AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-16)

Report of Reference Committee J

Candace E. Keller, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 1 - Infertility Benefits for Veterans
2. Council on Medical Service Report 3 - Providers and the Annual Wellness Visit
3. Council on Medical Service Report 5 - Incorporating Value into Pharmaceutical Pricing
4. Resolution 802 - Eliminating Fail First Policy in Addiction Treatment
5. Resolution 807 - Pharmacy Use of Medication Discontinuation Messaging Function

RECOMMENDED FOR ADOPTION AS AMENDED

6. Council on Medical Service Report 2 - Health Care while Incarcerated
7. Council on Medical Service Report 4 - Concurrent Hospice and Curative Care
   in lieu of
   Resolution 812 - Enact Rules and Payment Mechanisms to Encourage Appropriate Hospice and Palliative Care Usage
8. Council on Medical Service Report 6 - Integration of Mobile Health Applications and Devices into Practice
9. Council on Medical Service Report 7 - Hospital Discharge Communications
   in lieu of
   Resolution 818 - Improving Communications Among Health Care Clinicians
10. Resolution 804 - Parity in Reproductive Health Insurance Coverage for Same-Sex Couples
11. Resolution 808 - A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities
12. Resolution 809 - Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers
13. Resolution 810 - Medical Necessity of Breast Reconstruction and Reduction Surgeries
14. Resolution 814 - Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act
15. Resolution 815 - Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care

RECOMMENDED FOR REFERRAL

16. Resolution 805 - Health Insurance Companies Should Collect Deductible From Patients After Full Payments To Physicians

RECOMMENDED FOR REFERRAL FOR DECISION

17. Resolution 811 – Opposition to CMS Mandating Treatment Expectations and Practicing Medicine
18. Resolution 813 - Physician Payment for Information Technology Costs
19. Resolution 816 - Support for Seamless Physician Continuity of Patient Care

RECOMMENDED FOR NOT ADOPTION

20. Resolution 806 - Pharmaceutical Industry Drug Pricing is a Public Health Emergency
21. Resolution 820 - Retrospective Payment Denial of Medically Appropriate Studies, Procedures and Testing

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

22. Resolution 803 - Reducing Perioperative Opioid Consumption
23. Resolution 817 - Brand and Generic Drug Costs

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

- Resolution 801 - Increasing Access to Medical Devices for Insulin-Dependent Diabetics
- Resolution 819 - Nonpayment for Unspecified Codes by Third Party Payers

The following resolution was recommended against consideration:

- Resolution 821 - Support the ONE KEY QUESTION® Initiative to Improve the Discussion of Pregnancy Intention, Promote Preventive Reproductive Health Care and Improve Community Health Outcomes by Helping Women Prepare for Healthy Pregnancies and Prevent Unintended Pregnancies

(1) COUNCIL ON MEDICAL SERVICE REPORT 1 - INFERTILITY BENEFITS FOR VETERANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

Council on Medical Service 1 recommends that our AMA support lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; encourage interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries; encourage the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process; and support efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

Testimony on Council on Medical Service Report 1 was unanimously supportive. A member of the Council introduced the report and stated that, while legislation adopted in October 2016 allowing the VA to cover IVF costs for the next two years is a step in the right direction, this legislation only lasts for two years and does not lift the ban. The representative from the Veterans Health Administration (VHA) testified that the VHA is working hard to implement this new legislation. Accordingly, your Reference Committee recommends that Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL SERVICE REPORT 3 - PROVIDERS AND THE ANNUAL WELLNESS VISIT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-425.997 and H-160.921; support that the Medicare Annual Wellness Visit (AWV) is a benefit most appropriately provided by a physician or a member of a physician-led health care team that establishes or continues to provide ongoing continuity of care; support that, at a minimum, any clinician performing the AWV must enumerate all relevant findings from the visit and make provisions for all appropriate follow-up care; support that the Centers for Medicare & Medicaid Services (CMS) provide a means for physicians to determine whether or not Medicare has already paid for an AWV for a patient in the past

12 months; and encourage CMS to educate Medicare enrollees, that, in choosing their primary care physician, they are encouraged to make their AWVs with their primary care physician in order to facilitate continuity and coordination of their care.

Testimony on Council on Medical Service Report 3 was supportive. A member of the Council introduced the report emphasizing continuity of care and supporting the principles that preventive care should be coordinated by the physician and physician-led team. Your Reference Committee received a number of suggested amendments. One speaker suggested that Recommendations 3 and 6 reference not a physician-led health care team but rather a physician-led patient-centered medical home. In response, a number of speakers noted that not all physicians and patients are a part of a medical home. Your Reference Committee concurs and notes that a physician-led health care team already encompasses a physician-led patient-centered medical home. Another speaker suggested deletion of Recommendation 4. The recommendation requests that the clinician performing the AWV enumerate all relevant findings. However, as a member of the Council on Medical Service noted, because the statute allows for other clinicians to perform the AWV, Recommendation 4 acknowledges that reality and tries to work within those bounds. Your Reference Committee notes that this recommendation serves to not only hold all clinicians accountable for recording and follow-up care similar to the requirements put on physicians but also aims to mitigate disruptions in continuity of care. So although your Reference Committee appreciates the intent of that suggestion, in light of the current statute, your Reference Committee agrees with the Council's testimony.

Similarly, there was a suggestion to request that CMS not reimburse for the AWV if it is not provided by the patient's regular source of care. However, your Reference Committee notes that the language of the statute precludes this request and notes that this language impedes a provider from performing the AWV who is attempting to establish a relationship as the regular source of care and therefore does not accept this amendment. As a member of the Council on Medical Service stated, the report was drafted in response to the statute being written in such a way that it explicitly allows for various medical professionals to provide the AWV. The member noted that, while care is best coordinated and provided by the physician-led team, sometimes care is not provided in such a way and all parties must work to ensure continuity of care is preserved in these circumstances. Your Reference Committee concurs. Another speaker noted that the issues faced by physicians from the Medicare AWV mirror those from third party payer wellness visits and suggests a study of this issue. While your Reference Committee understands these concerns, it notes that the scope of this report is limited to the Medicare AWV. Additionally, your Reference Committee highlights that the Council on Medical Service is working on a report on retail health clinics for the 2017 Annual Meeting that may touch on such issues.

Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 5 - INCORPORATING VALUE INTO PHARMACEUTICAL PRICING

RECOMMENDATION:

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

Council on Medical Service Report 5 recommends that our AMA reaffirm Policies H-155.960, H-185.939, H-450.933, H-460.909 and D-390.961; support value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by outlined principles; support the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research; and support direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

There was generally supportive testimony on this report. A member of the Council on Medical Service introduced the report, noting that policymakers, insurers and other stakeholders are moving forward with efforts to integrate value into drug pricing. Testimony addressed the Council report's treatment of Medicare drug price negotiation. Your Reference Committee notes that the implementation of value-based pricing could have an impact on patient cost-sharing for prescription drugs in Medicare Part D. For example, pharmaceutical companies could be incentivized to list their drugs in accordance with value-based prices, which may include guaranteeing a drug's placement in the first tier of a Part D plan formulary and requiring no or nominal copayment or coinsurance if drugs have value-based prices. While acknowledging that Policy D-330.954 that supports eliminating the Medicare prohibition on drug price negotiation remains AMA policy, expanding the policy to grant the Secretary of HHS the authority to establish a formulary, develop a preferred tier in Medicare Part D, or set prices administratively in order to increase the likelihood of cost savings has the potential to adversely impact patient choice of Part D plans, as well as patient access to the prescription drugs they need. Of note, none of the legislation introduced in Congress that would allow the Secretary of HHS to negotiate drug prices in Part D included any Republican sponsors or cosponsors, which is significant given the majority party of the House of Representatives and Senate in the 115th Congress which begins next year. Overall, your Reference Committee believes that the recommendations of this report fill a noteworthy gap in AMA policy with respect to value-based pricing – an approach that has the potential to impact the prices of drugs across the health care system. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 5 be adopted and the remainder of the report be filed.

(4) RESOLUTION 802 - ELIMINATING FAIL FIRST POLICY IN ADDICTION TREATMENT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 802 be adopted.

Resolution 802 asks that our AMA advocate for the elimination of the "fail first" policy implemented by insurance companies for addiction treatment.

Testimony was supportive of Resolution 802. Speakers emphasized that patients with addiction and substance abuse disorders should not be subject to "fail first" policies that require them to fail, for example, an outpatient program before they are able to receive an appropriate level of care. Your Reference Committee agrees and recommends that Resolution 802 be adopted.

(5) RESOLUTION 807 - PHARMACY USE OF MEDICATION DISCONTINUATION MESSAGING FUNCTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 807 be adopted.

Resolution 807 asks that our AMA strongly encourage all software providers and those pharmaceutical dispensing organizations that create their own software to include the functionality to accept discontinuation message transmittals in their electronic prescribing software products; and strongly encourage all dispensing pharmacies accepting medication prescriptions electronically to activate the discontinuation message transmittal functionality in their electronic prescribing support software.

There was generally supportive testimony on this resolution. Your Reference Committee concurs with testimony on the need for additional policy specifically addressing the electronic cancellation of prescriptions, and as such recommends adoption of Resolution 807.

(6) COUNCIL ON MEDICAL SERVICE REPORT 2 - HEALTH CARE WHILE INCARCERATED

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

3. That our AMA support partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for ~~individuals~~ juveniles and adults in the correctional system. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

4. That our AMA encourage state Medicaid agencies to accept and process Medicaid applications from ~~individuals~~ juveniles and adults who are incarcerated. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Recommendation 5 in Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

5. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated ~~individuals~~ juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Recommendation 6 in Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

6. That our AMA encourage states to suspend rather than terminate ~~an individual's~~ Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community. (New HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends Council on Medical Service Report 2 be amended by addition of a new Recommendation to read as follows:

That our AMA urge the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism. (New HOD Policy)

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 2 be amended by addition of a new Recommendation to read as follows:

That our AMA advocate for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women. (New HOD Policy)

RECOMMENDATION G:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

Council on Medical Service Report 2 recommends that our AMA reaffirm Policy D-430.997; advocate for adequate payment to health care providers, including primary care and mental health professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community; support partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for individuals in the correctional system; encourage state Medicaid agencies to accept and process Medicaid applications from individuals who are incarcerated; encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated individuals who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid; encourage states to suspend rather than terminate an individual's Medicaid eligibility upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community; and rescind Policy D-430.994, which requested the study accomplished by this report.

Testimony on Council on Medical Service Report 2 was very supportive. A member of the Council on Medical Service introduced the report, noting that the incarcerated population has a higher rate of chronic disease and mental health conditions than the general population, and highlighting the report's recommendations, including several related to state Medicaid agencies. Additional testimony spoke to the importance of having Medicaid coverage in place and health care services available at the time individuals transition out of incarceration and into their communities. One speaker suggested that the report recommendations specifically address both juveniles and adults, and your Reference Committee recommends amendments to Recommendations 3, 4, 5 and 6 to accomplish this suggestion.

An amendment was offered asking the AMA to urge the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before release from correctional facilities to help establish care in the community and reduce recidivism. A second amendment was offered requesting that the AMA advocate for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetric care for pregnant and postpartum women. There was substantial support for these amendments and your Reference Committee therefore recommends the addition of new recommendations. Your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report filed.

(7) COUNCIL ON MEDICAL SERVICE REPORT 4 - CONCURRENT HOSPICE AND CURATIVE CARE RESOLUTION 812 - ENACT RULES AND PAYMENT MECHANISMS TO ENCOURAGE APPROPRIATE HOSPICE AND PALLIATIVE CARE USAGE

RECOMMENDATION A:

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

4. That our AMA encourage physicians to be familiar with local hospice and palliative care resources and their benefit structures, as well as clinical practice guidelines developed by national medical specialty societies, and to refer seriously ill patients accordingly. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 4 be adopted as amended in lieu of Resolution 812 and the remainder of the report be filed.

Council on Medical Service Report 4 recommends that our AMA reaffirm Policy H-85.966; support continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care; encourage CMS to identify ways to optimize patient access to palliative care, which relieves suffering and improves quality of life for people with serious illnesses, regardless of whether they can be cured, and to provide appropriate coverage and payment for these services; and encourage physicians to be familiar with local hospice and palliative care resources and their benefit structures, and to refer seriously ill patients accordingly.

Resolution 812 asks that our AMA amend Policy H-85.955, Hospice Care, by addition to advocate that the Centers for Medicare and Medicaid Services enact rules and payment mechanisms to encourage appropriate hospice and palliative care utilization for eligible patients.

Testimony was very supportive of Council on Medical Service Report 4 and the intent of Resolution 812. A member of the Council on Medical Service introduced the report, highlighting recommendations calling for continued study and pilot testing by the Centers for Medicare & Medicaid Services (CMS) of a variety of models for providing and paying for concurrent hospice, palliative and curative care, and also encouraging CMS to identify ways to optimize patient access to palliative care and to provide appropriate coverage and payment for these services. The sponsor of Resolution 812 testified in support of Council on Medical Service Report 4, suggesting that the report be adopted in lieu of Resolution 812. One speaker pointed out that several national medical specialty societies have developed clinical practice guidelines on hospice and palliative care. Your

Reference Committee recommends amending Recommendation 4 to encourage physicians to be familiar with these guidelines. Accordingly, your Reference Committee recommends that Council on Medical Service Report 4 be adopted as amended in lieu of Resolution 812.

(8) COUNCIL ON MEDICAL SERVICE REPORT 6 - INTEGRATION OF MOBILE HEALTH APPLICATIONS AND DEVICES INTO PRACTICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

3. That our AMA support the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that:

a) support the establishment or continuation of a valid patient-physician relationship;
b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness;
c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, ~~to the degree they are available,~~ to ensure patient safety, quality of care and positive health outcomes;
d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication;
e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models;
f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app;
g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and
h) ensure that the delivery of any services via the app be consistent with state scope of practice laws. (New HOD Policy)

RECOMMENDATION B:

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

That our AMA assess the feasibility of state and federal legislation, as well as other innovative alternatives, in an effort to mitigate the physician's potential risk of liability from the use or recommendation of mHealth apps. (Directive to Take Action)

RECOMMENDATION C:

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

Council on Medical Service Report 6 recommends that our AMA reaffirm Policies H-480.946 and H-100.980; support the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that follow outlined principles; support that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information; encourage the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used; encourage the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information; encourage physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws; encourage physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks; assess the potential liability risks to physicians for using, recommending, or prescribing mHealth apps, including risk under federal and state medical liability, privacy, and security laws; support further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy; and encourage national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

There was generally supportive testimony on this report. An amendment was offered to ensure that mHealth apps have the highest quality of evidence to support their use, and highlight the importance of evidence-based practice guidelines developed and produced by national medical specialty societies, and based on systematic reviews, being followed in mHealth app development and implementation. In addition, another amendment was

offered to support the AMA assessing the feasibility of state and federal legislation, as well as other innovative alternatives, in an effort to mitigate the physician's potential risk of liability from the use or recommendation of mHealth apps. The Council on Medical Service accepted both amendments as friendly. Your Reference Committee believes that the recommendations of this report effectively address the obstacles that physicians and patients face in accepting and utilizing mHealth technologies. Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

(9) COUNCIL ON MEDICAL SERVICE REPORT 7 - HOSPITAL DISCHARGE COMMUNICATIONS
RESOLUTION 818 - IMPROVING COMMUNICATIONS AMONG HEALTH CARE CLINICIANS

RECOMMENDATION A:

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

That our AMA support making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers. (New HOD Policy)

RECOMMENDATION B:

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

That our AMA develop model guidelines for physicians to improve communications to other physicians, hospital staff and patients, and promote these guidelines to payers, hospitals and patients. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 7 be adopted in lieu of Resolution 818 and the remainder of the report be filed.

Council on Medical Service Report 7 recommends that our AMA reaffirm Policies D-478.995, H-160.942 and D-160.945; encourage the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization; encourage the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care; encourage hospital

engagement of patients and their families/caregivers in the discharge process, using outlined guidelines; support implementation of medication reconciliation as part of the hospital discharge process, using suggested strategies to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged; encourage patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization; and encourage hospitals to review early readmissions and modify their discharge processes accordingly.

Resolution 818 asks that our AMA, in association with the AHA, assess the national impact of communication barriers and their negative impact on direct patient care in the hospital and after discharge between physician-physician in the hospital, in-hospital and after discharge care, and physician-patients and report to the HOD by the 2017 Interim Meeting; and research and develop guidelines that physicians can initiate in their communities to improve communication between physician-physician in the hospital, hospital and after discharge care, and physician-patients and report to the HOD by the 2017 Interim Meeting.

Testimony on Council on Medical Service Report 7 and Resolution 818 was generally supportive. A member of the Council on Medical Service testified that the report's recommendations are intended to complement the AMA's extensive policy by honing in on several critical elements of the discharge process-including hospital engagement of patients and their families, and medication reconciliation-that can be adapted locally. Testimony noted that the report is a follow-up to Council on Medical Service Report 6-A-16, which focused on physician communications during patient hospitalizations. Frustration with lengthy discharge documents, which are often not well understood by patients, was expressed by speakers. Your Reference Committee believes that Recommendation 5, which encourages the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, addresses this concern. Testimony also emphasized that improvements in interoperability of electronic health records and standardized electronic forms have the potential to enhance communications in the future.

An amendment was offered regarding patient access to discharge instructions via patient portals, as well as the ability of patients to delegate access to such portals to their designated caregivers. Your Reference Committee therefore recommends a new recommendation asking the AMA to support making hospital discharge instructions available to patients in both printed and electronic form, and specifically in online portals accessible to patients and their designated caregivers.

The sponsor of Resolution 818 expressed support for the report, and offered additional language requesting the AMA to develop guidelines for physicians to improve communications, and to promote such guidelines upon their completion. Your Reference Committee points out that the report references existing evidence-based programs including the SafeMed care transitions model, Project BOOST (Better Outcomes for Older Adults through Safe Transitions), and Project RED (Re-Engineered Discharge). Also, your Reference Committee recommends a new recommendation that asks the AMA to develop model guidelines for physicians to improve communications to other physicians, hospital staff and patients, and promote these guidelines to payers, hospitals and patients. Your Reference Committee recommends that Council on Medical Service Report 7 be adopted as amended in lieu of Resolution 818.

(10) RESOLUTION 804 - PARITY IN REPRODUCTIVE HEALTH INSURANCE COVERAGE FOR SAME-SEX COUPLES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 804 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support ~~parity in~~ insurance coverage for fertility treatments regardless of marital status or sexual orientation ~~for same-sex couples,~~ when insurance provides coverage for fertility treatments. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 804 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support local and state efforts to promote ~~parity in~~ reproductive health insurance coverage regardless of marital status or sexual orientation ~~for same-sex couples~~ when insurance provides coverage for fertility treatments. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 804 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the title of Resolution 804 be changed to read as follows:

REPRODUCTIVE HEALTH INSURANCE COVERAGE

Resolution 804 asks that our AMA support parity in insurance coverage for fertility treatments for same-sex couples, when insurance provides coverage for fertility treatments; and support local and state efforts to promote parity in reproductive health insurance coverage for same-sex couples when insurance provides coverage for fertility treatments.

Testimony on Resolution 804 was unanimously supportive. Several speakers noted that AMA policy supports measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits as afforded to opposite-

sex households (Policy H-65.973). Your Reference Committee believes this resolution is consistent with existing AMA work on non-discrimination and with existing policy on eliminating health care disparities. An amendment was offered to expand the resolution to include both sexual orientation and differing marital status. Your Reference Committee accepts this amendment. Additional testimony did not offer an amendment but noted that there is not infertility per se in some situations, specifically for same-sex couples, and that this policy should account for such situations. Your Reference Committee agrees and suggests striking mention of parity to address this issue. Accordingly, your Reference Committee recommends Resolution 804 be adopted as amended.

(11) RESOLUTION 808 - A STUDY ON THE HOSPITAL CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (HCAHPS) SURVEY AND HEALTHCARE DISPARITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 808 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the ~~potential healthcare disparities caused by~~ impact of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) on ~~in~~ Medicare ~~reimbursement~~ payments to hospitals serving vulnerable populations and on potential health care disparities. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 808 be adopted as amended.

Resolution 808 asks that our AMA study the potential healthcare disparities caused by Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in Medicare reimbursement.

The majority of testimony on Resolution 808 was supportive. Your Reference Committee discussed two amendments that were offered. The first, which asked the AMA to study the disproportionate impact of pay-for-performance penalties, including those related to HCAHPS, substantially expanded the parameters of the original study requested in Resolution 808. A second amendment asked the AMA to urge the Centers for Medicare & Medicaid Services to amend HCAHPS without studying the survey's impact on health care disparities. Your Reference Committee recommends that Resolution 808 be adopted as amended, and requests that the future study address the number of linguistic groups surveyed via HCAHPS and the need for adjustments that account for the socioeconomic status of patients and safety net disproportionate share hospitals.

(12) RESOLUTION 809 - ADDRESSING THE EXPLOITATION OF RESTRICTED DISTRIBUTION SYSTEMS BY PHARMACEUTICAL MANUFACTURERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 809 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek ~~Federal~~ Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 809 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities ~~the mandatory provision of samples~~ of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays (New HOD Policy); and be it further

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 809 be adopted as amended.

Resolution 809 asks that our AMA advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Federal Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system; support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; and advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.

There was mixed testimony on Resolution 809. Speakers raised concerns with the language of the second resolve that would require mandatory provision of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays. There were also calls for referral. While your Reference Committee agrees that generic drug companies need improved access to appropriate quantities of out-of-patent drugs, your Reference Committee has offered an

amendment to the second resolve to clarify that appropriate quantities should be accessible to generic drug manufacturers and available for purchase upon request. Your Reference Committee believes that Resolution 809 as amended would strengthen AMA policy addressing the utilization and impact of controlled distribution channels for pharmaceuticals, including those resulting from Risk Evaluation and Mitigation Strategies (REMS), as well as policy supporting an effective generic drug approval process. Accordingly, your Reference Committee recommends that Resolution 809 be adopted as amended.

(13) RESOLUTION 810 - MEDICAL NECESSITY OF BREAST RECONSTRUCTION AND REDUCTION SURGERIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 810.

MEDICAL NECESSITY AND UTILIZATION REVIEW

RESOLVED, That our American Medical Association support efforts to ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care (New HOD Policy); and be it further

RESOLVED, That our AMA support efforts to ensure that medical necessity and utilization review decisions are based on assessment of preoperative symptomatology for macromastia without requirements for weight or volume resected during breast reduction surgery. (New HOD Policy)

Resolution 810 asks that our AMA support efforts to adapt medical necessity and insurance coverage decisions for assessment of preoperative symptomatology for macromastia without requirements for weight of volume resected during breast reduction surgery.

There was unanimous supportive testimony on Resolution 810. Substitute language and a title change were offered to encompass both medical necessity broadly and the specific breast reduction surgery requirements as issue. Additional testimony supported this substitute, and your Reference Committee agrees. Your Reference Committee notes it may be helpful to change “insurance coverage” to “utilization review” because the phrase “insurance coverage” may be overly inclusive as it would include all aspects of paying for a patient that are not necessarily based on clinical evidence, such as a patient not paying his or her premiums. Accordingly, your Reference Committee recommends adoption of alternate language in lieu of Resolution 810.

(14) RESOLUTION 814 - ADDRESSING DISCRIMINATORY HEALTH PLAN EXCLUSIONS OR PROBLEMATIC BENEFIT SUBSTITUTIONS FOR ESSENTIAL HEALTH BENEFITS UNDER THE AFFORDABLE CARE ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 814.

RESOLVED, That our American Medical Association work with state medical societies to ensure that no health carrier or its designee may adopt or implement a benefit design that discriminates on the basis of health status, race, color, national origin, disability, age, sex, gender identity, sexual orientation, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (Directive to Take Action); and be it further

RESOLVED, That our AMA work with state medical societies to see that appropriate action is taken by state regulators when discrimination may exist in benefit designs (Directive to Take Action); and be it further

RESOLVED, That our AMA support improvements to the essential health benefits benchmark plan selection process to ensure limits and exclusions do not impede access to health care and coverage (New HOD Policy); and be it further

RESOLVED, That our AMA encourage federal regulators to develop policy to prohibit essential health benefits substitutions that do not exist in a state's benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage (New HOD Policy); and be it further

RESOLVED, That our AMA encourage federal regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights. (New HOD Policy)

Resolution 814 asks that our AMA work with state medical societies and their state regulators to facilitate the following: 1. Prohibit health plans from imposing arbitrary limits that are unreasonable or potentially discriminatory for coverage of the Essential Health Benefits (EHB). 2. Require any insurer, whose plans contain exclusions that are not in the state EHB benchmark plan, demonstrate that its benefits are substantially similar

and actuarially equivalent to the benchmark, in compliance with federal regulations. 3. Define the state habilitative EHB definition that goes beyond the federal minimum definition. 4. Review current plans for discriminatory exclusions and require insurers to revise these plans if discriminatory exclusions present. 5. Review consumer complaints for incidents of discriminatory benefit and formulary design, cost-sharing, problematic EHB substitutions or exclusions. 6. Prohibit insurer benefit substitutions in the EHB.

Resolution 814 also asks that our AMA work with federal regulators to: 1. Improve the EHB benchmark plan selection process to ensure arbitrary limits and exclusions do not impede access to healthcare and coverage. 2. Develop policy to prohibit EHB substitutions that do not exist in a state's benchmark plan or selective use of exclusions or arbitrary limits to prevent high-cost claims or that encourage high-cost enrollees to drop coverage. 3. Review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights.

There was limited yet mixed testimony on Resolution 814. A member of the Council on Medical Service raised concerns that the language of the resolution was overly prescriptive. There were also calls for referral. However, your Reference Committee has offered substitute language to address the concerns highlighted in testimony, while supporting the intent of the original resolution. Your Reference Committee recommends adoption of alternate language in lieu of Resolution 814.

(15) RESOLUTION 815 - PRESERVATION OF PHYSICIAN-PATIENT RELATIONSHIPS AND PROMOTION OF CONTINUITY OF PATIENT CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 815 be <u>amended by addition</u> to read as follows:

RESOLVED, That our AMA support the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care <u>when appropriate care is not available within a limited network of providers.</u> (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 815 be <u>adopted as amended</u>.

Resolution 815 asks that our AMA support policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; support the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care; and support policies that encourage patients to return to

their established primary care provider after emergency department visits, hospitalization or specialty consultation.

Testimony on Resolution 815 was generally supportive. A member of the Council on Medical Service testified that protection of physician-patient relationships was the focus of Council on Medical Service Report 4-A-10, and that reaffirmation of existing policy may be appropriate. Several speakers supported an amendment to the second Resolve clause, which supports the ability of physicians to refer patients out-of-network when appropriate care is not available within a limited network of providers. Your Reference Committee concurs and recommends that Resolution 815 be adopted as amended.

(16) RESOLUTION 805 - HEALTH INSURANCE COMPANIES SHOULD COLLECT DEDUCTIBLE FROM PATIENTS AFTER FULL PAYMENTS TO PHYSICIANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 805 be referred.

Resolution 805 asks that our AMA seek federal and state legislation that requires health insurers to reimburse physicians the full negotiated payment rate for services to enrollees in high deductible plans and that the health insurers collect any patient financial responsibility, including deductibles and co-insurance, directly from the patient.

There was generally supportive testimony on Resolution 805. Speakers stressed that patient collections have become a much more challenging issue with the advent of high-deductible health plans. However, your Reference Committee believes that Resolution 805 raises issues that warrant further study, due to the expected impact on physician practices, as well as the potential for unintended consequences. For example, some physicians may not want to cede patient collections to health plans as called for in Resolution 805. Physicians currently have the ability to offer discounts or payment plans to patients to facilitate good will – a business practice that would be impacted. Also, your Reference Committee believes that Resolution 805 has the potential to adversely affect physician payment, as well as the accounts receivable of physician practices. In addition, if Resolution 805 were implemented, health plans could potentially charge administrative fees or physician payment levels could be lowered resulting from a perceived decrease in the level of physician practice personnel needed, as well as overhead expenses. As such, your Reference Committee recommends that Resolution 805 be referred.

(17) RESOLUTION 811 - OPPOSITION TO CMS MANDATING TREATMENT EXPECTATIONS AND PRACTICING MEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 811 be referred for decision.

Resolution 811 asks that our AMA oppose CMS creating mandatory standards of care that may potentially harm patients, disrupt the patient-physician relationship, and fail to recognize the importance of appropriate physician assessment, evidence-based medicine and goal-directed care of individual patients; communicate to hospitals that some CMS mandatory standards of care do not recognize appropriate physician treatment and may cause unnecessary harm to patients; and communicate to members, state and specialty societies, and the public the dangers of CMS' quality indicators potentially harming the patient-physician relationship.

There was generally supportive testimony on Resolution 811. Members from the Board of Trustees, Council on Medical Service and Council on Legislation noted that a resolution addressing the unintended consequences of core measures was referred at the 2016 Annual Meeting, so a report on the issues raised in Resolution 811 is already being developed for the 2017 Annual Meeting. Similar to Resolution 811, the referred resolution also responded to the core measure addressing severe sepsis and septic shock. Despite the study underway, speakers spoke to the urgency of the resolution, as the implementation of core measures has already begun, with the potential to interfere with how physicians practice medicine. A speaker also called for a moratorium of the implementation of core quality measures that have not been vetted by the physician community, including affected national medical specialty societies. There were calls to refer Resolution 811 for decision, as action may need to be taken by the AMA prior to the 2017 Annual Meeting. A member of the Board of Trustees also welcomed the referral of the resolution for decision. Your Reference Committee agrees that Resolution 811 should be referred for decision, to ensure that our AMA can develop a comprehensive and consistent response to core quality measures of the Centers for Medicare and Medicaid Services.

(18) RESOLUTION 813 - PHYSICIAN PAYMENT FOR INFORMATION TECHNOLOGY COSTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 813 be <u>referred for decision</u>.

Resolution 813 asks that our AMA assist in gathering and providing data that physicians can use to convince public and private payers that payment must cover the increasing information technology costs of physicians.

Testimony on Resolution 813 was overall supportive. A member of the Council on Medical Service testified that the problem does not appear to be lack of data and finds further data gathering unnecessary. Your Reference Committee agrees. The Council member stated that the AMA partnered with Dartmouth-Hitchcock in a 2015 joint research project to establish the amount of time that physicians spend on administrative tasks versus clinical care. Board of Trustees Report 11-A-15 outlined the methodology and research plan for this study, which involved direct observation of physicians in sixteen practices across four medical specialties and four geographic regions. The AMA and Dartmouth-Hitchcock authors prepared a manuscript describing the results of this study, which were published in the Annals of Internal Medicine in September 2016. The member noted that EHRs are not a one-size-fits all mechanism and that the request of this resolution may not be feasible and is not focused enough to achieve its intended

objective. Your Reference Committee concurs and notes that this resolution may be overly simplistic since there are many cost facets of information technology including the cost of implementation, upgrades, maintenance, and time costs.

Additionally, your Reference Committee believes that adopting this resolution or the suggested amendment implicitly suggests that the AMA believes public and private payers must cover the information technology costs of physicians. Your Reference Committee believes this is potentially problematic and finds the issue to be more complex than the resolution or amendment convey. Accordingly, your Reference Committee recommends that Resolution 813 be referred for decision, with consideration of the proposed amendment.

(19) RESOLUTION 816 - SUPPORT FOR SEAMLESS PHYSICIAN CONTINUITY OF PATIENT CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 816 be referred for decision.

Resolution 816 asks that our AMA clearly support the concept of seamless continuity of care between hospital inpatient and outpatient care; and study whether there are instances of health insurers or HMO's precluding physicians via contracts from providing care to their patients in the in-patient setting for which the physician has clinical privileges.

Testimony on Resolution 816 was limited. Substitute language offered by the Senior Physicians Section asked the AMA to investigate the practice of risk management companies that require through Medicare Advantage subcontracts or by other means that physicians delegate care of their contracted patients to the management company's panel for approval of referrals, hospital and nursing home care, and put the physician at financial risk if they fail to follow such mandates.

A member of the Council on Medical Service testified that the substitute language offered by the Senior Physicians Section substantially changed the intent of Resolution 816 and suggested the item be referred for decision. Your Reference Committee agrees, and recommends that Resolution 816 be referred for decision.

(20) RESOLUTION 806 - PHARMACEUTICAL INDUSTRY DRUG PRICING IS A PUBLIC HEALTH EMERGENCY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 806 not be adopted.

Resolution 806 asks that our AMA request that the Secretary of Health and Human Services declare pharmaceutical drug pricing a public health emergency under section 319 of the Public Health Service Act and that the Secretary take appropriate actions in response to the emergency, including investigations into the cause, treatment, or prevention of egregious pharmaceutical drug pricing.

There was mixed testimony on this resolution. Speakers, including members of the Council on Medical Service and Council on Legislation, stressed that prescription drug pricing falls outside the scope of a public health emergency as outlined in Section 319 of the Public Health Service Act (PHSA). Section 319 of the PHSA confers the Secretary of HHS with the authority to provide assistance to states and suspend legal requirements in the face of disease or disorder presenting a public health emergency including infectious disease outbreaks or bioterrorist attacks. Your Reference Committee concurs with speakers that stressed that misusing this provision of Section 319 will not further efforts to address prescription drug affordability. Furthermore, your Reference Committee agrees with testimony that the AMA is unlikely to make a defensible case that high drug prices constitute a disease or disorder. Your Reference Committee believes that our AMA should continue its advocacy in this arena based on its strong and comprehensive policy foundation that supports market-based strategies to achieve the affordability of prescription drugs, include advocating for prescription drug price and cost transparency; opposing "pay for delay" agreements; supporting shortening the exclusivity period for biologics; and supporting efforts to ensure fair and appropriate pricing of generic medications. As such, your Reference Committee recommends that Resolution 806 not be adopted.

(21) RESOLUTION 820 - RETROSPECTIVE PAYMENT DENIAL OF MEDICALLY APPROPRIATE STUDIES, PROCEDURES AND TESTING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 820 not be adopted.

Resolution 820 asks that our AMA advocate for legislation to require insurers' medical policies to reflect current evidence-based medically appropriate studies and treatments including those for rare and uncommon diseases; advocate for legislation to require insurers to implement a streamlined process for exceptions for rare or uncommon disease states; and advocate for legislation to prohibit insurers from using medical coding as the sole justification to deny medical services and diagnostic or therapeutic testing.

Your Reference Committee received no testimony on Resolution 820. Overall, your Reference Committee does not believe legislating medical policies is appropriate. Further, your Reference Committee does not know what exceptions are being requested in the second Resolve and believes the clause is ambiguous. Regarding the third Resolve, your Reference Committee believes it is a reaffirmation of current policy. Policy H-70.914 was recently adopted at the 2016 Annual Meeting and states that the AMA opposes limitations in coverage for medical services based solely on diagnostic code specificity. Further, Policy H-70.958 requests that CMS ensure its carriers fully understand and implement the distinction between coding to the "highest level of specificity" within a code category and coding for the condition(s) to the "highest degree of certainty." Your Reference Committee notes that, traditionally, when a diagnosis has not been established or when a code does not exist for a specific rare disease, general coding guidelines indicate that it is acceptable to use codes that describe signs and symptoms. Additionally, as written, this Resolve may undermine the current payment

processing that allows for e-claims processing. As such, your Reference Committee recommends that Resolution 820 not be adopted.

(22) RESOLUTION 803 - REDUCING PERIOPERATIVE OPIOID CONSUMPTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-120.947 be reaffirmed in lieu of Resolution 803.

Resolution 803 asks that our AMA encourage hospitals to adopt practices for the management of perioperative pain that include services dedicated to acute pain management and the use of multimodal analgesia strategies aimed at minimizing opioid administration without compromising adequate pain control during the perioperative period.

Testimony on Resolution 803 was mixed, with substantial opposition to its adoption. A majority of speakers were concerned with encouraging hospitals to adopt practices for the management of perioperative pain that include services dedicated to acute pain management and the use of multimodal analgesia during the perioperative period. Some speakers viewed the resolution as overly prescriptive and as an unwanted mandate, emphasizing that decisions regarding pain management should be left to physicians and patients. Additionally, it was noted in testimony that pain management services may not be available in rural hospitals.

A member of the Council on Medical Service suggested reaffirming existing policy in lieu of Resolution 803. Additionally, the Council member pointed out that AMA advocacy efforts and the work of the AMA's Task Force to Reduce Opioid Abuse emphasize comprehensive pain management for all patients' pain whether it be perioperative, acute, emergency or chronic. Your Reference Committee agrees with this sentiment and recommends that Policy D-120.947 be reaffirmed in lieu of Resolution 803.

D-120.947 A More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief
1. Our AMA will consult with relevant Federation partners and consider developing by consensus a set of best practices to help inform the appropriate clinical use of opioid analgesics, including risk assessment and monitoring for substance use disorders, in the management of persistent pain. 2. Our AMA will urge the Centers for Disease Control and Prevention to take the lead in promoting a standard approach to documenting and assessing unintentional poisonings and deaths involving prescription opioids, including obtaining more complete information on other contributing factors in such individuals, in order to develop the most appropriate solutions to prevent these incidents. 3. Our AMA will work diligently with the Centers for Disease Control and Prevention and other regulatory agencies to provide increased leeway in the interpretation of the new guidelines for appropriate prescription of opioid medications in long-term care facilities, in much the same way as is being done for hospice and palliative care. (BOT Rep. 3, I-13; Appended: Res. 522, A-16)

(23) RESOLUTION 817 - BRAND AND GENERIC DRUG COSTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies D-100.983; H-120.934; H-120.945; D-120.949; H-110.987; H-110.989; H-155.962 and H-110.988 be reaffirmed in lieu of Resolution 817.

Resolution 817 asks that our AMA advocate for the following: 1. Investigate the purchasing of medications from outside the country with FDA guidance, on a temporary basis until availability in the U.S. improves; 2. Advocate to permit temporary compounding with FDA's guidance until medications are available; 3. Advocate to allow increased competition in the marketing of medications; 4. Advocate for participative pricing; 5. Advocate for accountability for outcomes; and 6. Advocate for increased regulation of the generic drug market.

There was limited, mixed testimony on Resolution 817. While testimony appreciated the intent of the resolution, speakers, including those from the Council on Legislation and Council on Medical Service, stressed that existing policy more appropriately responds to the issues outlined in the resolution. In addition, your Reference Committee notes that the language of Resolution 817 may not contain necessary safeguards, which could have unintended consequences. For example, supporting prescription drug reimportation without a requirement for track and trace, a requirement outlined in Policy D-100.983, could lead to significant safety concerns with the reimported prescription drugs, which may not be at the same quality or chemical makeup as those currently distributed in the US. There may also be unintended consequences associated with calling for blanket increased regulation of the generic drug market, and as such your Reference Committee believes that reaffirmation of Policy H-110.988 that outlines measures to help control the increasing costs of generic prescription drugs may be more appropriate. Your Reference Committee also notes that Council on Medical Service Report 5, Incorporating Value into Pharmaceutical Pricing, discusses outcomes-based pricing initiatives for prescription drugs, and presents recommendations to better incorporate value into pharmaceutical pricing. Overall, your Reference Committee believes that existing AMA policy appropriately responds to the issues raised in Resolution 817, and as such recommends that Policies D-100.983; H-120.934; H-120.945; D-120.949; H-110.987; H-110.989; H-155.962 and H-110.988 be reaffirmed in lieu of the resolution.

D-100.983 Prescription Drug Importation and Patient Safety
Our AMA will: (1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if: (a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations; (b) the drug distribution chain is "closed," and all drug products are subject to reliable, "electronic" track and trace technology; and (c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported; (2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured; (3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS)

Task Force on Drug Importation and, as appropriate, revise its position on whether or how patient safety can be assured under legalized drug importation; and (4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts. (BOT Rep. 3, I-04; Reaffirmation A-09)

H-120.934 Appropriate Use of Compounded Medications in Medical Offices
Our American Medical Association supports regulatory changes to improve access to (1) the compounding and repackaging of manufactured FDA-approved drugs and substances usually prepared in the office-based setting and (2) purchasing from compounding pharmacies of FDA-approved drugs, repackaged or compounded for the purpose of in-office use. (Res. 207, A-15 Reaffirmed: CMS Rep. 04, A-16 Reaffirmed: Res. 204, A-16)

H-120.945 Pharmacy Compounding
Our AMA: (1) recognizes that traditional compounding pharmacies must be subject to state board of pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications; (2) encourages all state boards of pharmacy to reference sterile compounding quality standards, including but not limited to those contained in United States Pharmacopeia Chapter 797, as the standard for sterile compounding in their state, and to satisfy other relevant standards that have been promulgated by the state in its laws and regulations governing pharmacy practice; (3) supports the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce be recognized as compounding manufacturers subject to FDA oversight and regulation; (4) supports the view that allowances must be made for the conduct of compounding practices that can realistically supply compounded products to meet anticipated clinical needs, including urgent and emergency care scenarios, in a safe manner; and (5) in the absence of new federal legislation affecting the oversight of compounding pharmacies, continues to encourage state boards of pharmacy and the National Association of Boards of Pharmacy to work with the United States Food and Drug Administration to identify and take appropriate enforcement action against entities that are illegally manufacturing medications under the guise of pharmacy compounding. (BOT Action in response to referred for decision Res. 521, A-06; Revised: CSAPH Rep. 9, A-13)

D-120.949 Ensuring the Safe and Appropriate Use of Compounded Medications
Our AMA will: (1) monitor ongoing federal and state evaluations and investigations of the practices of compounding pharmacies; (2) encourage the development of regulations that ensure safe compounding practices that meet patient and physician needs; and (3) report back on efforts to establish the necessary and appropriate regulatory oversight of compounding pharmacy practices. (Sub. Res. 923, I-12; Reaffirmed: Res. 204, A-16)

H-110.987 Pharmaceutical Cost

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting. (CMS Rep. 2, I-15)

H-110.989 Pay for Delay Arrangements by Pharmaceutical Companies
Our AMA supports: (1) the Federal Trade Commission in its efforts to stop "pay for delay" arrangements by pharmaceutical companies and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as "pay for delay," illegal in the United States.(Res. 520, A-08; Appended: Res. 222, I-12; Reaffirmed: CMS 2, I-15)

H-155.962 Maximum Allowable Cost of Prescription Medications
Our AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services.(CMS Rep. 2, A-07; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed: CMS Res. 2, I-15)

H-110.988 Controlling the Skyrocketing Costs of Generic Prescription Drugs
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs. 2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients. 3. Our AMA encourages the development of methods that increase

choice and competition in the development and pricing of generic prescription drugs. 4. Our AMA supports measures that increase price transparency for generic prescription drugs. (Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15)

Madam Speaker, this concludes the report of Reference Committee J. I would like to thank Alyn L. Adrain, MD; Heidi M. Dunniway, MD; Stephen K. Epstein, MD, MPP; Raj B. Lal, MD, MPA; Travis Meyer, MD; Vicki Wooll, MD, MPH; and all those who testified before the Committee.

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