DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2018 Interim 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 (I-18)

Report of Reference Committee B

Francis P. MacMillan, Jr., MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 4 – Increased Use of Body-Worn Cameras by Law Enforcement Officers (Resolution 208-I-17)
2. Board of Trustees Report 8 – 340B Drug Discount Program (Resolution 225-A-18 Resolve 3)
3. Resolution 201 – Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application
4. Resolution 207 – Defense of Affirmative Action
5. Resolution 209 – Sexual Assault Education and Prevention in Public Schools
6. Resolution 217 – Opposition to Medicare Part B to Part D Changes
7. Resolution 226 – Support for Interoperability of Clinical Data
8. Resolution 229 – Addressing Surgery Performed by Optometrists

RECOMMENDED FOR ADOPTION AS AMENDED

9. Board of Trustees Report 5 – Exclusive State Control of Methadone Clinics (Resolution 211-I-17)
10. Board of Trustees Report 7 – Advocacy for Seamless Interface Between Physicians Electronic Health Records (EHRs), Pharmacies and Prescription Drug Monitoring Programs (PDMPs) (Resolution 212-A-17; BOT Report 12-A-18)
11. Board of Trustees Report 11 – Violence Prevention (Resolution 419-A-18, Resolves 1 and 3)
    Resolution 213 – Increasing Firearm Safety to Prevent Accidental Child Deaths
    Resolution 233 – Opposing Unregulated, Non-Commercial Firearm Manufacturing
12. Resolution 205 – Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
13. Resolution 208 – Increasing Access to Broadband Internet to Reduce Health Disparities
14. Resolution 211 – Eliminating Barriers to Automated External Defibrillator Use
15. Resolution 212 – Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings

16. Resolution 216 – Medicare Part B Competitive Acquisition Program (CAP)
17. Resolution 220 – Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement
18. Resolution 224 – Fairness in the Centers for Medicare & Medicaid Services Authorized Quality Improvement Organization's (QIO) Medical Care Review Process
19. Resolution 232 – Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries
20. Resolution 235 – Inappropriate Use Of CDC Guidelines For Prescribing Opioids

RECOMMENDED FOR REFERRAL

21. Resolution 202 – Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
22. Resolution 204 – Restriction on IMG Moonlighting
23. Resolution 206 – Repealing Potential Penalties Associated with MIPS
Resolution 231 – Reducing the Regulatory Burden in Health Care

RECOMMENDED FOR REFERRAL FOR DECISION

24. Resolution 210 – Forced Organ Harvesting for Transplantation

RECOMMENDED FOR NOT ADOPTION

25. Resolution 215 – Extending the Medical Home to Meet Families Wherever They Go
26. Resolution 230 – Nonprofit Hospitals and Network Health Systems
27. Resolution 234 – Negligent Credentialing Actions Against Hospitals

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

28. Resolution 218 – Alternatives to Tort for Medical Liability
29. Resolution 225 – "Surprise" Out of Network Bills
30. Resolution 228 – Medication Assisted Treatment

Resolutions handled via the Reaffirmation Consent Calendar:

Resolution 203 – Support for the Development and Distribution of HIPAA-Compliant Communication Technologies
Resolution 214 – A Public Health Case for Firearm Regulation
Resolution 219 – Promotion and Education of Breastfeeding
Resolution 221 – Regulatory Relief from Burdensome CMS "HPI" EHR Requirements
Resolution 222 – Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS
Resolution 223 – Permanent Reauthorization of the State Children's Health Insurance Program

(1) BOARD OF TRUSTEES REPORT 4 – INCREASED USE OF BODY-WORN CAMERAS BY LAW ENFORCEMENT OFFICERS (RESOLUTION 208-I-17)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 4 be referred.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 208-1-17, and that the remainder of the report be filed. That our American Medical Association work with interested state and national medical specialty societies to support state legislation and/or regulation that would encourage the use of body-worn camera programs for law enforcement officers and fund the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies.

Your Reference Committee commends the Board of Trustees for an excellent and thorough board report. Your Reference Committee heard testimony largely in support of Board of Trustees Report 4. There was some testimony questioning whether the issues being raised were outside the expertise and scope of our AMA. The majority of the testimony, however, emphasized that the use of body-worn cameras by law enforcement was a matter of public health and directly related to existing AMA policy. The issues raised by this report are critical and very timely. Your Reference Committee agrees with testimony urging adoption, recognizing that there are nuances that will need to be addressed as our AMA works with interested state and specialty societies during any given state legislative and/or regulatory process. Your Reference Committee, therefore, recommends that Board of Trustees Report 4 be adopted.

(2) BOARD OF TRUSTEES REPORT 8 – 340B DRUG DISCOUNT PROGRAM (RESOLUTION 225-A-18 RESOLVE 3)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustees Report 8 be adopted and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 8 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of the third resolve Resolution 225-A-18 and the remainder of this report be filed 1. That our American Medical Association support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices. (New HOD Policy) 2. Our AMA will confer with national medical specialty societies on providing policymakers with specific

recommended covered entity criteria for the 340B drug discount program. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony on Board of Trustees Report 8. Your Reference Committee heard testimony that there should be equity in payment between community practice providers and those affiliated with hospitals. Your Reference Committee also heard testimony that the 340B rebate program should ultimately benefit patients who are underinsured or uninsured by providing rebates to those providers who actually provide medical care and treatment to them. Additionally, your Reference Committee heard testimony encouraging the collaboration with appropriate stakeholders when crafting and providing recommendations on covered entity criteria in the 340B discount program to policymakers. Accordingly, your Reference Committee recommends that Board of Trustees Report 8 be adopted.

(3) RESOLUTION 201 – REIMBURSEMENT FOR SERVICES RENDERED DURING PENDENCY OF PHYSICIAN'S CREDENTIALING APPLICATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 201 be adopted.

HOD ACTION: Resolution 201 adopted as amended.

RESOLVED, That our American Medical Association develop model state legislation for physicians being credentialed by a health plan to treat patients and retroactively receive payments if they are ultimately credentialed or to be deemed credentialed upon submission of a complete application if the physician is part of a group practice with an existing contract with that health plan.

Resolution 201 asks that our American Medical Association develop model state legislation for physicians being credentialed by a health plan to treat patients and retroactively receive payments if they are ultimately credentialed. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of the issues raised related to Resolution 201 and therefore recommends adoption.

(4) RESOLUTION 207 – DEFENSE OF AFFIRMATIVE ACTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 207 be adopted.

HOD ACTION: Resolution 207 adopted.

Resolution 207 asks that our American Medical Association oppose legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population. (New HOD Policy)

Your Reference Committee heard supportive testimony for Resolution 207. Your Reference Committee heard testimony that our AMA does have existing policy in support of creating a diverse student population. Your Reference Committee heard testimony that our AMA filed amicus briefs in *Fisher v. University of Texas at Austin*, and argued that racial diversity is a vital component of a successful medical education and that medical school admission officers should be allowed to consider applicants' race in order to achieve the schools' educational goals. Your Reference Committee also heard testimony that existing AMA policy falls short in addressing the necessity of affirmative action as mechanism for equality at the undergraduate level, which is necessary to bolster the pool of minority students able to apply to a medical program. Your Reference Committee agrees with this testimony and recommends adoption.

(5) RESOLUTION 209 – SEXUAL ASSAULT EDUCATION AND PREVENTION IN PUBLIC SCHOOLS

RECOMMENDATION:

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

HOD ACTION: Resolution 209 adopted.

Resolution 209 asks that our American Medical Association support state legislation mandating that public middle and high school health education programs include age appropriate information on sexual assault education and prevention, including but not limited to topics of consent and sexual bullying. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony in support of Resolution 209. The issues raised by Resolution 209 are both urgent and timely. Your Reference Committee, therefore, recommends adoption.

(6) RESOLUTION 217 – OPPOSITION TO MEDICARE PART B TO PART D CHANGES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 217 be adopted.

HOD ACTION: Resolution 217 adopted.

Resolution 217 asks that our American Medical Association advocate against Medicare changes which would recategorize Medicare Part B drugs into Part D. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 217. Your Reference Committee heard testimony that Congress and the Administration must do more to address the high cost of physician administered drugs and access challenges. Your Reference Committee also heard testimony that the Administration's proposal to move some drugs from the Medicare Part B benefit to the Part D benefit will not result in lower costs to Medicare beneficiaries and may disrupt the chain of custody needed to ensure that physician administered drugs have not been adultered or subjected to conditions that degrade the efficacy or undermine the safety of the treatment. Accordingly, your Reference Committee recommends adoption of Resolution 217.

(7) RESOLUTION 226 – SUPPORT FOR INTEROPERABILITY OF CLINICAL DATA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 226 be adopted.

HOD ACTION: Resolution 226 adopted.

Resolution 226 asks that our American Medical Association review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 226. Your Reference Committee heard testimony that our AMA has strong policy regarding the development and adoption of universal Electronic Health Records interoperability standards. Your Reference Committee also heard testimony that our AMA is working to eliminate unjustified information blocking and excessive costs which prevent data exchange. Your Reference Committee further heard testimony that Resolution 226 would complement this existing AMA policy. You Reference Committee also heard testimony in support of referral because Resolution 226 references a document outside our AMA's control. Your Reference Committee understands these concerns but would note that the Resolution 226 explicitly state that our AMA only advocate for appropriate recommendations in the document. Your Reference Committee believes that it is a better use of our AMA resources to have our AMA advocate directly to

Office of the National Coordinator to promote interoperability on the appropriate recommendations rather than drafting a report on interoperability. Accordingly, your Reference Committee recommends that Resolution 226 be adopted.

(8) RESOLUTION 229 – ADDRESSING SURGERY PERFORMED BY OPTOMETRISTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 229 be adopted.

HOD ACTION: Resolution 229 adopted.

Resolution 229 asks that our American Medical Association support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.988, "Laser Surgery" (New HOD Policy); and be it further that our AMA encourage state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and H-475.988, "Laser Surgery". (New HOD Policy).

Your Reference Committee heard overwhelming supportive testimony on Resolution 229 and therefore recommends adoption.

(9) BOARD OF TRUSTEES REPORT 5 – EXCLUSIVE STATE CONTROL OF METHADONE CLINICS (RESOLUTION 211-I-17)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation 1 of Board of Trustees Report 5 be amended by deletion to read as follows:

1. That our American Medical Association (AMA) support the right of federally certified Opioid Treatment Programs (OTPs) to be located ~~within residential, commercial and any other areas~~ where there is a demonstrated medical need; (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation in Board of Trustee Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustee Report 5 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 211-1-17, and that the remainder of the report be filed. 1. That our American Medical Association (AMA) support the right of federally certified Opioid Treatment Programs (OTPs) to be located within residential, commercial and any other areas where there is a demonstrated medical need; (New HOD Policy) 2. That our AMA encourage state governments to collaborate with health insurance companies and other payers, state medical societies, national medical specialty societies, OTPs and other health care organizations to develop and disseminate resources that identify where OTP providers operate in a state and take part in surveillance efforts to obtain timely and comprehensive data to inform treatment opportunities; and (New HOD Policy) 3. That our AMA advocate for the federal agencies responsible for approving opioid treatment programs to consider the views of state and local stakeholders when making decisions about OTP locations and policies. (New HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 5. While there was some testimony suggesting that states should be the sole arbiter of how Opioid Treatment Programs (OTPs) should operate, your Reference Committee heard testimony that strong data exists suggesting that OTPs are providing high-quality, evidence-based care to hundreds of thousands of patients under a federal structure. Your Reference Committee heard additional testimony that this federal structure appears to provide consistency while also leaving many areas governing medical practice to state control. This information in the Board Report and the testimony provided by proponents of the recommendations strongly suggests that OTPs are one area where state and federal efforts are working well together. Your Reference Committee heard further testimony that improvements to this structure can be made. Your Reference Committee agrees with the Board that all stakeholders must work together to an even greater extent to ensure that OTPs can prosper to an even greater extent so that patients with an opioid use disorder have greater access to care. Your Reference Committee heard testimony concerning retaining local control over placement of OTPs in residential and commercial areas.

Your Reference Committee heard testimony that an additional Recommendation should be added to the Board of Trustees Report 5 that our AMA support aligning 42 CFR Part 2 privacy protections with current HIPAA regulations in an effort to promote improved coordination of care for patients being treated for substance use disorder (SUD). Others testifying against alignment stated that our AMA has strong policy protecting the confidentiality of patient records and privacy rights of patients with SUD and that our AMA shares the goal of ensuring that physicians have a patient's entire medical record to review and care for their patients. Furthermore, your Reference Committee heard that 113 patient and provider groups oppose alignment stating that federal SUD confidentiality rules must be maintained to protect patient privacy and to encourage those with opioid and other substance use disorders to enter treatment.

Testimony stated that our AMA encourages patients to consent to share SUD information to help clinicians provide coordinated and holistic care. Your Reference Committee heard testimony that our AMA believes that to balance privacy with access to information, and to have truly coordinated care, patients must be willing and active participants. Testimony further indicated that patients who refuse to sign a consent are the very patients who would be deterred from seeking treatment if the laws were aligned, and, consequently, those patients would be kept out of the treatment system without even providing them a chance to better understand the benefits of providing consent.

Your Reference Committee heard further testimony that harmonization could negatively impact privacy of a vulnerable population. SUDs are widely stigmatized and disclosure of SUD-related information can have serious consequences for the patient. Testimony noted that there exists significant confusion and misunderstanding of how Part 2 allows information to be shared among clinicians and other parties, including payers, Accountable Care Organizations, and Health Information Exchanges. Clarifying guidance and regulations would be a meaningful step to help providers, payers, and patients understand rights and obligations under the current law as well as existing opportunities for information sharing. Your Reference Committee heard testimony that statutory and regulatory exceptions exist to the Part 2 consent requirements for emergency situations. Your Reference Committee also heard testimony that there are workable solutions to electronically track patient consent through EHRs that would be more effective in providing physicians with access to sensitive medical records while maintaining robust patient privacy protections.

Your Reference Committee heard testimony raising concerns that alignment of the two laws may not actually accomplish the goals of a professional being fully informed including:

- The current state of interoperability doesn't allow a physician to electronically access all of a patient's information, often requiring physicians to resort to fax or paper records. Many Part 2 facilities do not have EHRs. In most cases, alignment would not change the availability of SUD information.
- Many states have adopted their own laws restricting disclosure of sensitive medical information. Alignment will not preempt these more restrictive laws, which will further confuse patients and clinicians about how SUD information can be shared.
- If a patient's medical record needs to be shared for any reason other than for treatment, payment, or health care operations, a physician must remove all mentions of SUD information, which will be highly burdensome and time-consuming for a physician, likely needing to be done by hand.

Therefore, given the complexity and the differing views, your Reference Committee believes that adding an additional Recommendation about aligning Part 2 with HIPAA to a Board of Trustees Report regarding the exclusive state control of methadone clinics would not allow our AMA and other interested physician groups the opportunity to fully consider this important issue that directly implicates the access to appropriate treatment as well as strong patient privacy protections. Accordingly, your Reference Committee recommends that Board of Trustees Report 7 be adopted as amended.

(10) BOARD OF TRUSTEES REPORT 7 – ADVOCACY FOR SEAMLESS INTERFACE BETWEEN PHYSICIANS ELECTRONIC HEALTH RECORDS (EHRs), PHARMACIES AND PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs) (RESOLUTION 212-A-17; BOT REPORT 12-A-18)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Recommendation of Board of Trustees Report 7 be <u>amended by addition</u> to read as follows:

2. That our AMA urge EHR vendors <u>and Health Information Exchanges (HIEs)</u> to increase transparency of custom

connections and costs for physicians to integrate their products in their practices. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Recommendation of Board of Trustees Report 7 be amended by addition to read as follows

3. That our AMA support state-based pilot studies of best practices to integrate EHRs, HIEs, EPCS, and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. (New HOD policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 7 be amended by addition of a new Recommendation to read as follows:

That our AMA support initiatives to improve the functionality of state PDMPs, including; (1) lessening the time delay between when a prescription is dispensed and when the prescription would be available to physicians through a PDMP; and (2) directing state-based PDMP's to support improved integrated EHR interfaces. (Directive to Take Action)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the recommendations in Board of Trustee Report 7 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustee Report 7 adopted as amended and the remainder of the report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 212-A-17, and the remainder of the report be filed 1. That our American Medical Association (AMA) advocate for a federal study to evaluate the use of PDMPs to improve pain care as well as treatment for substance use disorders. This would include identifying whether PDMPs can distinguish team-based care from uncoordinated care, misuse, or "doctor shopping," as well as help coordinate care for a patient with a substance use disorder or other condition requiring specialty care. (Directive to Take Action) 2. That our AMA urge EHR vendors to increase transparency of custom connections and costs for physicians to integrate their products in their practice. (Directive to Take Action) 3. That our AMA support state-based pilot studies of best practices to integrate EHRs, EPCS and PDMPs as well as efforts to identify burdensome state and federal regulations that prevent such integration from occurring. (New HOD Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 7. Concern was raised, however, that the report did not go far enough. Several testified that the

issues raised are time sensitive and that our AMA needs to take a vocal and public stance on the issues raised in the report. Your Reference Committee acknowledges the aggressive advocacy our AMA is engaged in on the issues raised in this report as well as the extensive work done by nearly all state medical societies in negotiating the political pressures associated with rising mortality and the limited evidence showing PDMPs can help improve pain care. Your Reference Committee agrees that physicians need to be aware of the importance of checking PDMPs and that PDMP data needs to be incorporated into the EHR to truly improve clinical decision making at the point of care. Despite progress being made in data integration, your Reference Committee is concerned that each state is only in the initial stages of such integration and reaching agreements with PDMP vendors may not take into account how those agreements may ultimately pass costs along to physicians. While state PDMPs do not charge physicians to access the PDMP, health systems and others do incur costs for integrating HIE and PDMP data into EHRs. Each state does this differently. Further complicating this is that there are some state laws that may limit PDMP funding. Your Reference Committee received information that physicians have contacted our AMA and reported that access to a PDMP via an EHR has resulted in compounding fees where the EHR vendor, PDMP vendor, and additional third-party intermediaries separately charge physicians, health systems or hospitals. Furthermore, your Reference Committee heard that some states prohibit the use of certain sources of funding, or they rely predominantly on federal grants, thus limiting the potential range of funding mechanisms. For instance, Florida law specifically prohibits the use of state funds to support the PDMP—further tying PDMP financing to physician-bound fees. Because of the need to be very careful and cognizant of unintended consequences arising out of incredibly well intentioned proffered amendments, your Reference Committee recommends that Board of Trustees Report 7 be adopted as amended.

(11) BOARD OF TRUSTEES REPORT 11 – VIOLENCE PREVENTION (RESOLUTION 419-A-18, RESOLVES 1 AND 3)
RESOLUTION 213 – INCREASING FIREARM SAFETY TO PREVENT ACCIDENTAL CHILD DEATHS
RESOLUTION 233 – OPPOSING UNREGULATED, NON-COMMERCIAL FIREARM MANUFACTURING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation 1 of Board of Trustees Report 11 be <u>amended by addition and deletion</u> to read as follows:

1. That Policy H-145.996, “Firearm Availability” be amended by addition and deletion to read as follows:

H-145.996 Firearm Availability
1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials

that cannot be detected by airport and weapon detection devices.

2. Our AMA ~~policy is to~~ supports requiring ~~require~~ the licensing/permitting of ~~owners of~~ firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

~~3. Our AMA supports granting local law enforcement discretion over whether to issue concealed carry permits. in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding "concealed carry", by supporting "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and by supporting "red flag" laws for individuals who have demonstrated significant signs of potential violence. In supporting local law enforcement, we also support as well the importance of "due process" so that decisions could be reversible by individuals can petition petitioning in court for their rights to be restored. (Modify Current HOD Policy)~~

3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that recommendations of Board of Trustees Report 11 be amended by addition of new Recommendations 4 and 5 to read as follows.

4. That Policy H-145.990, "Prevention of Firearm Accidents in Children" be amended by addition and deletion to read as follows:
H-145.990, "Prevention of Firearm Accidents in Children"

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store

firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; ~~and~~ (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) support enactment of Child Access Prevention laws that are consistent with AMA policy.

5. That Policy H-145.994, "Control of Non-Detectable Firearms" be amended by addition to read as follows:

H-145.994, "Control of Non-Detectable Firearms"
The AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 11 be adopted as amended in lieu of Resolutions 213 and 233 and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 11 adopted as amended in lieu of Resolutions 213 and 233 and the remainder of the report filed.

3. That our American Medical Association: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals ~~relevant mental health records~~, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of ~~mental health records~~ relevant information to NICS to improve the quality and timeliness of the data. (New HOD Policy)

The Board of Trustees recommends that the following recommendations be adopted in lieu of the first and third resolves of Resolution 419-A-18 and the remainder of the report be filed. 1. That Policy H-145.996, "Firearm Availability" be amended by addition and deletion to read as follows: H-145.996 Firearm Availability - 1. Our AMA: (a) Advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. 2. Our AMA ~~policy is to~~ supports requiring ~~require~~ the licensing/permitting of ~~owners of~~ firearms ~~owners~~ and purchasers, including the completion of a required safety course, and registration of all firearms. 3. Our AMA supports granting local law enforcement

discretion over whether to issue concealed carry permits. ~~in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding "concealed carry",~~ ~~by supporting "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and by supporting "red-flag" laws for individuals who have demonstrated significant signs of potential violence.~~ In supporting local law enforcement, we also support ~~as well~~ the importance of ~~"~~due process~~"~~ so that ~~decisions could be reversible by~~ individuals can petition ~~petitioning in court~~ for their rights to be restored. (Modify Current HOD Policy) 2. That Policy H-145.972, "Firearms and High-Risk Individuals" be reaffirmed. Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (Reaffirm HOD Policy) 3. That our American Medical Association: (1) encourages the enactment of state laws requiring the reporting of relevant mental health records, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of mental health records to NICS to improve the quality and timeliness of the data. (New HOD Policy). Resolution 213 asks that our American Medical Association advocate for enactment of Child Access Prevention laws in all 50 states or as federal law. (New HOD Policy). Resolution 233 asks that our AMA support legislation that opposes: a) unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; b) production and distribution of 3-D firearm blueprints; and be it further that our AMA issue a statement of concern to Congress and the Bureau of Alcohol, Tobacco, Firearms and Explosives regarding the manufacturing of firearms using 3-D printers and the online dissemination of 3-D firearm blueprints as a public health issue.

Your Reference Committee heard mixed testimony on Board of Trustees Report 11. Your Reference Committee heard that our AMA has extensive policy on firearm safety and violence prevention including policy that supports requiring the licensing of firearm owners, including completion of a required safety course and registration of all firearms. Your Reference Committee heard testimony expressing concerns surrounding granting local law enforcement discretion over whether to issue concealed carry permits and that these decisions may be made arbitrarily and without just cause. However, testimony also indicated that our AMA should support gun violence restraining orders and extreme risk protection orders, commonly known as "red flag" laws, as currently stated in AMA policy H-145.996. Accordingly, your Reference Committee recommends that Board of Trustees 11 be adopted with amendment.

Your Reference Committee heard generally supportive testimony on Resolution 213. Your Reference Committee heard testimony that our AMA already has strong policy regarding the prevention of unintentional shooting deaths among children and firearm accidents in children including supporting efforts to reduce pediatric firearm morbidity and mortality. Your Reference Committee also heard testimony in support of the intent behind Resolution 213 in supporting Child Access Prevention (CAP) laws; however, the testimony raised concerns that supporting all Child Access Prevention laws could be problematic because an individual

state's CAP law may be contrary to existing AMA policy. Accordingly, given the strong existing AMA policy, your Reference Committee recommends adding a fourth recommendation to Board of Trustees Report 11 to amend existing policy by incorporating the intent of Resolution 213 where the CAP law is consistent with AMA policy.

Your Reference Committee heard generally supportive testimony on Resolution 233. Your Reference Committee heard testimony expressing concern regarding the accessibility of 3D printers and the ability to easily fabricate 3D printed firearms. Your Reference Committee heard testimony that using digital blueprints to a 3D printed firearms will increase access to guns in an unregulated manner. Your Reference Committee also heard testimony that our AMA already has policy supporting a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices and that this policy would cover 3D printed firearms. Testimony also indicated that a ban on all unregulated or non-commercial firearms is too broad and does not take into account how states vary in interpreting what are unregulated firearms. Accordingly, given the potential unintended consequences and the focus of the Resolution 233 is on 3D firearms and digital blueprints, your Reference Committee recommends adding a Fifth recommendation to Board of Trustees Report 11 that existing policy be amended to specifically reference 3D printed firearms and 3D digital blueprints.

Therefore, your Reference Committee recommends that Board of Trustees Report 11 be adopted as amended in lieu of Resolutions 213 and 233 and the remainder of the report be filed.

(12) RESOLUTION 205 – LEGALIZATION OF THE DEFERRED ACTION FOR LEGAL CHILDHOOD ARRIVAL (DALCA)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy D-255.979 be <u>amended by addition</u> as follows:

Our AMA will work with all relevant stakeholders to clear the backlog for conversion from H1-B visas for physicians to permanent resident status, <u>and support dependents of physicians on H-1B visas, who are admitted to the U.S. under the H-4 nonimmigrant classification to remain in the U.S. legally while their green card applications are pending.</u>

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that <u>Policy D-255.979 be adopted as amended in lieu of Resolution 205</u>.

HOD ACTION: Resolution 205 be **<u>referred</u>.**

Resolution 205 asks that our American Medical Association support legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (New HOD Policy); and be it further; that our AMA work with the appropriate agencies to allow DALCA children to start and finish

medical school and/or residency training until these DALCA children have officially become legal. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 205. Your Reference Committee heard testimony that there are thousands of children who arrive in our country with their H-1B physician parents legally. Your Reference Committee heard testimony that physicians with H-1B visas may bring their immediate dependents, such as their children, to the U.S. through the H-4 visa process; however, once their children turn 21 years of age they are at risk for deportation because they have aged out and are no longer dependents admitted to the U.S. under the H-4 non-immigration classification while their families' green cards are caught in the H-1B visa backlog. Your Reference Committee heard testimony that Deferred Action for Legal Childhood Arrival (DALCA), is a newly developed term used to draw a distinction from Deferred Action for Childhood Arrivals (DACA) students and is not widely-used by either immigration attorneys or public officials at the federal level. Your Reference Committee also heard testimony that many of these H-4 visa children are in medical schools or have already graduated from U.S. medical schools, but are subject to deportation because they have reached the age of 21. Your Reference Committee further heard testimony that our AMA already has strong policy regarding permanent residence status for physicians and that Resolution 205 should be incorporated into this existing policy. Accordingly, your Reference Committee recommends that current AMA policy D-255.979 be amended and adopted in lieu of Resolution 205.

(13) RESOLUTION 208 – INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH DISPARITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 208 amended by addition to read as follows:

RESOLVED, That our AMA advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. (New HOD Policy)

RECOMMENDATION B:

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

HOD ACTION: Resolution 208 adopted as amended.

RESOLVED, That our AMA advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (New HOD Policy)

Resolution 208 asks that our American Medical Association advocate for the expansion of broadband connectivity to all rural areas of the United States. (New HOD Policy)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 208. Your Reference Committee heard testimony that to address the access challenges in rural and other underserved areas that lack broadband and wireless connectivity, it is essential to advocate adequate federal support so that residents have access to digital health modalities. Your Reference Committee also heard testimony that innovations in health care delivery will increasingly rely on connectivity that is reliable, adequate, and affordable. In line with our AMA's effort to develop, support, and implement digital health technology across the United States, your Reference Committee recommends adoption of Resolution 208 with an amendment to include wireless in addition to broadband and underserved communities as well as rural.

(14) RESOLUTION 211 – ELIMINATING BARRIERS TO AUTOMATED EXTERNAL DEFIBRILLATOR USE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that third Resolve of Resolution 211 be amended by addition and deletion to be read as follows:

RESOLVED That our AMA support consistent and uniform legislation across states for the legal protection of ~~untrained personnel~~ those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim. (Directive to Take Action)

RECOMMENDATION B:

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

HOD ACTION: Resolution 211 adopted as amended.

Resolution 211 asks that our American Medical Association update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications (New HOD Policy); and be it further that our AMA urge AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators (Directive to Take Action); and be it further that our AMA support consistent and uniform legislation across states for the legal protection of untrained personnel who use AEDs in the course of attempting to aid a sudden cardiac arrest victim. (Directive to Take Action)

Your Reference Committee heard strong testimony in support of Resolution 211. Your Reference Committee heard testimony that Resolution 211 will help increase use of AEDs in public sudden cardiac arrest events. Your Reference Committee agrees with testimony that the term "untrained personnel" should to be deleted as it is confusing and ambiguous. Your Reference Committee heard testimony that by deleting this term, resulting policy will be unambiguous and consistent with the reasonable person standard that currently underlies Good Samaritan laws across the country. Accordingly, your Reference Committee recommends that Resolution 211 be adopted as amended.

(15) RESOLUTION 212 – DEVELOPMENT AND IMPLEMENTATION OF GUIDELINES FOR RESPONSIBLE MEDIA COVERAGE OF MASS SHOOTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 212:

DEVELOPMENT AND IMPLEMENTATION OF RECOMMENDATIONS FOR RESPONSIBLE MEDIA COVERAGE OF MASS SHOOTINGS

RESOLVED, that our AMA encourage the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage of mass shootings. (New HOD Policy)

HOD ACTION: The alternate resolution adopted in lieu of Resolution 212:

Resolution 212 asks that our American Medical Association encourage the Centers for Disease Control and Prevention, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 212. Testimony was provided that research suggests that an incident of a mass shooting increases the probability of another mass shooting in the immediate future, and the contagion effect was demonstrated in the mid-1990's with suicides, which led to the development of media coverage guidelines by the Centers for Disease Control and Prevention (CDC), the World Health Organization, and media organizations. Your Reference Committee also heard testimony that recommended that the resolution be amended to encourage the development of recommendations or best practices by the CDC, in collaboration with other public and private organizations, rather than "guidelines," for media coverage of mass shootings, and that the following language in the resolved clause should be deleted since it is too vague: "in a manner that is unlikely to provoke additional incidents." Accordingly, your Reference Committee recommends that an alternate resolution be adopted in lieu of Resolution 212.

(16) RESOLUTION 216 – MEDICARE PART B COMPETITIVE ACQUISITION PROGRAM (CAP)

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:
(1) it must be genuinely voluntary and not penalize practices ~~which~~ that choose not to participate;
(2) it should provide supplemental payments to ~~support complex care coordination and management for cancer patients, including~~ reimburse~~ment~~ for costs associated with ~~the administration of anticancer drugs such as~~ special handling and storage for Part B ~~hazardous~~ drugs
(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;
(~~3~~)(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
(~~4~~)(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
(~~5~~)(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
~~(6) it should not be tied to negotiated discounts~~ (7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
(~~7~~)(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 216 be adopted as amended.

HOD ACTION: Resolution 216 adopted as amended

Resolution 216 asks that our American Medical Association advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care: (1) it must be genuinely voluntary and not penalize practices which choose not to participate; (2) it should provide supplemental payments to support complex care coordination and management for cancer patients, including reimbursement for costs associated with the administration of anticancer drugs such as special handling and storage for hazardous drugs; (3) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations; (4) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards; (5) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician; and (6) it should not be tied to negotiated discounts such as rebates to pharmacy benefit managers given in exchange for implementing utilization management policies like step therapy. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 216. Your Reference Committee heard testimony that the physicians in community practice must have access to affordable Part B drugs and the payment should cover actual costs. Your Reference Committee also heard testimony that a new competitive acquisition program should account for all of the issues raised in the resolved of this resolution. Your Reference Committee heard testimony of an amendment that included a provision that our AMA oppose models that do not meet the criteria set out in Resolution 216. Your Reference Committee believes that this language could hamper our AMA's efforts to advocate and negotiate on this important issue because future alternatives may be offered and our AMA may not be able to support potentially beneficial options. Therefore, your Reference Committee recommends adoption of Resolution 216 as amended.

(17) RESOLUTION 220 – SUPPORTING MENTAL HEALTH TRAINING PROGRAMS FOR CORRECTIONS OFFICERS AND CRISIS INTERVENTION TEAMS FOR LAW ENFORCEMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 220 be amended by addition and deletion to read as follows.

RESOLVED, That our American Medical Association support legislation and federal funding for evidence-based training programs by qualified professionals aimed at educating corrections officers in effectively interacting with ~~mentally ill populations~~ people with mental health diagnoses in ~~federal prisons~~ all detention and correction facilities. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 220 be adopted as amended.

HOD ACTION: Resolution 220 adopted as amended.

RESOLVED, That our American Medical Association support legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with ~~mentally ill populations~~ people with mental health and other behavioral issues ~~diagnoses~~ in ~~federal prisons~~ all detention and correction facilities. (New HOD Policy)

Resolution 220 asks that our American Medical Association support legislation and federal funding for evidence-based training programs aimed at educating corrections officers in effectively interacting with mentally ill populations in federal prisons. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 220, which addresses the important issues of mental health training programs for corrections officers and crisis intervention teams for law enforcement. Your Reference Committee heard further testimony that corrections officers can play a vital role in the proper treatment of offenders with mental illness but generally receive very little training in mental health issues, making violence between inmates and officers commonplace.

Your Reference Committee also heard testimony that our AMA already has strong policy supporting mental health crisis interventions, H-345.972, "Mental Health Crisis Interventions", as a means for jail diversion and community-based treatment options for those with severe mental illness. Testimony further indicated that AMA policy also supports federal funding to encourage increased community and law enforcement participation training including evidence-based crisis intervention training programs, as they have been shown efficacious in promoting jail diversion for individuals experiencing a mental-health related crisis. However, this policy does not specifically apply to educating and supporting law enforcement officials in federal or state prisons. Your Reference Committee heard testimony (1) that evidence-based training programs should be conducted by qualified professionals; (2) to change "mentally ill populations" to "people with mental health diagnoses"; and (3) to change "federal prisons" to be more expansive and cover "all detention and correction facilities." Accordingly, your Reference Committee agrees with these changes and recommends that Resolution 220 be adopted as amended.

(18) RESOLUTION 224 – FAIRNESS IN THE CENTERS FOR MEDICARE & MEDICAID SERVICES AUTHORIZED QUALITY IMPROVEMENT ORGANIZATION'S (QIO) MEDICAL CARE REVIEW PROCESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 224 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate ~~seek by regulation and/or legislation~~ to change ~~amend~~ the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict (Directive to Take Action)

RESOLVED, that our AMA advocate ~~seek by regulation and/or legislation~~ to require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise (Directive to Take Action);

RESOLVED, that our AMA advocate ~~seek by regulation and/or legislation~~ to require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 224 be adopted as amended.

HOD ACTION: Resolution 224 adopted as amended.

Resolution 224 asks that our American Medical Association seek by regulation and/or legislation to amend the Centers for Medicare and Medicaid Services (CMS) quality improvement organization (QIO) process to mandate an opportunity for practitioners and/or providers to request an additional review when the QIO initial determination peer review and the QIO reconsideration peer review are in conflict (Directive to Take Action); and be it further, that our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose to practitioners and/or providers when the QIO peer reviewer is not a peer match and is reviewing a case outside of their area of expertise (Directive to Take Action); and be it further, that our AMA seek by regulation and/or legislation to require CMS authorized QIOs to disclose in their annual report, the number of peer reviews performed by reviewers without the same expertise as the physician being reviewed. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 224. Your Reference Committee heard testimony that our AMA has existing policy regarding Quality Improvement Organization (QIO), including offering due process and fairness for physicians, requiring physician consent before disclosure of QIO review determinations, mandating the utilization of specialty-specific physician reviewers, and to annually publish the names of physician reviewers with credentials and specialties. Your Reference Committee heard further testimony that our AMA submitted to CMS a letter in October that implements the Resolves of Resolution 224. This letter includes advocating for similar due process procedures for physicians and patients, allowing for physician-to-physician conversations at the second level of review, notifying physicians when a peer reviewer does not have similar expertise or specialty as the physician subject to the QIO process, and to disclose the number of peer reviews performed

by reviewers without the same expertise. However, your Reference Committee also heard testimony that existing AMA policy does not specifically address the issues identified in Resolution 224. Your Reference Committee believes that Resolution 224 should be amended to provide flexibility to our AMA in its advocacy activities to include potentially resolving the issues with CMS through subregulatory actions or other activities that are not explicitly regulation or legislation. Accordingly, your Reference Committee recommends that Resolution 224 be adopted as amended.

(19) RESOLUTION 232 – OPPOSITION TO MANDATORY LICENSING REQUIREMENTS FOR QUALIFIED CLINICAL DATA REGISTRIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 232.

HOD ACTION: The alternate resolution adopted in lieu of Resolution 232.

RESOLVED, that our American Medical Association (AMA) oppose any Centers for Medicare and Medicaid Services (CMS) proposal that would require Qualified Clinical Data Registries (QCDR) measure owners, as a condition of measure approval for reporting in Merit-based Incentive Payment System (MIPS) and other Medicare quality payment programs, to enter into a free license agreement with CMS that would allow other QCDRs to use the owner's measures without a direct license with the measure owner; and be it further (Directive to Take Action)

RESOLVED, that our AMA oppose any CMS proposal that would require inclusion of CMS as a party in a QCDR measure licensing agreement between the QCDR measure owner and another; and be it further (Directive to Take Action)

RESOLVED, that our AMA support in situations where QCDR measures are shared between the original measure owner and another QCDR, that the latter QCDR:

1. Must adhere to certain standards and terms set out by the QCDR measure owner on measure implementation and data capture, including data validity and reliability, plus fair remuneration for measure development and ongoing measure stewardship.
2. Must have demonstrated clinical expertise in medicine, quality measure development and improvement by providing methods to ensure data quality, routine metric reporting, and quality improvement consultation. (New HOD Policy)

Resolution 232 asks that our American Medical Association actively oppose any Centers for Medicare & Medicaid Services (CMS) proposal that would require qualified clinical data registry (QCDR) measure owners, as a condition of measure approval for reporting in the Merit-based Incentive Payment System and other Medicare quality payment programs, to enter into a license agreement with CMS that would allow other QCDRs to use the owner's measures without a fee or without a direct license with the measure owner. (Directive to Take Action)

Your Reference Committee heard generally supportive testimony for Resolution 232. Your Reference Committee heard testimony that our AMA opposed the CMS proposal to undermine QCDR measure ownership and development in the physician fee schedule. Your Reference Committee also heard testimony that CMS did not finalize the proposal. Your Reference Committee heard further testimony that even though CMS did not finalize the proposal, this issue may come up again in future rulemaking. An amendment was offered to address the concerns of Resolution 232 through adherence to and implementation of standards and terms set by a specialty's QCDR including demonstrating clinical expertise and providing methods to ensure data quality. Your Reference Committee understands that the first Resolve means that our AMA would oppose CMS requiring QCDR measure owners as a condition of measure approval to enter into a free license agreement. Your Reference Committee further understands that Resolution 232 does not prevent QCDR measure owners from providing to CMS the QCDR measures for free. Accordingly, your Reference Committee recommends that an alternate resolution that reflects these amendments be adopted in lieu of Resolution 232.

(20) RESOLUTION 235 – INAPPROPRIATE USE OF CDC GUIDELINES FOR PRESCRIBING OPIOIDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following alternate resolution be adopted in lieu of Resolution 235:

HOD ACTION: The alternate resolution adopted in lieu of Resolution 235:

RESOLVED, that our American Medical Association (AMA) applaud the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths (Directive To Take Action)

RESOLVED, that our AMA actively continue to communicate and engage with the nation's largest pharmacy chains, pharmacy benefit managers, National Association of Insurance Commissioners, Federation of State Medical Boards, and National Association of Boards of Pharmacy in opposition to communications being sent to physicians that include a blanket proscription against filing prescriptions for opioids that exceed numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical

nuances that would support such prescribing as falling within standards of good quality patient care. (Report back at A-19) (Directive To Take Action)

RESOLVED, that Policies H-120.924, D-95.987, D-160.981, H-265.998, and H-220.951 be reaffirmed. (Reaffirm Existing HOD Policy)

RESOLVED, that our AMA affirms that some patients with acute or chronic pain can benefit from taking opioid pain medications at doses greater than generally recommended in the CDC Guideline for Prescribing Opioids for Chronic Pain and that such care may be medically necessary and appropriate, and be it further

RESOLVED, that our AMA advocate against misapplication of the CDC Guideline for Prescribing Opioids by pharmacists, health insurers, pharmacy benefit managers, legislatures, and governmental and private regulatory bodies in ways that prevent or limit patients' medical access to opioid analgesia, and be it further

RESOLVED, that our AMA advocate that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance, and physicians should not be subject to professional discipline, loss of board certification, loss of clinical privileges, criminal prosecution, civil liability, or other penalties or practice limitations solely for prescribing opioids at a quantitative level above the MME thresholds found in the CDC Guideline for Prescribing Opioids."

Resolution 235 asks that our American Medical Association applaud the Centers for Disease Control and Prevention (CDC) for its efforts to prevent the incidence of new cases of opioid misuse, addiction, and overdose deaths; and be it further, that no entity should use MME (morphine milligram equivalents) thresholds as anything more than guidance and that MME thresholds should not be used to completely prohibit the prescribing of, or the filling of prescriptions for, medications used in oncology care, palliative medicine care, and addiction medicine care (New HOD Policy); and be it further, that our AMA communicate with the nation's largest pharmacy chains and pharmacy benefit managers to recommend that they cease and desist with writing threatening letters to physicians and cease and desist with presenting policies, procedures and directives to retail pharmacists that include a blanket proscription against filling prescriptions for opioids that exceed certain numerical thresholds without taking into account the diagnosis and previous response to treatment for a patient and any clinical nuances that would support such prescribing as falling within standards of good quality patient care (New HOD Policy); and be it further, that AMA Policy opposing the legislating of numerical limits on medication dosage, duration of therapy, numbers of pills/tablets, etc., be reaffirmed (Reaffirm HOD Policy); and be it further, that physicians should not be subject to professional discipline or loss of board certification or loss of clinical privileges simply for prescribing opioids at a quantitative level that exceeds the MME thresholds found in the CDC Guidelines (New HOD Policy); and be it further, that our AMA encourage the Federation of State Medical Boards and its member boards, medical specialty

societies, and other entities (including, possibly, the CDC) to develop improved guidance on management of pain and management of potential withdrawal syndromes and other aspects of patient care for "legacy patients" who may have been treated for extended periods of time with high-dose opioid therapy for chronic non-malignant pain. (New HOD Policy)

Your Reference Committee heard supportive testimony of the intent of Resolution 235. Your Reference Committee heard testimony that the third resolve should be amended to reflect that our AMA is already working with national pharmacy chains regarding physicians who have received letters about exceeding numerical thresholds. Your Reference Committee also heard testimony that our AMA already has strong policy regarding many of the resolves in Resolution 235, including opposing specific doses or durations limits on pharmacologic therapy not supported by medical evidence and protecting due process for medical staff, professional discipline, and board certifications that covers physicians being subject to professional actions for prescribing opioids at a quantitative level that exceeds CDC guidelines. Further testimony indicated that it would redundant to ask FSMB to develop improved guidance because our AMA's "End the Epidemic" website has more than 400 state- and specialty-specific resources. Accordingly, your Reference Committee recommends that an alternate resolution be adopted in lieu of Resolution 235, including reaffirming existing policy.

Evaluating Actions by Pharmacy Benefit Manager and Payer Policies on Patient Care H-120.924
Our AMA will: (1) urge the National Association of Boards of Pharmacy, Federation of State Medical Boards (FSMB), and National Association of Insurance Commissioners (NAIC) to support having national pharmacy chains, health insurance companies, and pharmacy benefits managers (PBMs) testify at state-level public hearings by state medical/pharmacy boards and state departments of insurance, on whether the pharmacy chains, health insurance companies, and PBMs' policies to restrict the prescribing/dispensing of opioid analgesics are in conflict with state insurance laws or state laws governing the practice of medicine and pharmacy; and (2) oppose specific dose or duration limits on pharmacologic therapy that are not supported by medical evidence and clinical practice.
BOT Rep. 17, A-18

Prevention of Opioid Overdose D-95.987
1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate. 2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose. 3. Our AMA will support the development and implementation of appropriate education programs for persons in recovery from opioid addiction and their friends/families that address how a return to opioid use after a period of abstinence can, due to reduced opioid tolerance, result in overdose and death. (Res. 526, A-06 Modified in lieu of Res. 503, A-12 Appended: Res. 909, I-12 Reaffirmed: BOT Rep. 22, A-16 Modified: Res. 511, A-18)

Promotion of Better Pain Care D-160.981
1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. 2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts. 3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages. 4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines. 5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality. (Res. 321, A-08 Appended: Res. 522, A-10 Reaffirmed in lieu of Res. 518, A-12 Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16 Appended: Res. 927, I-16 Appended: Res. 526, A-17 Modified: BOT Action in response to referred for decision Res. 927, I-16)

Guidelines for Due Process H-265.998
While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires: (1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her. (2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity of no less than 30 days to prepare for the hearing. (3) It is the duty and responsibility of the hearing officer to conduct a fair, objective, expeditious and independent hearing pursuant to established rules. (4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing. (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her. (6) The physician is entitled to the opportunity to present a defense to the charges against him or her. (7) To the extent feasible, the hearing panel should evaluate the issues and evidence presented related to the proposed corrective action while blinded to the patient outcome. (8) The hearing panel should render a decision based on the evidence produced at the hearing. (9) The hearing panel should include in its decision the conclusions reached and actions recommended and, as an important focus if feasible, remedial steps for the physician and for the health care facility itself. When feasible, the hearing panel should include terms that permit measurement and

validation of the completed remediation process. (10) The hearing panel should endeavor to state its findings, the clinical basis and support for its findings, its recommendations, and actions as clearly as possible. (11) Within 10 days of the receipt of the hearing panel's decision, the physician, medical executive committee or health care organization, if it brought the correction action, has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts and/or evidence in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical staff bylaws; or (b) the decision is against the manifest weight of the evidence. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician, medical executive committee and the health care organization. The MEC shall appoint an appeal board consisting of members of the medical staff who did not sit on the original hearing panel, or, at the request of the MEC, the governing body or at least three members thereof may sit as the appeal board. The appeal board shall consider the record of the hearing before the hearing panel. If the appeal board determines that significant relevant evidence, which could bear on the outcome of the proceeding, was not entertained by the hearing panel, it may refer the matter back to the hearing panel for further deliberation or, at the appeal board's discretion, it may receive and consider the new evidence. Similarly, if the appeals board determines that there was not substantial compliance with the hearing procedures in the medical staff bylaws, the appeal board may refer the matter back to the hearing body or, at the appeal board's discretion, it may convene additional hearings to correct any defect in the process. Upon completion of the appeal board's deliberations, the appeal board shall present its recommendation(s) to the governing body as to whether the recommendations(s) of the hearing body should be affirmed, modified, or reversed. (12) In any hearing, the interest of patients and the public must be protected. (BOT Rep. II, A-80 Reaffirmed: Sunset Report, I-98 Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05 Reaffirmed: Res. 12, A-06 Reaffirmed: BOT Rep. 06, A-16)

Medical Staff Membership H-220.951
Our AMA (1) requests The Joint Commission to require that conditions for hospital medical staff membership be based only on the physician's professional training, experience, qualifications, and adherence to medical staff bylaws; and (2) will work toward protecting the due process rights of physicians when medical staff privileges are terminated without appropriate due process as described by the medical staff bylaws. (Res. 721, I-91 Reaffirmed by Res. 802, I-94 Reaffirmed: CLRPD 1, A-04 Reaffirmation A-05 Modified: CMS Rep. 1, A-15)

(21) RESOLUTION 202 – ENABLING METHADONE TREATMENT OF OPIOID USE DISORDER IN PRIMARY CARE SETTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 202 be referred.

HOD ACTION: Resolution 202 referred.

Resolution 202 asks that our American Medical Association study the implications of removing those administrative and/or legal barriers that hamper the ability of primary care physician practices to dispense methadone, as part of medication assisted treatment (Directive to Take Action); and be it further, that our AMA study the implications of working with other Federation stakeholders to identify the appropriate educational tools that would support primary care practices in dispensing ongoing methadone for appropriate patients as part of medication-assisted treatment. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 202. Your Reference Committee heard testimony that our AMA should study the implications of removing barriers that hamper the ability of physician practices to dispense methadone. Your Reference Committee also heard testimony that our AMA does not need to study working with the state and specialty societies regarding these issues but instead should work directly with the Federation members on enabling methadone treatment. However, your Reference Committee also heard that no appropriate educational tools that would support primary care practices in dispensing ongoing methadone exist at this moment and that this also needs study. Your Reference Committee heard testimony on the need for the physician community to continue reducing the stigma associated with methadone use and medication assisted treatment. Of note, your Reference Committee heard concerns about providing access to methadone to primary care physicians without sufficient training, and only for the singular indication of opioid use disorder. Given the nature of the testimony, your Reference Committee recommends referral.

(22) RESOLUTION 204 – RESTRICTION ON IMG MOONLIGHTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 204 be <u>referred</u>.

HOD ACTION: Resolution 204 <u>referred</u>.

Resolution 204 asks that our American Medical Association advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight. (New HOD Policy)

Your Reference Committee heard supportive but mixed testimony on Resolution 204. Your Reference Committee heard testimony that our AMA has strong policy regarding limiting duty hours for residents/fellows. Your Reference Committee heard testimony that International Medical Graduates moonlighting will improve access to care for underserved populations in certain areas around the U.S. facing a physician shortage. Your Reference Committee also heard testimony that J-1 visa classifications are explicitly reserved for educational and cultural exchange. Further testimony indicated that J-1 visa classifications are not a work visa and, therefore, J-1 physician participants are not permitted to engage in any work outside of their approved program of graduate medical education. Your Reference Committee also heard testimony that more research needs to be done on the impact of a potential shift of AMA Policy including policies related to patient safety, fatigue/stress on the fellow, professional licensing, payment, and liability. As a result, your Reference Committee believes that Resolution 204 should be referred.

(23) RESOLUTION 206 – REPEALING POTENTIAL PENALTIES ASSOCIATED WITH MIPS
RESOLUTION 231 – REDUCING THE REGULATORY BURDEN IN HEALTH CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 206 and 231 be referred.

HOD ACTION: Resolutions 206 and 231 referred.

Resolution 206 asks that our American Medical Association advocate to repeal all potential penalties associated with the MIPS program. (Directive to Take Action) Resolution 231 asks that our American Medical Association work to support the repeal of the Merit-Based Incentive Payment System (MIPS) (Directive to Take Action); and be it further, that upon repeal of MIPS, our AMA oppose any federal efforts to implement any pay-for-performance programs unless such programs add no significant regulatory or paperwork burdens to the practice of medicine and have been shown, by evidence-based research, to improve the quality of care for those served. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolutions 206 and 231. Your Reference Committee heard testimony that a similar resolution was debated in June at our Annual Meeting, and that the House of Delegates voted against adoption. Your Reference Committee heard testimony that Congress passed the Bipartisan Budget Act of 2018 and included five key MACRA improvements supported by our AMA. These improvements will allow CMS and physicians three additional years to gradually transition into the MIPS program. Your Reference Committee also heard testimony that our AMA continues to work closely with CMS to recommend a variety of improvements to the MIPS program including simplified scoring methodology, reduced reporting burden, and the ability for physicians to report data across multiple performance categories. Your Reference Committee heard further testimony that the cost of repealing MIPS penalties would need to be offset and would potentially come at the expense of bonuses or across the board cuts in physician payments; and that would impact even the physicians who are currently exempt from MIPS, such as small practices. Testimony also indicated that the second Resolve in Resolution 231 would effectively disallow our AMA to continue its support for the Administration's and Congress' efforts to advance successful, innovative payment models as well as the technologies needed to support the models. Your Reference Committee also heard testimony that our AMA should continue to work to simplify and improve the MIPS program, and work with state and specialty societies to help develop more opportunities for physicians to participate in Alternative Payment Models, which would allow them to be exempt from the MIPS program. Your Reference Committee has concerns that repealing penalties associated with MIPS or repealing the entire program could result in an alternative program that may be less desirable. Your Reference Committee understands the continued efforts made by our AMA and specialties to improve MIPS; however, given the Board of Trustees interest in evaluating this issue further, your Reference Committee recommend that Resolutions 206 and 231 be referred.

(24) RESOLUTION 210 – FORCED ORGAN HARVESTING FOR TRANSPLANTATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 210 be referred for decision.

HOD ACTION: Resolution 210 referred for decision.

Resolution 210 asks that our American Medical Association reaffirm Ethical Opinion E-6.1.1, "Transplantation of Organs from Living Donors,", and believes that transplant surgeons, especially those who come to the United States for training in transplant surgery, must agree to these guidelines, and that American medical and hospital institutions not be complicit in any ethical violations or conflicts of interest (New HOD Policy); and be it further, that our AMA representatives to the World Medical Association request an independent, interdisciplinary (not restricted to transplant surgeons), transparent investigation into the Chinese practices of organ transplantation including (but not limited to): the source of the organs as well as the guidelines followed; and to report back on these issues as well as the status of Prisoners of Conscience as sources of transplantable organs (Directive to Take Action); and be it further that our AMA call upon the U.S. Government to protect the large number of transplant tourists by implementing legislation to regulate the evolving, ethical challenges by initiating a Reciprocal Transplant Transparency Act which would blacklist countries that do not meet the same transparency and ethical standards practiced in the U.S. (such as the public listing of annual transplant numbers by every transplant center to permit scrutiny). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 210. Testimony was presented by the sponsor and supporters of the resolution that according to the Executive Director and founder of Doctors Against Forced Organ Harvesting, a medical non-governmental organization, there are substantiated allegations of "state-sponsored domestic organ trafficking and harvesting" in China from executed prisoners, and from prisoners of conscience, including Uighurs, House Christians, Tibetans and Falun Gong practitioners. There was further testimony that although the Chinese Medical Association has stated that the practice of harvesting organs from the deceased prisoners was outlawed as of January 1, 2015, and that organ tourism is prohibited by Chinese law, there have been reports of dramatic increases in transplant tourism and evidence suggesting that the supply of organs in China could not realistically come from legitimate organ donation programs. Your Reference Committee also heard that transplant tourism has become a lucrative source of income in China, leading to a rapid expansion of the transplant infrastructure in China, and China has declared the Hainan Islands to be a special economic zone for medical tourism.

Testimony was also presented that ethical guidelines for transplantation are set forth by our AMA, the World Medical Association (WMA), and the World Health Organization, and the U.S. Congress passed House Resolution 343 in 2016, calling for an end to forced organ harvesting from Falun Gong prisoners of conscience in China; that a Resolution was introduced in the U.S. Senate in 2017; and the European Parliament also passed Written Declaration 48 in 2016, calling for investigations and an end to forced organ harvesting from Falun Gong prisoners of conscience in China.

Testimony was presented that the first Resolve clause of Resolution 210 is problematic and should not be adopted because technically, opinions in the Code of Medical Ethics, such as E-6.1.1, are not reaffirmed—they are AMA ethics policy in perpetuity until or unless CEJA proposes a revision at its own initiative or in response to a request from the HOD or the Board. Testimony was further presented that the ask in the second Resolve clause, for the WMA to conduct an investigation, is not within the scope of WMA's activity. While the WMA can conduct, and has conducted, fact-finding missions, the organization does not engage in investigations of member nations. Your Reference Committee also heard testimony that third Resolved clause is also problematic because it would require our AMA to call upon the federal government to initiate a treaty process to regulate the evolving, ethical challenges of transplant tourism. Your Reference Committee heard testimony that this is beyond our AMA's resources, and it is generally our AMA's practice to work through the WMA on international issues such as those raised in Resolution 210.

Accordingly, given the complicated and serious issue of forced organ harvesting and the concerns raised by the Resolve clauses of Resolution 210, your Reference Committee recommends that Resolution 210 be referred for decision.

(25) RESOLUTION 215 – EXTENDING THE MEDICAL HOME TO MEET FAMILIES WHEREVER THEY GO

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 215 not be adopted.

HOD ACTION: Resolution 215 referred.

Resolution 215 asks that our American Medical Association develop model legislation to permit primary care physicians, who work in medical homes/primary care practices that satisfy the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home Recognition Program guidelines, and who have documented a face-to-face patient-care relationship, to provide telehealth services for the patient when the patient travels to any of the fifty states. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 215. Your Reference Committee also heard testimony that our AMA has strongly advocated to protect the long-standing position of licensure being state based including that state laws where the patient is located should apply including licensure, medical practice, and liability laws. Your Reference Committee heard additional testimony that state-based exceptions and carve outs will further complicate oversight and regulation, patient protections, and spawn challenging conflicts of laws problems. Furthermore, your Reference Committee heard testimony that our AMA already has strong policy promoting quality telemedicine. Accordingly, your Reference Committee recommends that Resolution 215 not be adopted.

(26) RESOLUTION 230 – NONPROFIT HOSPITALS AND NETWORK HEALTH SYSTEMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 230 not be adopted.

HOD ACTION: Resolution 230 not adopted.

Resolution 230 asks that our American Medical Association lobby federal legislators, the Internal Revenue Service, and/or other appropriate federal officials to investigate and review whether non-profit hospitals and other applicable health systems are meeting the provisions of Internal Revenue Code relating to their tax-exempt status when they restrict or otherwise limit medical staff privileges or maintain closed medical staffs, and take appropriate action to ensure that non-profit hospitals and other applicable health systems continue to meet charitable purposes as required under applicable sections of the Internal Revenue Code. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 230. Your Reference Committee heard testimony that the Internal Revenue Service does not strictly say that limiting or closing a medical staff will cost a hospital its 501(c)(3) status and that this policy is long-standing. Your Reference Committee heard testimony that an effort to change this would likely be strenuously opposed by the hospital industry. Your Reference Committee heard testimony that existing AMA policy does not support this resolution—our AMA policy does not say that hospitals cannot close or limit their medical staffs or enter into exclusive contracts with select physicians; it says that the medical staff should be consulted before such actions are taken and that physicians who are not included on the medical staff need to be given due process before being excluded in support of referral. Accordingly, your Reference Committee recommends that Resolution 230 be not adopted.

(27) RESOLUTION 234 – NEGLIGENT CREDENTIALING ACTIONS AGAINST HOSPITALS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 234 not be adopted.

HOD ACTION: Resolution 234 referred for decision.

Resolution 234 asks that our American Medical Association recognize that “negligent credentialing” lawsuits undermine the overall integrity of the credentialing process, potentially resulting in adverse impacts to patient access and quality of care (New HOD Policy); and be it further, that our AMA actively oppose state legislation and court action recognizing “negligent credentialing” as a cause of action that would allow for patients to sue a hospital and medical staff (Directive to Take Action); and be it further, that our AMA work with state medical societies and medical specialty associations in those states that recognize the tort of negligent credentialing to advocate that such claims should place the highest standard of proof on the plaintiff. (Direct to Take Action)

Your Reference Committee heard mixed testimony on Resolution 234. Your Reference Committee heard testimony that patients are already protected under various medical liability or medical malpractice laws and that the threat of liability for negligent credentialing may result in hospitals and health plans adopting more stringent criteria to credential licensed physicians. Your Reference Committee also heard testimony that negligent credentialing is an action that is taken against a hospital and not a physician. Testimony further indicated that our AMA should focus our resources on protecting physicians from liability. Your Reference Committee also heard testimony that removing the hospital from a liability action could be at the expense of the physician and leave the physician with having greater liability. Your Reference Committee heard further testimony that asking our AMA to argue for the highest standard of proof (which is reasonable doubt) for a negligence case weakens AMA's advocacy efforts because proof beyond reasonable doubt is only meant for criminal cases. Accordingly, your Reference Committee recommends that Resolution 234 not be adopted.

(28) RESOLUTION 218 – ALTERNATIVES TO TORT FOR MEDICAL LIABILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-435.943, H-435.978, H-435.993, D-435.974, and D-435.992 be reaffirmed in lieu of Resolution 218.

HOD ACTION: Policies H-435.943, H-435.978, H-435.993, D-435.974, and D-435.992 reaffirmed in lieu of Resolution 218.

That our American Medical Association study and/or develop options for alternatives to the tort system that will: assure fair compensation to individuals harmed as a result of systems or clinician error in the process of receiving medical care and separately; identify and hold accountable physicians, other practitioners and health care delivery systems for questionable practice through professional review and quality management as well as identify opportunities for improving systems to maximize the safety of medical care (as in New Zealand and other countries or the Candor strategy). (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 218. Your Reference Committee heard testimony that our AMA remains on the forefront on the medical liability issue by advocating at both the federal and state levels and conducting research to improve the liability system. Our AMA remains committed to advocate for proven reforms—such as caps on non-economic damages—to resolve this problem. Your Reference Committee also heard testimony that based on existing AMA policy our AMA will continue advocating for innovative reforms, such as health courts and early disclosure models, to complement traditional reforms. Your Reference Committee also heard testimony that a fair or no-fault compensation system as proposed in Resolution 218 runs contrary to AMA policy by lowering the standard of proof required for a judgment against a physician, lacks requirements that medical experts have the same or similar expertise as the defendant, and could increase National Practitioner Databank Reporting. Accordingly, given the strong AMA policy on medical liability, your Reference Committee recommends reaffirming policy in lieu of Resolution 218.

AMA Support for State Medical Societies' Efforts to Implement MICRA-Type Legislation H-435.943

Our AMA supports state medical associations in their opposition to proposals to replace a state medical liability system with a no-fault liability or Patient Compensation System, unless those proposals are consistent with AMA policy. (BOT Rep. 02, I-16)

Federal Medical Liability Reform H-435.978
Our AMA: (1) supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of $250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages; (2) reaffirms its support for the additional reforms identified in Report L (A-89) as appropriate for a federal reform vehicle. These are: (a) a certificate of merit requirement as a prelude to filing medical liability cases; and (b) basic medical expert witness criteria; (3) supports for any federal initiative incorporating provisions of this type would be expressly conditional. Under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. Federal preemptive legislation that endangers state-based reform will be actively opposed. Federal initiatives incorporating extended or ill-advised regulation of the practice of medicine also will not be supported. Effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. (BOT Rep. S, I-89, BOT Rep. I-93-53, Reaffirmed: BOT Rep. 8, I-98, Reaffirmation A-00, Reaffirmation I-03, Reaffirmed: Sub. Res. 910, I-03, Reaffirmed: Res. 206, I-09, Reaffirmation A-10, Reaffirmed: Sub. Res. 222, I-10, Reaffirmed: Res. 206, A-11, Reaffirmed in lieu of Res. 205, I-11, Reaffirmed in lieu of first resolve of Res. 214, I-15)
Tort Liability Reform H-435.993
Our AMA: (1) supports the efforts of state medical societies to form coalitions supporting tort reform in each state and representing the numerous interests adversely affected by present escalating tort liability costs; and (2) believes these coalitions should address such issues as reform of laws governing product and professional liability, and development of appropriate public education programs regarding the impact and cost to consumers of present liability laws. (Sub. Res. 6, A-84, Reaffirmed by CLRPD Rep. 3 - I-94, Reaffirmation A-00, Reaffirmation I-08, Reaffirmed: BOT Rep. 09, A-18)

Health System and Litigation Reform D-435.974
Our AMA will: (1) press vigorously and creatively for inclusion of effective medical litigation reforms as part of the comprehensive federal health system/insurance reform debate now underway in Washington, DC; and (2) consider and, as necessary, negotiate with federal policymakers on a wide range of litigation reform policy options to gain inclusion of a remedy in the health system reform package. These options might include traditional tort reforms, recovery limitations similar to those of the Veterans Administration (VA) system, demonstration/pilot programs on alternate dispute resolution systems such as the VA model and health courts, and/or other effective options to preserve patient access to care. (Res. 209, A-09, Reaffirmed: Sub. Res. 222, I-10)

Liability Reform D-435.992
Our AMA: (1) in concert with a coalition for civil liability reform, shall develop a broad-based and sustained grassroots member mobilization campaign to communicate its

call for immediate legislative relief from the current tort system to our congressional representatives and senators; (2) will work for passage of significant legislation in both houses of the US Congress on liability reform in this congressional year; and (3) will work with state and national medical specialty societies to develop and implement a comprehensive strategic plan that will address all aspects of the growing medical liability crisis to ensure that federal medical liability reform legislation continues to move forward through the legislative process. (Sub. Res. 215, A-02, Reaffirmation I-03, Appended: Sub. Res. 910, I-03, Modified: BOT Rep. 28, A-13)

(29) RESOLUTION 225 – "SURPRISE" OUT OF NETWORK BILLS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-285.904 be reaffirmed in lieu of Resolution 225.

HOD ACTION: Policy H-285.904 reaffirmed in lieu of Resolution 225.

Resolution 225 asks that our American Medical Association advocate that any federal legislation on "surprise" out of network medical bills be consistent with AMA Policy H-285.904, "Out-of-Network Care," and apply to ERISA plans not subject to state regulation (New HOD Policy); and be it further, that our AMA advocate that such federal legislation protect state laws that do not limit surprise out of network medical bills to a percentage of Medicare or health insurance fee schedules. (New HOD Policy)

Your Reference Committee heard testimony that our AMA is committed to developing patient-centered solutions to unanticipated out-of-network care and addressing the financial burden patients may face when they incur unexpected expenses for care not covered by their health insurance company. Your Reference Committee heard that concepts addressed in Resolution 225 already addressed in existing out-of-network policy H-285-904, which was recently adopted after substantial conversation with state and specialty societies. Testimony also stated that this policy clearly outlines both a fair payment standard and requires that advocacy around our out-of-network policy should be directed at all health plans, including ERISA-regulated plans.

Your Reference Committee heard testimony for and against the addition of a recommendation that our AMA develop model federal legislation consistent with existing policy relative to this subject. Testimony for adoption suggested that our AMA develop model federal legislation consistent with existing policy. Testimony against adding this language raised concerns that drafting a federal model bill could limit our AMA's and other physician groups' flexibility to work with Congress to craft a workable solution. Your Reference Committee heard that if our AMA drafted a federal bill, and then Congress uses different language or a different statutory pathway than what our AMA proposed, our AMA would potentially be in a position of having to oppose or not support the bill that would otherwise achieve the same result, while other physician groups and other stakeholders would not be under the same constraint. Your Reference Committee agrees with these concerns, and notes that our current AMA Policy H-285.904 was just amended at our 2018 Annual Meeting with language that is very clear—our AMA will advocate for Policy H-285.904 "for all health plans, including ERISA plans." Your Reference Committee heard testimony that this means our AMA will continue to advocate for federal legislation, whether it is achieved through the Public Health Service Act, the Social

Security Act, the Internal Revenue Code, ERISA, or other federal statutes, as long as it meets the criteria of our policy. Furthermore, your Reference Committee heard testimony that our AMA is currently engaged in discussions with Members of Congress who are attempting to draft a federal solution to balance billing. These discussions include working with other physician groups, and that these physician groups have all been largely aligned around current AMA policy as the basis for negotiations. Your Reference Committee agrees with the concerns raised that altering course now could impact not just our AMA's progress, but that of other physician groups engaged in this advocacy activity. Accordingly, your Reference Committee recommends that Policy H-285.904 be reaffirmed in lieu of Resolution 225.

Out-of-Network Care H-285.904
1. Our AMA adopts the following principles related to unanticipated out-of-network care: A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider. B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans. C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur. D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians. E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered. F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company. G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization. H. Mediation should be permitted in those instances where a physicians unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard. 2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans. (Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18)

(30) RESOLUTION 228 – MEDICATION ASSISTED TREATMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-185.931, H-95.944, and D-160.981 be reaffirmed in lieu of Resolution 228.

HOD ACTION: Policies H-185.931, H-95.944, and D-160.981 reaffirmed in lieu of Resolution 228.

Resolution 228 asks that our American Medical Association advocate for all insurance plans (public and private payers) to provide coverage for medication assisted treatment of opioid use disorder by all qualified physicians. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 228. Your Reference Committee heard testimony that all insurance plans should provide coverage for medication assisted treatment (MAT) of opioid use disorder. Testimony also indicated that our AMA already has existing policy that our AMA advocate for all payers to provide coverage for MAT. Further testimony stated that our AMA is also already advocating for all forms of MAT to be on the lowest cost-sharing tier of a plan formulary and also to remove prior authorization and other health plan barriers to MAT. Accordingly, your Reference Committee recommends reaffirming Policies H-185.931, H-95.944, and D-160.981.

Workforce and Coverage for Pain Management H-185.931
1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living. 2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets. 3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain. 4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits. 5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process. 6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable. (CMS/CSAPH Rep. 1, A-15 Reaffirmed: BOT Rep. 5, I-15 Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16 Modified: BOT Rep. 38, A-18)

Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944
Our AMA opposes 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. (Res. 710, A-13)

Promotion of Better Pain Care D-160.981

1. Our AMA: (a) will express its strong commitment to better access and delivery of quality pain care through the promotion of enhanced research, education and clinical practice in the field of pain medicine; and (b) encourages relevant specialties to collaborate in studying the following: (i) the scope of practice and body of knowledge encompassed by the field of pain medicine; (ii) the adequacy of undergraduate, graduate and post graduate education in the principles and practice of the field of pain medicine, considering the current and anticipated medical need for the delivery of quality pain care; (iii) appropriate training and credentialing criteria for this multidisciplinary field of medical practice; and (iv) convening a meeting of interested parties to review all pertinent matters scientific and socioeconomic. 2. Our AMA encourages relevant stakeholders to research the overall effects of opioid production cuts. 3. Our AMA strongly urges the US Drug Enforcement Administration to base any future reductions in aggregate production quotas for opioids on actual data from multiple sources, including prescribing data, and to proactively monitor opioid quotas and supply to prevent any shortages that might develop and to take immediate action to correct any shortages. 4. Our AMA encourages the US Drug Enforcement Administration to be more transparent when developing medication production guidelines. 5. Our AMA and the physician community reaffirm their commitment to delivering compassionate and ethical pain management, promoting safe opioid prescribing, reducing opioid-related harm and the diversion of controlled substances, improving access to treatment for substance use disorders, and fostering a public health based-approach to addressing opioid-related morbidity and mortality. (Res. 321, A-08 Appended: Res. 522, A-10 Reaffirmed in lieu of Res. 518, A-12 Reaffirmed: BOT Rep. 19, A-16 Reaffirmed in lieu of Res. 117, A-16)

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Sue Bornstein, MD, Tilden Childs, MD, Daniel P. Edney, MD, Ross F. Goldberg, MD, Raymond Lorenzoni, MD, Bruce A. MacLeod, MD, and all those who testified before the Committee.

Sue Bornstein, MD
American College of Physicians

Ross F. Goldberg, MD (Alternate)
Arizona

Tilden L. Childs, MD
American College of Radiology

Raymond Lorenzoni, MD
Medical Society of the State of New York
(Resident and Fellow Delegate)

Daniel P. Edney, MD (Alternate)
Mississippi

Bruce A. MacLeod, MD (Alternate)
Pennsylvania

Francis P. MacMillan, Jr., MD
Massachusetts
Chair