing based on the results of that TB risk assessment.

516. EARLY TREATMENT AND PARTNER SERVICES FOR HIV
Introduced by California

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-20.922

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.

517. DECLINING AVAILABILITY OF INEXPENSIVE GENERIC MEDICATIONS
Introduced by Iowa

Resolution 517 considered with Council on Science and Public Health Report 8.
See Council on Science and Public Health Report 8.

RESOLVED, 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.

518. FDA RECOMMENDATION ON SCHEDULING OF HYDROCODONE COMBINATION PRODUCTS
Introduced by American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-120.948

RESOLVED, That our AMA issue a public statement to the US Food and Drug Administration, urging the FDA to maintain hydrocodone combination products as Schedule III of the Controlled Substances Act.

519. GENOME ANALYSIS AND VARIANT IDENTIFICATION
Introduced by College of American Pathologists and
American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-460.971

RESOLVED, That our American Medical Association encourage payers, regulators and providers to make clinical variant data and their interpretation publicly available through a system that assures patient and provider privacy protection; 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.

520. UPDATING AMA POLICY ON BIOSIMILARS
Introduced by American Academy of Neurology and American College of Rheumatology

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-125.988

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.

Resolution 521 was withdrawn.

522. THE NEXT TRANSFORMATIVE PROJECT: IN SUPPORT OF THE BRAIN INITIATIVE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee E.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-460.904

RESOLVED, That our American Medical Association 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; 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 initiative.

601. ADVANCED DIRECTIVES COUNSELING AND PHYSICIAN BILLING FOR INVOLVED SERVICES
Introduced by Illinois

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association 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.

602. MOCK RESIDENCY INTERVIEW PROGRAM
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED
See Policy H-255.967

RESOLVED, That our American Medical Association promote the AMA-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 be it further

RESOLVED, That our AMA promote the AMA-IMG Section's Mock Residency Interview Program as one of the benefits of AMA membership.

603. POTENTIAL CONFLICTS OF DATES IF THE AMA INTERIM MEETINGS ARE COMBINED WITH THE NATIONAL ADVOCACY CONFERENCE AND NATIONAL SPECIALTY ANNUAL MEETINGS
Introduced by New Jersey, Nevada, California and American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association conduct a survey to ascertain the dates of the future national specialty meetings; and be it further

RESOLVED, That our AMA make every effort to avoid future conflicting dates.

604. CONFLICT IN DATES BETWEEN AMA INTERIM MEETINGS AND SPECIALTY ANNUAL MEETINGS
Introduced by New Jersey, Nevada, California and American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association conduct another survey to ascertain the future conflicts of the Interim Meeting and specialty societies' annual meetings; and be it further

RESOLVED, That our AMA make every effort to avoid future conflicting dates.

605. REVISION OF THE AMA CURRENT PROCEDURAL TERMINOLOGY TO REFLECT EHR-EMR DOCUMENTATION AND WORK PROCESSES
Introduced by New York

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association 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; and be it further

RESOLVED, That our AMA request 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.

606. AMA TO DEVELOP CONFLICT OF INTEREST DISCLOSURE FOR CANDIDATES
Introduced by Florida

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That the American Medical Association 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 for review; and be it further

RESOLVED, That our AMA ensure that the members of the AMA House of Delegates have access to the conflict of interest declaration forms of all candidates and all elected and appointed individuals.

Resolution 607 was withdrawn.

608. PRESIDENTIAL MEDAL OF FREEDOM
Introduced by Maryland

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED FOR DECISION

RESOLVED, That our American Medical Association write a letter of support to President Obama on behalf of Dr. R Adams Cowley to posthumously receive the Presidential Medal of Freedom.

609. REAL PRIMARY PREVENTION AS A NEW FACE OF OUR AMA
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy G-625.020

RESOLVED, That our American Medical Association 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.

610. FAIR ACCESS TO SCIENCE AND TECHNOLOGY RESEARCH ACT FOR IMPROVED ACCESS TO MEDICAL RESEARCH
Introduced by Texas

Reference committee hearing: see report of Reference Committee F.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association urge its members and physicians across the country to support initiatives about open access to research literature.

701. IMPLEMENTATION AND FUNDING OF CHILDCARE SERVICES FOR PATIENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: NOT ADOPTED

RESOLVED, That our American Medical Association encourage primary care and emergency department settings, where feasible, to offer inexpensive or free childcare services to patients.

702. PATIENT PROTECTION AND THE AFFORDABLE CARE ACT, ACCOUNTABLE CARE ORGANIZATIONS, PUBLIC HEALTH AND ORGANIZED MEDICINE
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED IN LIEU OF RESOLUTION 703
See Policy D-385.963

RESOLVED, That our American Medical Association recommend that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available; and be it further

RESOLVED, That our AMA recommend that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health; and be it further

RESOLVED, That our AMA 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.

703. POPULATION BASED PRACTICES IN ACCOUNTABLE CARE ORGANIZATIONS
Introduced by American Association of Public Health Physicians

Considered with Resolution 702. See Resolution 702.

RESOLVED, That our American Medical Association recommend that Accountable Care Organization (ACO) developers be physicians with the skills to:

1. develop a population-based strategy to assess health risks, prevent disease and disability, and create policy to improve the ACO community health status;
2. define methods to measure community health status, clinical quality improvement, patient and provider satisfaction; and a regular reporting system for these data to be shared with patients, providers and system managers;
3. develop connections between the ACO and the appropriate local and state public health organizations to assure that communicable and environmentally induced health problems are managed by appropriately trained professionals within the ACO, in concert with appropriate health department professionals; and be it further

RESOLVED, That our AMA encourage that clinical and community ACO quality data become part of the information provided to all purchasers of health insurance during the annual State Health Insurance Exchange program in every state along with the health benefit package provided by each insurance company.

704. GUIDELINES FOR MOBILE MEDICAL APPLICATIONS AND DEVICES
Introduced by Ohio

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-480.975

RESOLVED, That our American Medical Association 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.

705. ENHANCING ACCOMMODATIONS FOR PEOPLE WITH DISABILITIES
Introduced by American Academy of Physical Medicine and Rehabilitation, American College of Rheumatology and American Academy of Pediatrics and American Association of Neuromuscular and Electrodiagnostic Medicine

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-90.971

RESOLVED, That our American Medical Association encourage physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

706. GOVERNMENT INTERFERENCE IN THE PRACTICE OF MEDICINE
Introduced by American College of Physicians and Wisconsin

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-270.959

RESOLVED, That our American Medical Association endorse the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:

1. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
2. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
3. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
4. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

707. PEDIATRIC MEDICAL ORDERS BETWEEN STATES
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association advocate so that board certified physicians currently licensed and registered to practice medicine in any of the United States can duly execute conventional medical orders for their patients who are moving out of their state and into another state for use in any of the United States for a transitional period of no more than sixty days to allow a child with special health care needs to attend early child care, daycare, nursery, preschool, and school safely in their new location while the family secures a new medical home, health insurance, and, when indicated, sub-specialty care.

708. MENTAL HEALTH SERVICES FOR SCHOOL-AGED CHILDREN
Introduced by American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

Resolved, That our American Medical Association work with child psychiatrists, primary care physicians, the public schools, multiple groups of mental health professionals, and other organizations to develop school-based programs that assure at-risk children/adolescents access to appropriate mental health screening and treatment services.

709. IMPROVING ACCESS TO PHYSICIANS WITH THE SPECIAL SKILLS REQUIRED IN GERIATRIC CARE
Introduced by American Medical Directors Association

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-25.999

RESOLVED, That our American Medical Association 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.

710. THIRD-PARTY PAYER POLICIES ON OPIOID USE DISORDER PHARMACOTHERAPY
Introduced by American Society of Addiction Medicine

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-95.944

RESOLVED, That our American Medical Association oppose federal, state, third-party and other laws, policies, rules and procedures, including those imposed by Pharmacy Benefit Managers working for Medicaid, Medicare, TriCare, and commercial health plans, that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care.

711. DEVELOPMENT OF MODELS/GUIDELINES FOR MEDICAL TEAMS
Introduced by Maryland

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-160.935

RESOLVED, that our American Medical Association study and report back on the definition of leadership in physician-led medical teams; and be it further

RESOLVED, That our AMA propose acceptable models that value the expertise of the physician and models that could be used by medical teams that address specific issues such as patient safety, the nature of physician authority within the teams and the ethical and legal issues of the team model.

712. PATIENT ACCESS TO INDEPENDENT APPEAL AND GRIEVANCE PROCEDURES
Introduced by Maryland

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-320.952

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…

713. VALUE OF GROUP MEDICAL APPOINTMENTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-160.911

RESOLVED, That our American Medical Association promote education about the potential value of group medical appointments for diagnoses that might benefit from such appointments including chronic diseases, pain, and pregnancy.

714. MANDATING E-PRESCRIBING
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-120.958

RESOLVED, That our American Medical Association work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.

715. UTILIZATION OF EMR AND THE PRACTICE OF "CUTTING AND PASTING" OR CLONING
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy D-175.985

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; 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.

716. CRIMINALIZATION OF GOOD FAITH ERRORS
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-160.954

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, do~~es~~ 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.

717. GOVERNMENT INTERFERENCE IN THE PATIENT-PHYSICIAN RELATIONSHIP
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-373.995

RESOLVED, That our American Medical Association 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 be it further RESOLVED, That our AMA educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient- physician relationship or what occurs during the patient-physician encounter:

1. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
2. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
3. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
4. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?

5. Is the proposed law or regulation required to achieve a public policy goal – such as protecting public health or encouraging access to needed medical care – without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
6. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
7. Is there a process for appeal to accommodate individual patients' circumstances?

718. HEALTH LITERACY IN HEALTHCARE INSTITUTIONS
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-160.931

RESOLVED, That the 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; and be it further

RESOLVED, That the AMA 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; and be it further

RESOLVED, That the AMA encourage the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.

719. PRESCRIPTION MANAGEMENT - CHANGING THE RENEWAL LENGTH TO IMPROVE PRACTICE EFFICIENCY AND QUALITY OF CARE
Introduced by Wisconsin

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED
See Policy H-120.952

RESOLVED, That Policy H-120.952 be amended by addition to read as follows:

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.

720. STANDARDS FOR ELECTRONIC MEDICAL RECORDS
Introduced by Mississippi

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-478.995

RESOLVED, That our American Medical Association request that the Centers for Medicare & Medicaid Services (CMS) 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

RESOLVED, That our AMA request that CMS develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

721. PROMOTING ELECTRONIC HEALTH RECORD CONNECTIVITY
Introduced by New York

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 721 AND 723
See Policy D-478.995

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; and be it further

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.

722. ON-CALL COVERAGE MODELS
Introduced by Iowa

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS WITH CHANGE IN TITLE
See Policy D-130.965

RESOLVED, That the American Medical Association compile and make available to the physician community various examples of on-call solutions intended to avoid subjecting physicians to unrealistic and unduly burdensome on-call demands, and educate AMA physician members regarding these options.

723. BARRIERS TO ELECTRONIC HEALTH RECORD CONNECTIVITY
Introduced by Michigan

Considered with Resolution 721. See Resolution 721.

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services to compel and /or incentivize health systems to work with physician practices to achieve interconnectivity of electronic health records through interfaces.

724. DEFECTIVE ELECTRONIC HEALTH RECORDS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICIES H-480.971, D-478.995 AND D-478.996 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association work with the Centers for Medicare & Medicaid Services or seek federal legislation so that physicians can improve patient care and possibly reduce costs by requiring the Office of Inspector General, US Department of Health and Human Services, 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 offer: 1) user friendly functions to facilitate, not hinder, the work of clinicians and health care workers; 2) modular architectures with interfaces that allow extension of product capabilities; 3) innovative use of data, bundled, best-of-breed, interoperable, substitutable technologies that can be optimized for use in health care improvement; 4) transferable or readily retrievable health data stored in other health information technology systems worldwide, subject to patient consent; 5) user interfaces similar enough that a clinician working in one health system can intuitively discern how to use another without extensive retraining; 6) the ability to perform all HHS requirements for efficient patient care, payment for meaningful use, encryption and other safeguards to meet HIPAA standards, and prevention of medical record breaches; 7) protections to physicians from meaningful use and electronic breach penalties that occur as a result of technical failures; and 8) an information backbone for accountable care, patient safety, and health care reform.

725. ELECTRONIC HEALTH RECORD PENALTIES: TAXATION WITHOUT REPRESENTATION?
Introduced by Michigan

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICY H-478.991 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association 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.

726. PHYSICIAN PARTICIPATION IN MULTIPLE MEDICARE ACCOUNTABLE CARE ORGANIZATIONS
Introduced by American Medical Directors Association

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: FOLLOWING SUBSTITUTE RESOLUTION ADOPTED IN LIEU OF RESOLUTIONS 726 AND 733
See Policy D-160.934

RESOLVED, That our American Medical Association 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.

727. ALIGN THE RECOGNITION PERIODS FOR THE BRIDGES TO EXCELLENCE AND THE NATIONAL COMMITTEE ON QUALITY ASSURANCE RECOGNITION PROGRAMS
Introduced by Texas

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy D-450.963

RESOLVED, That our American Medical Association 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.

728. DATA TRANSITION COSTS WHEN SWITCHING ELECTRONIC MEDICAL RECORDS
Introduced by Texas

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: REFERRED

RESOLVED, That our American Medical Association work with the Office of the National Coordinator for Health Information Technology (ONC) and other interested parties to make EMR-to-EMR medical record data transition capabilities a requirement of ONC's EMR product certification; and be it further

RESOLVED, That if the ONC is unwilling or unable to make EMR medical record data transition a certification requirement, our AMA seek legislative action requiring this of EMR vendors.

729. COORDINATION OF BENEFITS
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: POLICY H-190.969 REAFFIRMED IN LIEU OF FOLLOWING RESOLUTION

RESOLVED, That our American Medical Association 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.

730. DIABETIC DOCUMENTATION REQUIREMENTS
Introduced by New Jersey

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy D-185.983

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 on diabetic patients to procure medically necessary durable medical equipment and supplies; and be it further

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 diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes.

731. MEDICAL STAFF-HOSPITAL COMPACTS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED AS FOLLOWS
See Policy H-235.962

RESOLVED, That given the limited utility of medical staff-hospital compacts relative to their significant potential unintended consequences, the AMA recommends that organized medical staffs and physicians not enter into compacts or similar agreements with their hospitals' governing bodies or administrations. Instead, the AMA encourages organized medical staffs and hospital governing bodies to:

1. Clearly define within the medical staff bylaws the obligations of each party;
2. Outline within the medical staff bylaws the processes by which conflicts between the organized medical staff and the hospital governing body are to be resolved; and
3. Regard the medical staff bylaws as a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body; and be it further

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.

732. ERRORS IN ELECTRONIC CLAIMS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: ADOPTED
See Policy H-190.956

RESOLVED, That our American Medical Association (AMA) publicize and encourage physicians to make use of AMA resources created to help physicians submit accurate electronic claims; and be it further

RESOLVED, That our AMA 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.

733. PHYSICIAN PARTICIPATION IN MULTIPLE ACCOUNTABLE CARE ORGANIZATIONS
Introduced by Organized Medical Staff Section

Considered with Resolution 726. See Resolution 726.

RESOLVED, That our American Medical Association (AMA) advocate that physicians be permitted to participate fully in multiple Accountable Care Organizations.