DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2017 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-17)

Report of Reference Committee G

J. Clay Hays, Jr., MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 20 – Study of Minimum Competencies and Scope of Medical Scribe Utilization
2. Council on Medical Service Report 5 – Hospital Consolidation
3. Council on Medical Service Report 8 – Prior Authorization and Utilization Management Review
4. Council on Medical Service Report 10 – Physician-Focused Alternative Payment Models: Reducing Barriers
5. Resolution 713 – Urge AMA to Release a White Paper on ACOs
6. Resolution 717 – Allowing Exceptions to the Centers for Medicare & Medicaid Services' Locum Tenens 60-Day Limit
7. Resolution 719 – System Approach to Medical Staff Governance
8. Resolution 720 – Medical Staff Non-Punitive Reporting Processes

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

9. Board of Trustees Report 9 – Physician and Medical Staff Member Bill of Rights
10. Board of Trustees Report 12 – Unforeseen Consequences of Core Measures
11. Council on Medical Service Report 4 – Survey of Addiction Treatment Centers' Availability
12. Council on Medical Service Report 7 – Retail Health Clinics
13. Resolution 701 – Third Party Payers Mandating Doctor and Patient Transfers of Prescriptions
14. Resolution 706 – Concurrent and Overlapping Surgery
15. Resolution 709 – Management of Physician and Medical Student Stress
16. Resolution 715 – Prescription Availability for Weekend Discharges
17. Resolution 716 – Understanding and Correcting Imbalances in Physician Work Attributable to Electronic Health Records
18. Resolution 721 – Secret Ballots in Medical Staff Voting Processes

RECOMMENDED FOR REFERRAL

19. Board of Trustees Report 18 – Eliminate the Requirement of H&P Update

20. Resolution 705 – Regulating Health Plans Medical Advice
21. Resolution 714 – Timely Referral to Pain Management Specialist

RECOMMENDED FOR REFERRAL FOR DECISION

22. Resolution 707 – Inclusion of Continuing Care Retirement Centers and Long-Term Care Facilities in Accountable Care Organizations Investment Model
23. Resolution 708 – Removing 'Three Star Minimum' Requirement for Skilled Nursing Facilities to Participate in Next Gen Accountable Care Organizations & Bundled Payments for Care Improvement Programs and Care for Patients with Waiver of Three Night Hospital Stay Requirement
24. Resolution 711 – Expanding Access to Screening Tools for Social Determinants of Health
25. Resolution 718 – Developing Physician Leadership in the Implementation of Diagnostic Error Surveillance

RECOMMENDED FOR NOT ADOPTION

26. Resolution 702 – Credentials/Specialty Added to Clinical Note Signatures

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

27. Resolution 703 – Certified Translation Services
28. Resolution 712 – Pay-for-Performance Incentives

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:

- Resolution 704 – Prior Authorization Abuse
- Resolution 710 – Payment for Medicaid Interpreter Services

(1) BOARD OF TRUSTEES REPORT 20 – STUDY OF MINIMUM COMPETENCIEES AND SCOPE OF MEDICAL SCRIBE UTILIZATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 20 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 20 adopted and the remainder of the report filed.

Board of Trustees Report 20 recommends that our AMA reaffirm Policy H-35.966, "Protecting Physician-Led Health Care," continue to review and promote strategies that help improve physician practice workflow, and monitor the medical scribe industry periodically to identify important trends.

Your Reference Committee heard limited yet supportive testimony on Board of Trustees Report 20. A member of the Board of Trustees introduced the report and reviewed the recommendations, namely calling on our AMA to continue to monitor the medical scribe industry to identify trends that can help improve physician office workflow and encourage greater EHR innovation. Additional testimony noted the thoroughness of the report and emphasized the importance of medical scribes, especially for medical students. Accordingly, your Reference Committee recommends that the recommendations in Board of Trustees Report 21 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 5 – HOSPITAL CONSOLIDATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

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

Council on Medical Service Report 5 recommends that our AMA reaffirm policy on competition among health care facilities, antitrust relief, and opposition to the ban on self-referrals, and recommends reaffirmation of additional policies intended to help guide and protect physicians working in consolidated systems, including support for physician involvement in integrated leadership structures.

Testimony strongly supported Council on Medical Service Report 5. A member of the Council introduced the report and described the findings from a recent AMA analysis of hospital market concentration that found that the vast majorities (90 percent) of hospital markets are highly concentrated, and 70 percent of hospitals are members of hospital

systems. The Council member acknowledged concerns regarding potential negative consequences for physicians and patients in highly concentrated hospital markets, underscoring the Council's belief that highly concentrated markets dominated by any type of health care entity may be harmful and that competition in the marketplace is essential to a well-functioning health care system. Testimony recognized that our AMA is a strong advocate for competitive health care markets and for physician involvement in integrated leadership structures.

A member of the Board of Trustees reiterated that our AMA strongly supports and encourages competition in health care markets because competitive marketplaces provide more choices for physicians and patients. Testimony from the Board of Trustees also referenced the findings of our AMA's newly released Physician Practice Benchmark Survey, which shows that physician movement toward hospital-owned practices and direct hospital employment appears to have leveled off.

The author of the referred resolution addressed by Council on Medical Service Report 5 stated that the negative effects of hospital consolidation were correctly identified by the Council and asked that our AMA study the issue. The Reference Committee believes our AMA has studied the issue and also points out, in response to testimony, that Recommendation 3 reaffirms longstanding AMA policy (Policy H-140.984) opposing an across-the board ban on self-referrals, which would allow for the expansion and new construction of physician-owned hospitals, which would in turn increase competition. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 8 – PRIOR AUTHORIZATION AND UTILIZATION MANAGEMENT REFORM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 8 adopted and the remainder of the report filed.

Council on Medical Service Report 8 recommends that our AMA reaffirm Policies H-320.948, H-320.961, and H-320.949; continue its widespread prior authorization advocacy and outreach; and oppose health plan determinations on physician appeals based solely on medical coding.

Considerable supportive testimony was received on Council on Medical Services Report 8. Testimony noted that prior authorization continues to be a significant source of frustration and administrative burden for physicians and staff, with representatives from various specialties emphasizing the negative impact prior authorization has on care delivery and physician and staff burnout.

The majority of testimony supported Council on Medical Service Report 8 and adoption of its recommendations; however, limited testimony was also offered in support of rescinding language in the report that states physicians should not be compensated for their time spent pursuing prior authorization. One speaker noted that prior authorization is not a patient care issue but rather a payer approval and reimbursement issue. As such, since physician time spent on prior authorization is for the benefit of health plans, physicians should be compensated for this time. Additional testimony was offered in opposition to this request to rescind, noting that there are two paths available for our AMA to pursue with regards to prior authorization moving forward: either physicians are compensated for prior authorization, signaling to health plans that prior authorization is an acceptable practice which could ultimately limit physicians' ability to push back on future prior authorization expansion, or our AMA can continue to push back against prior authorization expansion through its current legislative and advocacy efforts. Although the Reference Committee understands and appreciates physicians' desire to be compensated for time spent on prior authorization, there is concern making prior authorization an advocacy priority would run counter to and negatively impact our AMA's current prior authorization advocacy efforts. Recently, our AMA has dedicated significant resources to improving the prior authorization process for physicians including: identifying the burden of prior authorization through a national physician survey, releasing a collection of 21 Prior Authorization and Utilization Management Reform Principles, and working with states' legislatures on prior authorization regulations, among others. Throughout all of these advocacy efforts, our AMA has abstained from promoting prior authorization compensation out of concern that it would lead to more widespread use of prior authorization without a guarantee that physicians would be fairly compensated for their time. With this concern in mind, the Reference Committee does not wish to modify the Report to promote prior authorization compensation or make this a prior authorization advocacy priority; however, the Reference Committee believes it is worth monitoring potential physician prior authorization reimbursement opportunities in the future.

Overall, there was significant testimony offered in support of Council on Medical Services Report 8 and as such the Reference Committee supports adoption of the recommendations.

(4) COUNCIL ON MEDICAL SERVICE REPORT 10 – PHYSICIAN-FOCUSED ALTERNATIVE PAYMENT MODELS: REDUCING BARRIERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 10 be adopted.

HOD ACTION: Recommendations in Council on Medical Service Report 10 adopted and the remainder of the report filed.

Council on Medical Service Report 10 offers a set of recommendations intended to address the barriers that interfere with the shift to value-based payment including health

information technology and resource use measurement, including risk adjustment, attribution, and performance targets.

Testimony on Council on Medical Service Report 10 was unanimously supportive. A member of the Council introduced the report. Testimony thanked the Council on Medical Service for its thorough report and focus on reducing barriers to the development and implementation of Alternative Payment Models. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 10 be adopted and the remainder of the report be filed.

(5) RESOLUTION 713 – URGE AMA TO RELEASE A WHITE PAPER ON ACOS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 713 be adopted.

HOD ACTION: Resolution 713 adopted.

Resolution 713 asks that our AMA seek objective, independent data on Accountable Care Organizations and release a whitepaper regarding their effect on cost savings and quality of care.

There was limited testimony on Resolution 713. Your Reference Committee notes the utility of such a study on Accountable Care Organizations. Accordingly, your Reference Committee recommends adoption Resolution 713.

(6) RESOLUTION 717 – ALLOWING EXCEPTIONS TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES' LOCUM TENENS 60-DAY LIMIT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 717 be adopted.

HOD ACTION: Resolution 717 adopted.

Resolution 717 asks that our AMA request that the Centers for Medicare & Medicaid Services (CMS) create an exception process to the 60-day locum tenens limit for those physicians with unforeseen circumstances, such as serious illness, physical impairment, or family emergency; and to ensure that the exception process contains the same requirements as are necessary to currently bill under a CMS locum tenens arrangement.

There was limited testimony on Resolution 717. A concern was raised that there may not be due process to evaluate the locum tenens physicians and that they may not be going through proper credentialing. Your Reference Committee notes that CMS already requires that a locum tenens physician be a credentialed Medicare provider, and that the exception called for is only for exceptional circumstances and is not calling for a fundamental change in policy. Further, your Reference Committee notes that the second

Resolve of this resolution requests that our AMA ensure that the exception process contains the same requirements as are necessary to currently bill under a CMS locum tenens arrangement. Therefore, your Reference Committee does not believe this concern should preclude the exception called for in this resolution. Accordingly, your Reference Committee recommends that Resolution 717 be adopted.

(7) RESOLUTION 719 – SYSTEM APPROACH TO MEDICAL STAFF GOVERNANCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 719 be adopted.

HOD ACTION: Resolution 719 adopted.

Resolution 719 asks that our AMA provide guidance to medical staffs on the potential benefits and risks of applying a system approach to medical staff governance, including but not limited to guidance on instituting system-wide processes and leadership structures and otherwise standardizing medical staff bylaws.

Testimony on Resolution 719 was limited and supportive of the recommended guidance. In addition to the sponsor's introduction of the item, other testimony noted that multi-hospital systems can have either an individual or a system-wide medical staff, but that the choice must be specified in the bylaws. Accordingly, your Reference Committee recommends adoption.

(8) RESOLUTION 720 – MEDICAL STAFF NON-PUNITIVE REPORTING PROCESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 720 be adopted.

HOD ACTION: Resolution 720 adopted.

Resolution 720 asks that our AMA provide guidance, including but not limited to model medical staff bylaws language, to help medical staffs develop and implement reporting procedures that effectively protect medical staff members from retaliation when they report deficiencies in the quality, safety, or efficacy of patient care.

Testimony on Resolution 720 was limited and supportive of the recommended guidance. In addition to the sponsor's introduction of the item, other testimony noted the importance of contractual language to protect "whistle blowers." Accordingly, your Reference Committee recommends adoption.

(9) BOARD OF TRUSTEES REPORT 9 – PHYSICIAN AND MEDICAL STAFF MEMBER BILL OF RIGHTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 9 be amended by addition to read as follows:

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, ~~and~~ (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.

b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body.

c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.

d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments.

e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.

f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

~~g. The right to determine which individual non-physician health care professionals may be members of the medical staff.~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Board of Trustees Report 9 be amended by addition and deletion to read as follows:

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, ~~or~~ contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.

b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.

c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

d. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.

e. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

f. The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 9 adopted as amended and the remainder of the report filed.

Board of Trustees Report 9 recommends the adoption and widespread distribution of a concise series of fundamental medical staff rights and responsibilities based on existing AMA policy.

Testimony on Board of Trustees Report 9 was supportive. A member of the Board of Trustees noted that the report takes a fresh look at the bill of rights for medical staff and that all of the points included in the report's recommendation are supported by existing AMA policy. An amendment was offered to add "independent" to Section IV of the report's recommendation to ensure that the rights apply to physicians practicing independently. An additional amendment suggested the addition of new language to Section II to affirm that our AMA recognizes the right of medical staffs to determine which non-physician health care professionals may be members of the medical staff. Your Reference Committee concurs with these suggestions and recommends that the recommendations in Board of Trustees Report 9 be adopted as amended and the remainder of the report be filed.

(10) BOARD OF TRUSTEES REPORT 12 – UNFORESEEN CONSEQUENCES OF CORE MEASURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 12 be amended by addition of a new Recommendation to read as follows:

That our American Medical Association discourage the implementation of indiscriminant and not medically indicated screening or testing for "pre-existing" infection in patients in order to avoid penalties. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 12 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 12 adopted as amended and the remainder of the report filed.

Board of Trustees Report 12 recommends that Resolution 716-A-16 not be adopted and the remainder of the report be filed.

There was minimal testimony on this report. A member of the Board of Trustees introduced the report. An amendment was offered to add a recommendation to specifically discourage inappropriate screenings, and your Reference Committee agrees with the amendment. An additional amendment was offered stating that our AMA oppose any elected officials or elected legislative body from enacting a medical screening, diagnosis, or treatment protocol into statute. Your Reference Committee believes this amendment may have numerous undesirable and unintended consequences. Accordingly, your Reference Committee recommends that Board of Trustees Report 12 be adopted as amended and the remainder of the report be filed.

(11) COUNCIL ON MEDICAL SERVICE REPORT 4 – SURVEY OF ADDICTION TREATMENT CENTERS' AVAILABILITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 4 be amended by addition of a new Recommendation to read as follows:

That our AMA encourage SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 4 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 4 recommends that our AMA encourage the Substance Abuse and Mental Health Services Administration (SAMHSA) to use its national surveys to increase the information available on the type of insurance (e.g., Medicaid, Medicare, private insurance) accepted by substance use disorder treatment programs listed in SAMHSA's "treatment locators," and encourage physicians who are authorized to provide medication assisted treatment to opt in to be listed publicly in SAMHSA's "treatment locators."

Testimony on Council on Medical Service Report 4 was generally supportive. A member of the Council introduced the report, stating that the Council concluded after thorough study that a costly national survey of practicing physicians will do little to accomplish the intent of the referred resolution, and that the report's recommendations are intended to increase the inclusiveness of existing "treatment locators." Additional testimony noted that increased awareness of community treatment providers as well as a breakdown of public and private insurance accepted by these programs would be extremely useful to physicians looking to make patient referrals. An amendment from the American Society of Addiction Medicine suggested the addition of a third recommendation that would encourage SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities. Your Reference Committee heard supportive testimony of this amendment and recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

(12) COUNCIL ON MEDICAL SERVICE REPORT 7 – RETAIL HEALTH CLINICS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 6 of Council on Medical Service Report 7 be amended by addition and deletion to read as follows:

6. That our AMA supports that any individual, company, or other entity that establishes and/or operates retail health clinics adhere to the following principles:
a. Retail health clinics must help patients who do not have a primary care physician or usual source of care to identify one in the community;
b. Retail health clinics must use electronic health records to transfer a patient's medical records to his or her primary care physician and to other health care providers, with the patient's consent;
c. Retail health clinics must produce patient visit summaries that are transferred to the appropriate physicians and other health care providers in a meaningful format that prominently highlight salient patient information;
~~d. Retail health clinics make provisions for all appropriate follow-up patient care;~~
~~e.~~ d. Retail health clinics should work with primary care physicians and medical homes to support continuity of care and ensure provisions for appropriate follow-up care are made;
~~f.~~ e. Retail health clinics should use local physicians as medical directors or supervisors of retail clinics; ~~and~~
~~g.~~ f. Retail health clinics should neither ~~not~~ expand their scope of services beyond minor acute illnesses including but not limited to sore throat, common cold, flu symptoms, cough, and sinus infection nor expand their scope of services to include infusions or injections of biologics; and
g. Retail health clinics should have a well-defined and limited scope of clinical services, provide a list of services provided by the clinic, provide the qualifications of the on-site health care providers prior to services being rendered, and include that any marketing materials the qualifications of the on-site health care providers. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 7 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 7 recommends that our AMA reaffirm policies on store-based health clinics, the corporate practice of medicine, the physician-led health care team, physician choice of practice and method of earning a living, and proper vaccination protocol; and recommends the adoption of additional safeguards and guidelines to encourage value in retail health clinics consistent with current AMA policy.

Testimony on Council on Medical Service Report 7 was unanimously supportive. A member of the Council introduced the report emphasizing the importance of the recommended safeguards and guidelines. An amendment was offered to add that a retail health clinic should provide a list of services provided by the clinic and the qualifications of the on-site provider. Your Reference Committee agrees and accepts this amendment. An amendment was offered to note that retail health clinics should not expand their scope of services to include injectable medications or biologics. The Council on Medical Service accepts this amendment with a change to reflect that disallowing all injectable medications may not be necessary or feasible. For example, many retail health clinics provide basic injectables such as flu shots and tetanus, among others. Therefore, your Reference Committee offers language saying that retail health clinics should not expand their scope of service to infusions or injections of biologics. Your Reference Committee believes this captures the spirit of the amendment offered. A further amendment was offered to delete Recommendation 6(d) and amend Recommendation 6(e) to reflect that all action should be taken through the primary care physician or usual source of care. This amendment takes into consideration the fact that not all follow-up care arranged by the retail health clinic is necessary and therefore should be undertaken in consultation with the primary care provider. Your Reference Committee agrees.

Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the report be filed.

(13) RESOLUTION 701 – THIRD PARTY PAYERS MANDATING DOCTOR AND PATIENT TRANSFERS OF PRESCRIPTIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 701 be amended by addition to read as follows:

RESOLVED, That our AMA advocate that when an insurance company or other third party payer mandates prescription transfers due to a change in their retail pharmacy network, that the payer and pharmacies within network have mechanisms in place to seamlessly transfer the prescription, as initially prescribed with regard to refills, substitutions, and other pertinent prescription details, to the patient's pharmacy of choice without the need for the patient/physician to initiate such transfer, as well as safety mechanisms to ensure that the formulation which has been established and tolerated is available to the patient without a lapse in dispensing. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 701 be adopted as amended.

HOD ACTION: Resolution 701 adopted as amended.

Resolution 701 asks that our AMA advocate that insurers or other third party payers must provide 60 days advance notice of changes in retail pharmacy networks to both patients and all physicians treating these patients; advocate that insurers or other third party payers making changes to their pharmacy network must allow patients to designate a new pharmacy of choice within the network; and advocate that when an insurance company or other third party payer mandates prescription transfers due to a change in their retail pharmacy network, that the payer and pharmacies within network have mechanisms in place to seamlessly transfer the prescription to the patient's pharmacy of choice without the need for the patient/physician to initiate such transfer.

There was generally supportive testimony on Resolution 701. Three amendments were proposed to the third Resolve clause. These amendments were intended to highlight the importance of transferring prescriptions as originally prescribed, both with regards to avoiding substitutions and any potential refill calculation errors, and patient safety, especially with regard to receiving properly formulated drugs. Supporting testimony for these amendments focused on concerns about patients receiving incorrect drugs or additional refills appearing following the pharmacy transfer. One proposed hypothetical situation outlined a scenario wherein a patient's prescription has been transferred to a new pharmacy, but the pharmacy does not acquire its drugs from the same source as the patient's former pharmacy. Testimony was presented that this could potentially lead to complications for patients who receive individually prepared drugs. Another

hypothetical offered involved a patient who currently has one refill left on his or her prescription but was originally prescribed five refills. After the prescription transfer, due a system error the patient received a prescription with five more refills, rather than the one he or she actually has remaining. A third hypothetical situation outlined concerns about generics being substituted in lieu of a name brand drug after the transfer, despite the original prescription not allowing for generic substitution.

Limited testimony was offered with regard to amending the language of the resolution to allow for prescriptions to be transferred across state lines. However, due to regulatory concerns surrounding this practice, the Reference Committee has decided not to pursue this amendment at this time.

Accordingly, your Reference Committee recommends that Resolution 701 be adopted as amended.

(14) RESOLUTION 706 – CONCURRENT AND OVERLAPPING SURGERY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 706:

HOD ACTION: The following resolution adopted in lieu of Resolution 706.

RESOLVED, That our American Medical Association work with interested national medical specialty societies on issues related to concurrent and overlapping surgery. (New HOD Policy)

Resolution 706 asks that our AMA advocate for physicians to have an opportunity to engage in policy development related to concurrent and overlapping surgery; recommend that any new policies be based on best available evidence; participate in efforts to educate physicians on various issues associated with concurrent and overlapping surgery, such as quality of care, patient safety, and medical liability; and work with key entities to explore the potential impacts of changing policies regarding concurrent and overlapping surgeries on the future of medical education, physician reimbursement and productivity, physician wellness, and patient access to care.

Testimony on Resolution 706 was supportive of alternate language that simplified the original Resolution 706. It was noted in testimony that there has been media attention on safety issues associated with concurrent surgery. The American College of Surgeons and other surgical specialties testified in support of the alternate language. A speaker also noted that the Federation of State Medical Boards should be consulted on these issues. There was strong support for the alternate language. Your Reference Committee points out that AMA policy must be established by the House of Delegates and recommends adoption of alternate language, which calls on our AMA to work with interested national medical specialty societies on concurrent and overlapping surgery, in lieu of Resolution 706.

(15) RESOLUTION 709 – MANAGEMENT OF PHYSICIAN AND MEDICAL STUDENT STRESS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 709:

HOD ACTION: The following resolution adopted in lieu of Resolution 709.

RESOLVED, That our AMA produce a report on administrative and regulatory burdens placed on physicians, residents and fellows, and medical students, and pursue strategies to reduce these burdens. (Directive to Take Action)

Resolution 709 asks that our AMA produce a report summarizing current research and efforts to address physician practice sustainability and satisfaction.

At the start of testimony, alternate language was offered by the sponsor, who stated that the original resolution crafted by the New York delegation had lost some of its intent before being transmitted to our AMA. The sponsor added that the resolution had come from a state task force on physician stress and burnout. Testimony largely supported the alternate language. A representative of the Federation of State Medical Boards testified about some of our AMA's work on stress and burnout, including the Joy in Medicine Research Summit and the STEPS Forward™ Practice Improvement Strategies. Your Reference Committee recommends that alternate language directing be adopted in lieu of Resolution 709.

(16) RESOLUTION 715 – PRESCRIPTION AVAILABILITY FOR WEEKEND DISCHARGES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 715 be amended by addition of a fourth Resolve to read as follows:

RESOLVED, That these PBMs, health insurers, and pharmacists are always available to resolve these issues of coverage and/or formulary on holidays and weekends to protect patient safety and prevent readmissions.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 715 be adopted as amended.

HOD ACTION: Resolution 715 adopted as amended.

Resolution 715 asks that our AMA work with pharmacy benefit managers (PBMs), health insurers, and pharmacists at a national level to address the problem of patients, discharged by a health care facility on a weekend or holiday, being denied access to vital medications because the patient's health insurance carrier or applicable PBM does not have staff available on weekends or holidays to resolve coverage and/or formulary issues.

There was limited but supportive testimony for Resolution 715; however, some testimony highlighted concern that the current language does not go far enough to protect patient safety. Additional testimony proposed amending the resolution by adding a second Resolve clause that is intended to provide patients with greater support in the event of a weekend or holiday discharge. Your Reference Committee recommends that Resolution 715 be adopted as amended.

(17) RESOLUTION 716 – UNDERSTANDING AND CORRECTING IMBALANCES IN PHYSICIAN WORK ATTRIBUTABLE TO ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that that the following resolution be adopted in lieu of Resolution 716.

HOD ACTION: The following resolution adopted in lieu of Resolution 716.

RESOLVED, That our American Medical Association work with health care leaders and policymakers to use industrial engineering principles and evidence-based best practices to study and then propose systematic reforms to reduce physicians' electronic health record workload. (Directive to Take Action)

Resolution 716 asks that our AMA work with leaders of the health care delivery system (clinics, hospitals and health systems) and federal governmental leaders at the highest level to use industrial engineering and quality improvement principles and practices to examine the imbalances that have evolved in the time allocation of physician work in order to propose systematic reforms that will reduce the amount of a physician's time in data entry tasks and allow physicians to maximize the time available in their daily work to interact directly with patients and families and maximize the time available for them to design and implement treatment plans within health care teams and to be able to do what they are uniquely trained to do: make appropriate evidence-based medical decisions on behalf of patients.

Testimony on Resolution 716 and the alternate language offered in lieu of the item was very supportive. The author stated that the resolution is not about eliminating electronic health records (EHRs) and that it does not relate to existing AMA policy on interoperability, usability, government mandates or linking payment to EHR use. The author also testified that the resolution calls for involving people from outside as well as inside medicine "to go back to square one" to design and build a system of electronic

storage and sharing of health information. Several speakers emphasized that a fresh start is indeed needed and that they would be extremely displeased if existing AMA policy is reaffirmed in lieu of this item. Because testimony unanimously supported the intent of the resolution, your Reference Committee recommends adoption of alternate language which maintains the resolution's intent.

(18) RESOLUTION 721 – SECRET BALLOTS IN MEDICAL STAFF VOTING PROCESSES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 721 be amended by addition of a third Resolve to read as follows:

RESOLVED, That our AMA support the inclusion of provisions for secret balloting and confidential requests for secret balloting in model medical staff bylaws.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 721 be adopted as amended.

HOD ACTION: Resolution 721 adopted as amended.

Resolution 721 asks that our AMA advocate for the use of secret ballots by medical staffs in all decision-making matters where voting members of the medical staff may be unwilling to publicly vote due to employer or other pressures that could impact how individual members vote; and provide guidance to help organized medical staffs develop and implement secret balloting processes, including specific procedures that allow for individual members of the medical staff to confidentially request a vote by secret ballot.

Testimony on Resolution 721 was limited and supportive of secret ballots by medical staffs, and the ability of medical staffs to confidentially request secret ballots. In addition to the sponsor's introduction of the item, other testimony noted the importance of incorporating these provisions in model medical staff bylaws. Accordingly, your Reference Committee recommends that Resolution 712 be adopted as amended.

(19) BOARD OF TRUSTEES REPORT 18 – ELIMINATE THE REQUIREMENT OF H&P UPDATE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 18 be referred.

HOD ACTION: Board of Trustees Report 18 referred.

Board of Trustees Report 18 recommends that Resolution 710-A-16 be adopted and the remainder of the report be filed.

Testimony on Board of Trustees Report 18 was mixed but mostly negative. While there was some support for the report's recommendation, a preponderance of the testimony expressed concerns about adopting Resolution 710-A-16. Testimony emphasized the importance of documenting the medical history and physician examination (H&P) updates on the day of a procedure or surgery and the potential risks associated with not documenting these encounters. A speaker noted that failing to document the H&P update would be a violation of conventional risk management practices. Others questioned whether the documentation is in fact an H&P update. The importance of pre-operative visits was also emphasized and it was noted that patients can change their minds about surgeries at the last minute. Because a preponderance of the testimony was in opposition to the report's recommendation, your Reference Committee believes clarification is needed and recommends that it be referred.

(20) RESOLUTION 705 – REGULATING HEALTH PLANS MEDICAL ADVICE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 705 be referred.

HOD ACTION: Resolution 705 referred.

Resolution 705 asks that our AMA define when medical advice is the practice of medicine; and study options for regulating medical advice given by health plans.

Testimony on Resolution 705 was mixed, with a preponderance of testimony requesting that the item be referred for further study. While there was general agreement that it is problematic for health plans to be giving medical advice to patients, several speakers emphasized the complexity of the issues raised in the resolution. Additional testimony noted that our AMA has policy affirming that diagnosis of disease constitutes the practice of medicine and that physician-patient relationships should be reinforced and not disrupted by health plan communications to patients. Because several speakers asked for thorough study of the issue of health plans giving medical advice and how states have addressed the issue, your Reference Committee recommends that Resolution 705 be referred.

(21) RESOLUTION 714 – TIMELY REFERRAL TO PAIN MANAGEMENT SPECIALIST

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 714 be referred.

HOD ACTION: Resolution 714 referred.

Resolution 714 asks that our AMA urge the Centers for Medicare and Medicaid Services and the Medicare Contractor Advisory Committee to endorse and adopt evidence-based clinical practice guidelines on the management and treatment of pain including but not limited to timely and appropriate referral to pain management specialists.

A majority of testimony on Resolution 714 opposed mandating that physicians should refer patients to pain management specialists. Several speakers described the lack of access to pain management specialists in their communities as well as long waiting times to see pain specialists, making timely referrals to see these specialists problematic. Testimony emphasized the need to address these issues due to opioid epidemic and the need to help patients manage acute and chronic pain. Your Reference Committee points out the complexities of this resolution because a variety of clinical guidelines for managing pain and referring patients to pain management specialists have already been developed. Your Reference Committee believes that these clinical guidelines should be examined further before new AMA policy is developed and recommends that Resolution 714 be referred.

(22) RESOLUTION 707 – INCLUSION OF CONTINUING CARE RETIREMENT CENTERS & LONG-TERM CARE FACILITIES IN ACCOUNTABLE CARE ORGANIZATIONS INVESTMENT MODEL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 707 be referred for decision.

HOD ACTION: Resolution 707 referred for decision.

Resolution 707 asks that our AMA advocate to the Centers for Medicare & Medicaid Services to enable Continuing Care Retirement Centers and long-term care facilities and physicians working in those settings to initiate ACO Investment Models.

Testimony on Resolution 707 was mixed. Numerous speakers raised concerns that the action called for in the resolution may result in the potential for abuse and that more information is needed on this issue. A member of the Council on Medical Service offered an amendment by an additional resolve to increase the reach of this resolution to include not only those physicians wanting to participate in ACOs but also those looking to participate in Comprehensive Primary Care Plus and other medical home models. Your Reference Committee sees the potential for Resolution 707 to increase the availability of Alternative Payment Models available to physicians yet also agrees with the concerns raised by numerous speakers that this action may require more thoughtful analysis. Accordingly, your Reference Committee recommends that Resolution 707 be referred for decision.

(23) RESOLUTION 708 – REMOVING 'THREE STAR MINIMUM' REQUIREMENT FOR SKILLED NURSING FACILITIES TO PARTICIPATE IN NEXT GEN ACCOUNTABLE CARE ORGANIZATIONS & BUNDLED PAYMENTS FOR CARE IMPROVEMENT PROGRAMS AND CARE FOR PATIENTS WITH WAIVER OF THREE NIGHT HOSPITAL STAY REQUIREMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 708 be referred for decision.

HOD ACTION: Resolution 708 referred for decision.

Resolution 708 asks that our AMA advocate to the Centers for Medicare & Medicaid Services to remove the three star quality requirement for skilled nursing facilities to participate in Next Gen Accountable Care Organizations and the Bundled Payments for Care Improvement programs with waiver of three night hospital stays for patients.

Testimony on Resolution 708 was mixed. Concerns were raised that there is difficulty obtaining quality data from skilled nursing facilities and that this resolution may be premature. The sponsor of the resolution addressed concerns by clarifying that this resolution is not a mandate to send patients to a facility with less than three stars but rather that this resolution removes the government requirement that transfer may only occur to facilities with at least three stars. Furthermore, the sponsor clarified that the resolution is particular to risk-bearing models participating in an Alternative Payment Model (APM). A member of the Council on Medical Service offered an amendment to broaden the resolution such that the removal of minimum quality requirements would apply across all post-acute care settings, including skilled nursing facilities, and in all Medicare APMs, included Next Gen ACOs and the Bundled Payment for Care Improvement program. The member stated that this amendment is consistent with our AMA's current efforts to remove the three night stay requirement and efforts to increase the availability of APMs for physicians. Additionally, the member raised concerns whether the star rating system is a true measure of quality and therefore does not believe that this resolution in any way compromises patient care or quality of care. The author welcomed this amendment. Despite the author's testimony and the amendment offered, your Reference Committee agrees with the numerous speakers citing concerns with this resolution, including those around patient safety. Accordingly, your Reference Committee recommends that Resolution 708 be referred for decision.

(24) RESOLUTION 711 – EXPANDING ACCESS TO SCREENING TOOLS FOR SOCIAL DETERMINANTS OF HEALTH

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 711 be referred for decision.

HOD ACTION: Resolution 711 referred with report back.

Resolution 711 asks that our AMA provide access to evidence-based screening tools for evaluating and addressing social determinants of health in their physician resources; support the continued integration of evidence-based screening tools evaluating social determinants of health into the electronic medical record and electronic health record; and support fair compensation for the use of evidence-based social determinants of health screening tools and interventions in clinical settings.

Testimony on Resolution 711 was largely supportive; however, there were concerns about adopting the resolution as written because of the need to better understand the variety of available screening tools and the time it takes to screen patients. A member of the Medical Student Section, which sponsored the resolution, testified that physicians must be adequately equipped to screen their patients for social determinants, which have been shown to impact patient health and quality of life, and that disparities created by social determinants of health have been shown to negatively affect health outcomes. Other testimony emphasized that existing policy already encourages screening for social and economic risk factors in order to improve patient care and pointed out that our AMA generally does not provide screening tools to physicians, as requested by the first Resolve clause. Your Reference Committee agrees that the resolution addresses an important and timely issue but believes that there are complexities to screening for social determinants of health (e.g., usability, availability and evidence supporting current tools; and how to address issues uncovered during screenings) that should be explored further. Accordingly, your Reference Committee recommends that Resolution 711 be referred for decision.

(25) RESOLUTION 718 – DEVELOPING PHYSICIAN LEADERSHIP IN THE IMPLEMENTATION OF DIAGNOSTIC ERROR SURVEILLANCE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 718 be referred for decision.

HOD ACTION: Resolution 702 referred for decision.

Resolution 718 asks that our AMA endorse the recommendations of the Improving Diagnosis in Health Care report published by the National Academy of Medicine in 2015; support having physician satisfaction with administrative and support systems as a standard measure when assessing diagnostic error; analyze from a policy perspective how best to position physicians in what may be increasing review of a physician's diagnostic skills; and report the findings of this analysis, and any recommendations based on these findings, at the 2018 Annual Meeting of the House of Delegates.

Testimony on Resolution 718 was mixed. The Council on Medical Service offered alternative language advocating that measures of diagnostic accuracy should incorporate the perspective of physicians including physician satisfaction. As testimony noted, our AMA generally does not endorse reports promulgating a complex set of recommendations without a thorough review. The resolution calls for our AMA to endorse complex, multifaceted recommendations on clinical practice, scientific diagnostic processes, and medical liability issues. In the interest of prudence, the Council member noted that such an endorsement should only take place after a

comprehensive review of the report. Further, as testimony indicated, the third Resolve clause of Resolution 718 may be problematic because the creation of diagnostic accuracy programs or the development of recommendations on how physicians should handle this type of assessment in practice is outside the scope of our AMA. Additional testimony highlighted the importance of expeditious action on this item because the National Quality Forum is releasing a report on measuring diagnostic accuracy, and that taking action on this resolution would allow us the opportunity to comment and take expedient action on this issue. Accordingly, your Reference Committee recommends that Resolution 718 be referred for decision.

(26) RESOLUTION 702 – CREDENTIALS/SPECIALTY ADDED TO CLINICAL NOTE SIGNATURES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 702 not be adopted.

HOD ACTION: Resolution 702 not adopted.

Resolution 702 asks that our AMA work collaboratively with appropriate national and state hospital associations and other appropriate organizations to encourage those entities, when feasible, to provide the treating practitioner's specialty/credentials to signed progress/consult/operative notes.

There was mixed testimony on Resolution 702 with numerous speakers citing concerns with this resolution. Testimony noted that providing credentials is a more complex and burdensome issue than the resolution recognizes. For example, such credentials include board certification, additional degrees, and fellow status, among others, and the Reference Committee believes such options to be numerous and potentially limitless. Further, testimony stated that undertaking this work may not be within the purview of our AMA but rather should be dealt with at a local level and with hospitals and hospital associations. Your Reference Committee agrees and believes that our AMA and others must balance the additional demands requested in EHR design versus focusing on issues such as interoperability and easing the administrative burden of EHRs. As such, your Reference Committee recommends that Resolution 702 not be adopted.

(27) RESOLUTION 703 – CERTIFIED TRANSLATION SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-385.978, D-160.992, and H-160.924 be reaffirmed in lieu of Resolution 703.

HOD ACTION: Resolution 703 adopted as amended with change in title.

CERTIFIED TRANSATION AND INTERPRETER SERVICES

RESOLVED, That our American Medical Association work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act. (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates. (Directive to Take Action)

Resolution 703 asks that our AMA work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act.

There was supportive testimony on Resolution 703. A member of the Council on Medical Service stressed that existing policy already fulfills the issue outlined in the resolution and noted that our AMA is actively engaging the Administration on the burden of providing translation services. An amendment was offered by the sponsor to request that payment for such services be furnished from the insurer directly to the translator. However, your Reference Committee not only believes that this request is potentially problematic but also finds the abundance of current AMA policy and advocacy on the issue to be appropriate. Your Reference Committee agrees that our AMA is already working to relieve the burden associated with translation services and is exploring all avenues of relieving this burden on physicians. Accordingly, Reference Committee recommends that Policies D-385.978, D-160.992, and H-160.924 be reaffirmed in lieu of Resolution 703.

Language Interpreters D-385.978
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services;
(2) redouble its efforts to remove the financial burden of medical interpretive services from physicians;
(3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement;
(4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and
(5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense. (Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13)

Appropriate Reimbursement for Language Interpretive Services D-160.992
1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care. (Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12; Reaffirmation A-14)

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924
AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care;
(2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;
(3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid LEP patients' involvement in meaningful decisions about their care; and
(4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements. (BOT Rep. 8, I-02; Reaffirmation I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13)

(28) RESOLUTION 712 – PAY-FOR-PERFORMANCE INCENTIVES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-450.947, H-155.960, H-390.849, and H-165.838 be reaffirmed in lieu of Resolution 712.

HOD ACTION: Policies H-450.947, H-155.960, H-390.849, and H-165.838 reaffirmed in lieu of Resolution 712.

Resolution 712 asks that our AMA advocate with payers and other physician performance review organizations a new standard whereby performance incentives would be linked to the performance of the physician in providing and documenting appropriate advice on preventative care and self-care to patients and/or their parents and applicable incentives would be earned through delivery and documentation of appropriate advice that are considered equal to the performance incentive based on a

clinical outcome; and work with any organization measuring physicians through incentive or performance programs to adopt standards that do not penalize physicians for the actions of patients who cannot or who will not comply with excellence in clinical recommendations.

Testimony on Resolution 712 was limited. Several speakers called for reaffirmation of current policy in lieu of Resolution 712. A member from the Council on Medical Service noted numerous policies that already state that pay-for-performance (PFP) programs must recognize outcome limitations caused by patient non-adherence, PFP designs should attempt to minimize non-adherence effects, PFP programs must not financially penalize physicians based on factors outside their control, and PFP programs should attempt to minimize non-adherence through plan design. Testimony went on to state that current policy supports continued AMA advocacy that physicians be supported in providing lifestyle counseling to patients through adequate third-party payment and inclusion of lifestyle counseling in quality measurement and PFP incentives. Your Reference Committee agrees and therefore recommends reaffirmation of policy in lieu of Resolution 712.

Pay-for-Performance Principles and Guidelines H-450.947
PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS
Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:
1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.
GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program.

1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.

1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome

and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.
Program Rewards
- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted

guidelines.
2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance." (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res. 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmed in lieu of Res. 808, I-10; Modified: BOT Rep. 8, I-11; Reaffirmed: Sub. Res. 226, I-13; Appended: BOT Rep. 1, I-14; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of Res. 216, I-15; Reaffirmation I-15; Reaffirmed: BOT Rep. 20, A-16)

Strategies to Address Rising Health Care Costs H-155.960
(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
(b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
(d) promote "value-based decision-making" at all levels;
(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
(9) Our AMA will, in all reform efforts, continue to identify appropriate cost

savings strategies for our patients and the health care system. (CMS Rep. 8, A-07; Reaffirmed: CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 828, I-08; Reaffirmation A-09; Reaffirmation I-09; Reaffirmation A-11; Reaffirmation I-11; Appended: Res. 239, A-12; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: CMS Rep. 1, I-12; Modified: CMS Rep. 2, A-13; Reaffirmed in lieu of Res. 122, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed: CMS Rep. 05, I-16; Reaffirmation I-16)

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:

a) promote improved patient access to high-quality, cost-effective care;

b) be designed with input from the physician community;

c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;

d) not require budget neutrality within Medicare Part B;

e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;

f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;

g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;

h) use adequate risk adjustment methodologies;

i) incorporate incentives large enough to merit additional investments by physicians;

j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;

k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;

l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and

m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment. (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-

12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16)

Health System Reform Legislation H-165.838

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

a. Health insurance coverage for all Americans

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

c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials

d. Investments and incentives for quality improvement and prevention and wellness initiatives

e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care

f. Implementation of medical liability reforms to reduce the cost of defensive medicine

g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services

b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system

c. Medicare payments cuts for higher utilization with no operational

mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted

d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate

e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

(Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15)

Madam Speaker, this concludes the report of Reference Committee G. I would like to thank Rose Berkun, MD, John Bizon, MD, A. Michael Booth, MD, James A. Bull, MD, Daniel Pfeifle, Jennifer Wiler, MD, MBA, and all those who testified before the Committee.

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