DISCLAIMER

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2016 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-16)

Report of Reference Committee B

Ann R. Stroink, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 201 - Removing Restrictions on Federal Funding for Firearm Violence Research
2. Resolution 203 - Universal Prescriber Access to Prescription Drug Monitoring Programs
3. Resolution 204 - Seamless Conversion of Medicare Advantage Programs
   Resolution 210 - Automatic Enrollment into Medicare Advantage
   Resolution 216 - Ending Medicare Advantage "Auto-Enrollment"
4. Resolution 214 - Firearm-Related Injury and Death: Adopt a Call to Action
5. Resolution 218 - Support for Prescription Drug Monitoring Programs
6. Resolution 220 - Distracted Driver Reduction

RECOMMENDED FOR ADOPTION AS AMENDED

7. Board Report 2 - AMA Support for State Medical Societies' Efforts to Implement MICRA-type Legislation
8. Board Report 3 - Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing
9. Resolution 202 - Inclusion of Sexual Orientation and Gender Identity Information in Electronic Health Records
   Resolution 212 - Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
10. Resolution 205 - AMA Study of the Affordable Care Act
    Resolution 209 - Affordable Care Act Revisit
    Resolution 223 - Emergency Post-Election Support for Principles of the Patient Protection and Affordable Care Act
    Resolution 224 - Protecting Patient Access to Health Insurance and Affordable Care Act
    Resolution 226 - Continuing AMA Advocacy on the Patient Protection and Affordable Care Act
11. Resolution 208 - MIPS and MACRA Exemptions
12. Resolution 213 - SOAP Notes and Chief Complaint

13. Resolution 215 - Parental Leave
14. Resolution 217 - The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services
15. Resolution 219 - Protect Individualized Compounding in Physicians' Offices as Practice of Medicine
16. Resolution 222 - Prohibition of Clinical Data Blocking

RECOMMENDED FOR REFERRAL

17. Resolution 206 - Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers)
18. Resolution 207 - Limitation on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care
    Resolution 225 - Limitation on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

19. Resolution 211 - Electronic Health Records
20. Resolution 221 - Electronic Medical Recovery Fees

(1) RESOLUTION 201 - REMOVING RESTRICTIONS ON FEDERAL FUNDING FOR FIREARM VIOLENCE RESEARCH

RECOMMENDATION:

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

HOD ACTION: Resolution 201 adopted.

Resolution 201 asks that our American Medical Association provide an informational report on recent and current organizational actions taken on our existing AMA policies regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Your Reference Committee heard minimal but supportive testimony in favor of this resolution. Testimony supported studies of our AMA's advocacy in this area and noted that this is important work that should be carried through to the new Administration. Other testimony in support of this resolution stated that our AMA should expand advocacy in this area generally. Therefore, our Reference Committee recommends that Resolution 201 be adopted.

(2) RESOLUTION 203 - UNIVERSAL PRESCRIBER ACCESS TO PRESCRIPTION DRUG MONITORING PROGRAMS

RECOMMENDATION:

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

HOD ACTION: Resolution 203 adopted.

Resolution 203 asks that our American Medical Association support legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.

Your Reference Committee heard unanimous support for Resolution 203. Your Reference Committee agrees that it is critical for resident physicians, who routinely prescribe controlled substances for their patients including opioid pain medications, to have access to their state's prescription drug monitoring program (PDMP). Since most state laws do not explicitly grant resident physicians access to PDMPs, your Reference Committee agrees that it is appropriate for our AMA to support legislation and regulatory action that would allow residents such access. Your Reference Committee recognizes testimony related to the need to include "designated licensed office and/or hospital personnel." Not only does your Reference Committee believe that this resolution's focus should remain on residents, but we also want to point out that existing AMA policy covers the concerns raised related to "other designated licensed office and/or hospital

personnel." Specifically, H-95.939, entitled "Development and Promotion of Single National Prescription Drug Monitoring Program," states, "Our American Medical Association . . . 3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law." As a result, your Reference Committee recommends that Resolution 203 be adopted.

(3) RESOLUTION 204 - SEAMLESS CONVERSION OF MEDICARE ADVANTAGE PROGRAMS
RESOLUTION 210 - AUTOMATIC ENROLLMENT INTO MEDICARE ADVANTAGE
RESOLUTION 216 - ENDING MEDICARE ADVANTAGE "AUTO-ENROLLMENT"

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 216 be adopted in lieu of Resolution 204 and Resolution 210.

HOD ACTION: Resolution 216 adopted in lieu of Resolution 204 and Resolution 210.

Resolution 204 asks that our American Medical Association collaborate with senior groups, including AARP, to raise awareness among physicians and seniors regarding the implications of the practice of "seamless conversion"; and be it further, that our AMA immediately begin to advocate with Congress and the Centers for Medicare and Medicaid Services to implement an immediate moratorium on the practice of seamless conversion.

Resolution 210 asks that our American Medical Association work to make seamless conversion enrollment into a Medicare Advantage Plan an opt-in rather than an opt-out process.

Resolution 216 asks that our American Medical Association work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of "auto-enrollment" of individuals into Medicare Advantage Plans.

Your Reference Committee heard strong testimony in support of Resolution 216, which your Reference Committee believes is broad and strong enough to accomplish the goals of Resolutions 204 and 210. Your Reference Committee also heard that, due to AMA advocacy efforts, on October 24, 2016, CMS announced that it has temporarily stopped accepting new proposals from health insurance companies seeking to automatically enroll their commercial beneficiaries into their Medicare Advantage plans. Adoption of Resolution 216 is thus consistent with AMA past, current, and future advocacy on Medicare Advantage plans. For these reasons, your Reference Committee recommends adoption of Resolution 216 in lieu of Resolutions 204 and 210.

(4) RESOLUTION 214 - FIREARM-RELATED INJURY AND DEATH: ADOPT A CALL TO ACTION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 214 be adopted.

HOD ACTION: Resolution 214 adopted.

Resolution 214 asks that our American Medical Association endorse the specific recommendations made by an interdisciplinary, inter-professional group of leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American Congress of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, American Public Health Association, and the American Bar Association in the publication "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," which is aimed at reducing the health and public health consequences of firearms and lobby for their adoption.

Your Reference Committee heard extensive, passionate, and supportive testimony related to Resolution 214. Like those testifying, your Reference Committee commends the eight national health professional organizations, including the American Academy of Family Physicians, American Academy of Pediatrics, American College of Emergency Physicians, American Congress of Obstetricians and Gynecologists, American College of Physicians, American College of Surgeons, American Psychiatric Association, and American Public Health Association, as well as the American Bar Association, for articulating and advocating a series of measures aimed at reducing the health and public health consequences of firearms. AMA policy is wholly consistent with the recommendations contained within the publication articulating these measures, titled "Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health Professional Organizations and the American Bar Association," published within the April 7, 2015 edition of the *Annals of Internal Medicine*. Your Reference Committee recognizes the concern raised by several individuals related to referencing specific articles, documents, etc., in AMA policy. However, your Reference Committee believes that in this instance it is appropriate and without risk. Our AMA already has policy that supports every tenant in the document at issue. Moreover, AMA staff, as well as the AMA Council on Legislation, have thoroughly reviewed this publication and are comfortable with our AMA endorsing it in its entirety. At this time, we do not believe it is necessary to summarize the specific recommendations made in this document and as a result of doing so, creating new (essentially redundant) policy. Therefore, your Reference Committee recommends that Resolution 214 be adopted.

(5) RESOLUTION 218 - SUPPORT FOR PRESCRIPTION DRUG MONITORING PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 218 be adopted.

HOD ACTION: Resolution 218 adopted.

Resolution 218 asks that our American Medical Association continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and be it further, that our AMA work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.

Your Reference Committee heard limited but unanimously supportive testimony for Resolution 218. Your Reference Committee agrees that funding of state prescription drug monitoring programs (PDMPs) is critical and, therefore, recommends that Resolution 218 be adopted.

(6) RESOLUTION 220 - DISTRACTED DRIVER REDUCTION

RECOMMENDATION:

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

HOD ACTION: Resolution 220 adopted.

Resolution 220 asks that our American Medical Association develop model state legislation to limit cell phone use to hands-free use only while driving.

Your Reference Committee heard strong support for Resolution 220. AMA policy, H-15.952, entitled “The Dangers of Distraction While Operating Hand-Held Devices,” already provides “2. Our AMA will endorse legislation that would ban the use of hand-held devices while driving.” Your Reference Committee received a report indicating that 46 states and the District of Columbia (DC) prohibit texting while driving and 14 states and the DC prohibit all drivers from using hand-held cell phones while driving, thereby providing a strong basis of sample legislative best practices from which to draw. Your Reference Committee also received information that our AMA state Advocacy Resource Center is already working with interested state medical associations and national medical specialty societies across the country in implementing our existing policy. Given the passionate support for Resolution 220, and specifically, the interest in model state legislation, your Reference Committee recommends adoption.

(7) BOARD OF TRUSTEES REPORT 2 - AMA SUPPORT FOR STATE MEDICAL SOCIETIES' EFFORTS TO IMPLEMENT MICRA-TYPE LEGISLATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second recommendation of Board of Trustees Report 2 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ~~the efforts of interested~~ state medical associations in their opposition to ~~defeat efforts to replace~~ 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. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations of Board of Trustees Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Board of Trustees Report 2 adopted as amended.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 214-I-15 and that the remainder of the report be filed: that our American Medical Association (AMA) reaffirm Policy H-435.967, "Report of the Special Task Force and the Advisory Panel on Professional Liability" and that our AMA support the efforts of interested state medical associations to defeat efforts to replace a state medical liability system with a no-fault liability or Patient Compensation System.

Your Reference Committee heard generally supportive testimony on Board of Trustees Report 2. Your Reference Committee heard testimony from several states that have considered, or are expecting to consider, legislation proposing no-fault liability systems. For many of the reasons outlined in this Board Report, all such states have opposed such proposals. This testimony suggested that the support of our AMA in these state legislative efforts would be welcome. At the same time, your Reference Committee offers an amendment to respond to testimony intended to ensure that our AMA maintains the flexibility to support innovative medical liability reforms that are consistent with AMA policy, such as the National Vaccine Injury Compensation program and birth related neurological injury compensation funds. For these reasons, as well as the reasons stated in the Board's excellent and thorough report, your Reference Committee recommends that the recommendations of Board of Trustees Report 2 be adopted as amended and the remainder of the report be filed.

(8) BOARD OF TRUSTEES REPORT 3 - MODEL STATE LEGISLATION PROMOTING THE USE OF ELECTRONIC TOOLS TO MITIGATE RISK WITH PRESCRIPTION OPIOID PRESCRIBING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 4 of Board of Trustees Report 3 be amended by addition and deletion to read as follows:

4. That our AMA ~~support~~ advocate for the interoperability of state PDMPs with electronic health records (EHRs) ~~(New HOD Policy)~~(Directive to Take Action);

RECOMMENDATION B:

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

HOD ACTION: Board of Trustees Report 3 adopted as amended.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 222-I-15, and that the remainder of the report be filed; and that our American Medical Association (AMA) support the ability of prescription drug monitoring programs (PDMPs) to have the capability for physicians to know when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame; and that our AMA advocate to key stakeholders, including the National Association of State Controlled Substances Authorities, the National Association of Boards of Pharmacy, and the National Governors Association, to ensure that efforts to reduce Multiple Provider Events (MPEs) are done in a manner that supports continuity of care; and that our AMA work with the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA) and other relevant federal agencies, to better understand the factors that lead to MPEs and develop medically and ethically appropriate strategies for reducing them; and that our AMA support the interoperability of state PDMPs with electronic health records (EHRs); and that Policies D-478.972, "EHR Interoperability," D-478.994, "Health Information Technology," and D-478.996, "Information Technology Standards and Costs," be reaffirmed; and that our AMA advocate for the Centers for Medicaid and Medicare Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) to better incorporate feedback from physicians to focus on outcomes and focusing ONC certification on testing for product safety, security, usability, and interoperability.

Your Reference Committee commends the Board of Trustees for an extensive, thorough, and well written report and we laud our AMA's leadership in forming our AMA's Task Force to Reduce Opioid Abuse. Your Reference Committee recognizes that

one of the Task Force's areas of focus includes the support of physicians registering for and using prescription drug monitoring programs (PDMPs). PDMP use is essential, as is PDMP integration with electronic health records (EHRs). Your Reference Committee agrees with the widespread support heard for Board of Trustees Report 3. Therefore, your Reference Committee recommends that the report be adopted as amended and the remainder of the report be filed.

(9) RESOLUTION 202 - INCLUSION OF SEXUAL ORIENTATION AND GENDER IDENTITY INFORMATION IN ELECTRONIC HEALTH RECORDS
RESOLUTION 212 - PROMOTING INCLUSIVE GENDER, SEX, AND SEXUAL ORIENTATION OPTIONS ON MEDICAL DOCUMENTATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the First Resolve of Resolution 212 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s)~~, and (if applicable) surrogate identifications~~ in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 212 be adopted as amended in lieu of Resolution 202.

HOD ACTION: Resolution 212 adopted as amended.

Resolution 202 asks that our American Medical Association advocate for inclusion of sexual orientation and gender in electronic health records (EHRs).

Resolution 212 asks that our American Medical Association support the inclusion of a patient's biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and (if applicable) surrogate identifications in medical documentation and related forms in a culturally-sensitive and voluntary manner; and be it further that our AMA advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health.

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 202, noting that the inclusion of this patient data in medical documentation is paramount

to providing quality care to the LGBT community. Your Reference Committee agrees with testimony that information about a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s) should be collected and included in medical documentation and related forms, in a culturally-sensitive and voluntary manner. Your Reference Committee also agrees such information should be included in electronic health records (EHRs), if utilized. However, your Reference Committee believes that the scope and definition of "surrogate identification" is unclear, and encourages the sponsor of Resolution 212 to clarify and educate our House of Delegates about this term and its relation to medical documentation. Your Reference Committee heard overwhelmingly supportive testimony on Resolution 212, noting that the inclusion of this patient data in medical documentation is paramount to providing quality care to the LGBT community. Your Reference Committee therefore recommends amending Resolution 212 by including the reference to documentation in the electronic health record.

(10) RESOLUTION 205 - AMA STUDY OF THE AFFORDABLE CARE ACT
RESOLUTION 209 - AFFORDABLE CARE ACT REVISIT
RESOLUTION 223 - EMERGENCY POST-ELECTION SUPPORT FOR PRINCIPLES OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
RESOLUTION 224 - PROTECTING PATIENT ACCESS TO HEALTH INSURANCE AND AFFORDABLE CARE ACT
RESOLUTION 226 - CONTINUING AMA ADVOCACY ON THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends <u>adoption of the following resolution in lieu of Resolutions 205, 209, 223, 224, and 226</u>:

PROTECTING PATIENT ACCESS TO HEALTH INSURANCE COVERAGE, PHYSICIANS, AND QUALITY HEALTH CARE

HOD ACTION: Alternate <u>resolution adopted in lieu of Resolutions 205, 209, 223, 224, and 226</u>:

RESOLVED, That our American Medical Association actively engage the new Administration and Congress in discussions about the future of health care reform, in collaboration with state and specialty medical societies, emphasizing our AMA's extensive body of policy on health system reform; and be it further

RESOLVED, That our AMA craft a strong public statement for immediate and broad release, articulating the priorities and firm commitment to our current AMA policies and our dedication in the development of comprehensive health care reform that continues and improves access to care for all patients; and be it further

RESOLVED, That our AMA Board of Trustees report back to our AMA House of Delegates at the Annual 2017 Meeting (A-17).

Resolution 205 asks that our American Medical Association study, and using our extensive HOD policy, identify what needs to be changed/fixed with the ACA; and be it further, and that our AMA compile a policy compendium of AMA HOD Policy or links to that policy, to provide to legislators, think tanks, and the public with reliable accurate ideas and knowledge; and be it further that a comprehensive report on how to change and improve the ACA be presented back to the House of Delegates at the 2017 Annual Meeting.

Resolution 209 asks that our American Medical Association House of Delegates no longer support the Affordable Care Act (ACA) in its current form and to work for replacement or substantial revision of the act to include these changes: 1) Allowing health insurance to be sold across state lines; 2) Allowing all businesses to self-insure and to purchase insurance through business health plans or association health plans; 3) Improving the individual mandate with a refundable tax credit that would be used to purchase health insurance; Improving health-related savings accounts so as to help ACA insureds afford their higher deductibles and co-pays; Reversing cuts to traditional Medicare and Medicare Advantage programs; Encouraging states to develop alternatives to Medicaid by using federal funds granted under provisions of the ACA; Eliminating all exemptions, loopholes, discounts, subsidies and other schemes to be fair to those who cannot access such breaks in their insurance costs (New HOD Policy); and be it further that our AMA maintain the following provisions to the ACA if it is replaced: 1) Full coverage of preventive services; 2) Family insurance coverage of children living in a household until age 26; 3) Elimination of lifetime benefit caps; and 4) Guaranteed insurability.

Resolution 223 asks that our American Medical Association make a public statement that any health care reform legislation considered by Congress ensure continued improvement in patient access to care and patient health insurance coverage by maintaining: 1) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, 2) Income-dependent tax credits to subsidize private health insurance for eligible patients, 3) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), 4) Maintaining dependents on family insurance plans until the age of 26, 5) Coverage for preventive health services, 6) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs. (Directive to Take Action)

Resolution 224 asks that our American Medical Association advocate that any health care reform legislation considered by Congress ensures continued improvement in

patient access to care and patient health insurance coverage by maintaining: (1) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting, (2) Income-dependent tax credits to subsidize private health insurance for eligible patients, (3) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979), (4) Maintaining dependents on family insurance plans until the age of 26, (5) Coverage for preventive health services, (6) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and (7) Coverage for mental health and substance use disorder services at parity with medical and surgical benefits. (New HOD Policy)

Resolution 226 asks that our American Medical Association actively and in a timely manner engage the new Administration in discussions about the future of the Patient Protection and Affordable Care Act, emphasizing our AMA's body of policy on health system reform. (Directive to Take Action)

Your Reference Committee heard very passionate testimony from many witnesses representing a wide range of opinions and perspectives from a broad mix of state, specialty, and regional delegations and sections, as well as individual physicians. Your Reference Committee agrees with comments that the recent presidential and congressional elections present our AMA with an opportunity to actively engage the new Administration and Congress in discussions about the future of health care reform. Your Reference Committee also heard substantial testimony in favor of AMA support of efforts to provide coverage for the uninsured and that our AMA should be a resource for policy makers and other stakeholders to advance health care insurance coverage. This testimony noted that our AMA has a strong foundation of existing policy on health system reform and coverage for the uninsured, including policy on the issues included in Resolutions 209, 223, and 224. Furthermore, your Reference Committee heard testimony from the Council on Medical Service (CMS) and the Council on Legislation that our AMA has conducted numerous studies on various health system reform provisions in the Affordable Care Act, including CMS Report 5-I-13, Monitoring the Affordable Care Act, and CMS Report 9-A-14, Improving the Affordable Care Act. Therefore, your Reference Committee believes that additional policy or creation of a policy compendium called for in Resolutions 205, 209, 223, and 224 is not necessary at this time. Instead, your Reference Committee agrees with testimony that existing policy and reports are sufficient for our AMA to determine the best course of action in the new political environment, and that our AMA is well-positioned to be an effective advocate for advancing and improving upon the current health care system. Your Reference Committee also agrees with testimony that our AMA actively engage the new Administration and Congress in discussions about the future of health care reform, and collaborate with state and specialty medical societies. Furthermore, your Reference Committee heard testimony urging our AMA to move forward with a simple, clear statement communicating our message on health care reform, and recommending adoption of Resolution 226 along with the second and third resolves from a proposed amendment that would have revised Resolution 209. Your Reference Committee agrees with this approach and recommends adoption of a resolution that calls on our AMA to actively engage with the new Administration and Congress on the future of health care reform (based on our extensive AMA policy), collaborate with state and specialty medical societies, and craft a strong public statement articulating our commitment to our current AMA policy.

(11) RESOLUTION 208 - MIPS AND MACRA EXEMPTIONS

RECOMMENDATION A:

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

RESOLVED, That our American Medical Association ~~support~~ advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and C~~hip~~HIP Reauthorization Act of 2015 (MACRA) for small practices ~~since these rules will hasten the demise of small private practice in the U.S~~.

RECOMMENDATION B:

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

HOD ACTION: Resolution 208 adopted as amended.

Resolution 208 asks that our American Medical Association support an exemption from the merit-based incentive payment system (MIPS) and Medicare Access and Chip Reauthorization Act of 2015 (MACRA) for small practices since these rules will hasten the demise of small private practice in the U.S.

Your Reference Committee heard strong support for Resolution 208. Testimony noted concerns that participation in the Merit-Based Incentive Payment System (MIPS) poses challenges for small practices, and that our AMA should advocate for an exemption for small practices. We heard from multiple specialties with a large number of members in small practices that supported this resolution. We also heard testimony that the need for an exemption for small practices from MIPS was no longer necessary due to the recent release of the Quality Payment Program (QPP) final rule, which included a low-volume threshold that had been significantly increased. Other testimony argued that the low-volume threshold needs to be higher to exclude a greater number of practices. Some testimony supported the resolution, but noted that the low-volume threshold affects specialties differently. Testimony also noted that we have existing policy, D-390.949, which already supports an exemption for small practices under MIPS. Your Reference Committee also heard testimony and received amendments noting that the budget neutrality provisions of the QPP need to be reformed and that physicians nearing retirement should be exempted from the QPP. While your Reference Committee agrees that these are important issues to be considered, we believe that they go beyond the scope of this resolution. Finally, while your Reference Committee supports this resolution, we recommend the language referring to the demise of small practices in the U.S. should be removed. Supporting an exemption for small practices aligns with current AMA policy and was strongly supported by testimony; however, your Reference Committee has concerns that including the language regarding the demise of small

private practice in Resolution 208 may actually impede our AMA's ability to successfully advocate for this policy. Your Reference Committee also recommends minor editorial amendments to the references to the Merit-Based Incentive Payment System (MIPS) and CHIP. Therefore, your Reference Committee recommends that Resolution 208 be adopted as amended.

(12) RESOLUTION 213 - SOAP NOTES AND CHIEF COMPLAINT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy D-320.991 be amended by addition and deletion to read as follows:

3) Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during an ~~RAC~~ audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered;

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy D-320.991 be adopted as amended in lieu of Resolution 213.

HOD ACTION: Policy D-320.991 adopted as amended in lieu of Resolution 213.

Resolution 213 asks that our American Medical Association amend AMA Policy D-320.991, Creating a Fair and Balanced Medicare and Medicaid RAC Program, by addition to read as follows: 1) Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices; 2) Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment; 3) Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during a RAC audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered; 4) Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors; 5) Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social

Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors; 6) Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians; 7) Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs; 8) Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

Your Reference Committee heard limited and supportive testimony on Resolution 213. Your Reference Committee strongly believes that the RAC program in the Medicare program is deeply flawed and has negatively impacted individual physician practices despite the RACs' poor track record on appeals. Our AMA is well-positioned to provide information on lessons learned and shared strategies for addressing the Medicaid RAC programs. Your Reference Committee also supports the author’s minor amendment that would broaden the scope of this Resolution by deleting the reference to RAC, and therefore, recommends that Resolution 213 be adopted as amended.

(13) RESOLUTION 215 - PARENTAL LEAVE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the First Resolve of Resolution 215 be <u>amended by addition</u> to read as follows:

RESOLVED, That our American Medical Association encourage the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA):
- a reduction in the number of employees from 50 employees;
- an increase in the number of covered weeks from 12 weeks; and
- creating a new benefit of paid parental leave (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 215 be adopted as amended.

HOD ACTION: Resolution 215 adopted as amended.

Resolution 215 asks that our American Medical Association study the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave; and be it further, that our AMA study the effects of FMLA expansion on physicians in varied practice environments.

Your Reference Committee heard mixed testimony on Resolution 215. Arguments in favor of the resolution noted that this issue has significant implications for the health of parents and infants alike and is worthy of AMA study accordingly. Testimony in favor also noted that paid leave allows parents to take longer leave and is associated with greater improvements in infant mortality compared to unpaid leave. Testimony also noted that longer use of parental leave improves health outcomes for the child by decreasing infant mortality, increasing the likelihood of the child having routine medical check-ups and being vaccinated, and increasing cognitive and behavioral scores in early childhood. Your Reference Committee also heard testimony that longer use of parental leave reduces the risk of maternal depressive symptoms and improves the physical health status of both mothers and fathers.

Testimony against adoption of this resolution noted that, at the 2016 Annual Meeting, the HOD approved Council on Medical Service (CMS) Report 3-A-16, which provided a comprehensive review of sick leave and paid leave policies, and adopted new policy (H-440.823) that recognizes the public health benefits of paid sick leave and other discretionary paid time off; supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome. Testimony further noted that in light of this new policy, the high fiscal note of implementing Resolution 215, and that this is primarily an employer issue, adoption may not be the best use of our AMA's limited resources.

Your Reference Committee believes that paid parental leave is an important issue and recognizes the benefits of paid parental leave for parents and their children. However, your Reference Committee also notes the high fiscal note to conduct the studies called for in Resolution 215 and acknowledges that paid parental leave is primarily an employer issue. Given that the Council on Medical Service (CMS) recently provided a comprehensive review relating to the first resolve, your Reference Committee recommends that going forward we encourage the study of health implications among patients. Therefore, your Reference Committee amending the first resolve and adopting the second resolve.

(14) THE RIGHTS OF RESOLUTION 217 - PATIENTS, PROVIDERS AND FACILITIES TO CONTRACT FOR NON-COVERED SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Second Resolve of Resolution 217 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA engage in efforts to convince the CMS ~~to rescind the CMS guidance that bundled all blepharoptosis procedures with all functional and aesthetic aspects of blepharoplasty and~~ to abstain from inappropriate bundling ~~other~~ in situations in which functional and aesthetic considerations should ~~be able to~~ be considered separately (Directive to Take Action);

RECOMMENDATION B:

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

HOD ACTION: Resolution 217 adopted as amended.

Resolution 217 asks that our American Medical Association reaffirm Policy D-380.997 and any other applicable policies; and be it further that our AMA engage in efforts to convince the CMS to rescind the CMS guidance that bundled all blepharoptosis procedures with all functional and aesthetic aspects of blepharoplasty and to abstain from bundling other situations in which functional and aesthetic considerations should be able to be considered separately; and be it further that our AMA actively oppose further regulations that would interfere with the rights of patients, providers, and facilities to privately contract for non-covered services.

Your Reference Committee heard testimony in support of Resolution 217. Testimony noted that the recent policy issued by Centers for Medicare and Medicaid Services (CMS) regarding the bundling of blepharoptosis and blepharoplasty procedures have negatively affected physicians' ability to provide aesthetic surgical procedures requested by their patients. Testimony was also presented agreeing that our AMA should support the right of physicians and patients to privately contract for non-covered services.

Moreover, testimony noted that our AMA has several resolutions supporting the right to privately contract which have already been adopted. While most testimony supported Resolution 217, a significant amount of testimony also addressed the impact these inappropriate bundling policies may have on other specialties and the dangerous precedent this may set for bundling other procedures. Other testimony noted the trend in medicine toward reduced patient choice. Therefore, your Reference Committee believes the second resolve should be expanded to include not only blepharoptosis and blepharoplasty procedures, but all situations in which CMS inappropriately bundles services in which functional and aesthetic considerations should be able to be considered separately.

(15) RESOLUTION 219 - PROTECT INDIVIDUALIZED COMPOUNDING IN PHYSICIANS' OFFICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends adoption of the following resolution in lieu of Resolution 219:

RESOLVED, That our American Medical Association ~~strongly request~~ advocate that the US Food and Drug Administration (FDA) remove physician offices and ambulatory surgery centers from its definition of a compounding facility.

HOD ACTION: Alternate resolution adopted as amended in lieu of Resolution 219.

Resolution 219 asks that our American Medical Association strongly request that the US Food and Drug Administration (FDA) withdraw its draft guidance “Insanitary Conditions at Compounding Facilities” and that no further action be taken by the agency until revisions to the USP Chapter <797> on Sterile Compounding, have been finalized; and be it further, that our AMA work with the US Congress to adopt legislation that would preserve physician office-based compounding as the practice of medicine and codify in law that physicians compounding medications in their offices for immediate or subsequent use in the management of their patients are not compounding facilities under the jurisdiction of the FDA.

Your Reference Committee heard mixed testimony on Resolution 219. Testimony focused on concerns that patients will be unable to receive needed medication if small-level in-office compounding is eliminated, and the significant impact the US Food and Drug Administration’s (FDA) draft guidance, *Insanitary Conditions at Compounding Facilities,* may have on the practice of medicine. Other testimony noted that none of the recent deaths from compounded drugs have resulted from in-office physician compounding on a small scale. Other testimony recommended referral for report given the complexity of this issue. In addition, we heard testimony from a USP representative that noted the release of USP Chapter 797 on Sterile Compounding may not be finalized

for several years. Your Reference Committee also received a proposed amendment that would require our AMA to advocate for the removal of physicians' offices from the definition of a compounding facility within the FDA draft guidance, Insanitary Conditions at Compounding Facilities. Your Reference Committee understands that there is pronounced frustration and concern that the FDA and Congress have not addressed the negative consequences to patient access and health outcomes of limiting in-office preparations of treatments. However, based on a majority of the testimony heard, your Reference Committee believes that a new resolution would more adequately cover the intent of those testifying. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended.

(16) RESOLUTION 222 - PROHIBITION OF CLINICAL DATA BLOCKING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Second Resolve of Resolution 222 be amended by deletion to read as follows:

RESOLVED, ~~That our AMA advocate for the adoption of federal and state legislation and regulations to place strict limits on the fees imposed by electronic health record vendors for the implementation and ongoing use of data sharing interfaces. (New HOD Policy)~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 222 be adopted as amended.

HOD ACTION: Resolution 222 adopted as amended.

Resolution 222 asks that our American Medical Association advocate for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data to non-affiliated physicians who participate in the care of shared patients, thereby interfering with the provision of optimal, safe and timely care; and be it further that our AMA advocate for the adoption of federal and state legislation and regulations to place strict limits on the fees imposed by electronic health record vendors for the implementation and ongoing use of data sharing interfaces.

Your Reference Committee heard mixed testimony on Resolution 222. Some testimony supported the resolution and agreed that practices such as information blocking and excessive charges for the transfer of information are directly antithetical to efficient interoperability and must be stopped. In addition, your Reference Committee heard testimony that receipt of data from non-affiliated physicians is a problem when they participate in the care of the patient but are not on the same electronic health record system as other physicians providing care. Your Reference Committee also heard

compelling testimony that our AMA already has policies covering clinical data blocking and limiting the fees imposed by electronic health record vendors for the implementation and ongoing use of data sharing interfaces. However, testimony was also presented that passing another similar resolution may emphasize the need for the elimination of data blocking in upcoming legislative efforts. Your Reference Committee reviewed existing AMA policy on the issues of information blocking and electronic health record vendors charging excessive fees for the transfer of information. Your Reference Committee believes the first resolve offers an addition to existing policy, as it asks our AMA to expand advocacy efforts to prohibit the blocking of clinical data to non-affiliated physicians who participate in the shared care of patients. The second resolve, however, is already addressed in existing AMA policies including D-478.972 and D-478-973. Accordingly, your Reference Committee recommends that Resolution 222 be amended by deletion and adopted.

(17) RESOLUTION 206 - ADVOCACY AND STUDIES ON AFFORDABLE CARE ACT SECTION 1332

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 206 be referred.

HOD ACTION: Resolution 206 referred.

Resolution 206 asks that that our American Medical Association advocate that the "deficit-neutrality" component of the current HHS rule for Section 1332 waiver qualification be considered only on long-term, aggregate cost savings of states' innovations as opposed to having costs during any particular year, including in initial "investment" years of a program, reduce the ultimate likelihood of waiver approval; and that our AMA study reforms that can be introduced under Section 1332 of the Affordable Care Act in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same.

Your Reference Committee heard extensive testimony on the need to refer Resolution 206. Given the current political environment and the complexity of issues raised by Resolution 206, your Reference Committee agrees. Your Reference Committee, therefore, recommends that Resolution 206 be referred.

(18) RESOLUTION 207 - LIMITATION ON REPORTS BY INSURANCE CARRIERS TO THE NATIONAL PRACTITIONER DATA BANK UNRELATED TO PATIENT CARE
RESOLUTION 225 - LIMITATIONS ON REPORTS BY INSURANCE CARRIERS TO THE NATIONAL PRACTITIONER DATA BANK UNRELATED TO PATIENT CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolutions 207 and 225 be referred.

HOD ACTION: Resolutions 207 not adopted and Resolution 225 adopted.

Resolution 207 asks that our American Medical Association formally request that the Health Resources and Services Administration (HSRA) clarify that reports of medical malpractice settlements by physicians are contingent upon treatment, the provision of or failure to provide healthcare services, of the plaintiff; and that our AMA formally request that HSRA audit the National Practitioner Data Bank (NPDB) for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity's settlement of a claim that included the name of the physician in his/her administrative role at the entity; and that HSRA should be compelled to remove the name of any physician from the NPDB who was reported by a medical malpractice carrier as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff.

Resolution 225 asks that our American Medical Association seek legislation and/or regulation that would require the Health Resources and Services Administration (HRSA) to clarify that reports to the National Practitioner Data Bank (NPDB) of medical malpractice settlements by physicians be limited to those cases in which the named physician was directly involved in the provision of or failure to provide healthcare services; and that our AMA seek legislation and/or regulation that would require HRSA to audit the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity's settlement of a claim that included the names of those physicians in their administrative roles at the entity; and that our AMA seek legislation and/or regulation that would require HRSA to remove reports from the NPDB of any physician who was reported as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff; and that our AMA provide a report to the House of Delegates at the 2017 Interim Meeting regarding our AMA's interactions with HRSA and detailing the actions taken or planned by HRSA to eliminate inappropriate reporting of physicians to the NPDB.

Your Reference Committee heard supportive testimony on Resolution 207 and Resolution 225. Your Reference Committee also heard not only that our AMA has existing policy and has advocated consistent with this resolution, but also that this policy and advocacy led to inclusion of the following language in the 2015 revision to the National Practitioner Data Bank (NPDB) guidebook: "Medical malpractice payments are

limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner's provision of or failure to provide health care services." While your Reference Committee believes that the NPDB guidebook revisions have clarified some of the issues raised in Resolutions 207 and 225, there are situations in which reporting requirements are not clear, as testimony suggested.

These are important issues that warrant further study. Therefore, your Reference Committee recommends that Resolution 207 and Resolution 225 be referred.

(19) RESOLUTION 211 - ELECTRONIC HEALTH RECORDS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-478.982 be reaffirmed in lieu of Resolution 211.

HOD ACTION: Policy D-478.982 reaffirmed in lieu of Resolution 211.

Resolution 211 asks that our American Medical Association support federal legislation that will replace current meaningful use with common sense meaningful use developed by the medical profession that is user friendly and practical.

Your Reference Committee heard supportive testimony on Resolution 211. However, your Reference Committee also heard testimony that current AMA policy captures the intent of this resolution. Specifically our AMA has policy stating that our AMA will work with the federal government and the Department of Health and Human Services to set realistic targets for the meaningful use of electronic health records and improve the electronic health records incentive program. We also heard testimony that given the recent release of the Quality Payment Program (QPP) final rule, which replaces the Meaningful Use incentive program with the Advancing Care Information beginning January 1, 2017, this resolution is no longer needed. In addition, we heard testimony in support of a resolution that would require our AMA to advocate to CMS that all EMR meet the AMA/Rand guidelines from the AMA/Rand white paper. Your Reference Committee believes that the intent of all the testimony is included in AMA's existing policies on electronic health records and the Meaningful Use incentive program. Therefore, your Reference Committee recommends that existing policies be reaffirmed in lieu of Resolution 211.

D-478.982 Redefine "Meaningful Use" of Electronic Health Records
Our AMA will work with the federal government and the Department of Health and Human Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation. 2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare and Medicaid Services suspend

penalties to physicians and health care facilities for failure to meet Meaningful Use criteria.

(20) RESOLUTION 221 - ELECTRONIC MEDICAL RECORDS RECOVERY FEES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-478.972 be reaffirmed in lieu of Resolution 221.

HOD ACTION: Policy D-478.972 reaffirmed in lieu of Resolution 221.

Resolution 221 asks that our American Medical Association work to create legislation to be introduced to the US Congress that would eliminate the costs to physicians associated with recovering patient health care records from a previous electronic medical records (EMRs) vendor, when they upgrade to a new EMR vendor.

Your Reference Committee heard mixed testimony on Resolution 221. Some who supported the Resolution argued that the prohibitive costs associated with recovering health care records from a previous electronic health record vendor significantly impact physicians, and that the inability to move patient records to a new system, prohibited physicians from changing electronic health record vendors. Testimony also noted that many physicians adopt an electronic health record system, and accept the initial cost; however, the costs continue to increase each year. Other testimony suggested that a penalty should be imposed on electronic health record vendors when they do not support interoperability. Some testimony suggested that this resolution should be expanded to include reporting to registries. Testimony also asked for clarification on whether the resolution would require an electronic health record vendor to provide data in a PDF format or in a more compatible, useful way, which may be significantly more costly. Finally, your Reference Committee heard compelling testimony that our AMA has extensive policies on data migration, data portability and reducing electronic health record costs for physicians. Specifically, existing AMA policy states that our AMA will support and encourage Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange. Accordingly, your Reference Committee recommends that policy D-478.972 be reaffirmed in lieu of Resolution 221.

D-478.972 EHR Interoperability
Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in

selecting or migrating between EHR systems that are independent from hospital or health system mandates; and (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Vijayalakshmi Appareddy, MD, E. Rawson Griffin, III, MD, Kristina Novick, MD, Gary J. Price, MD, Sharon Richens, MD, Stephen J. Rockower, MD, and all those who testified before the Committee as well as AMA staff Ashley McGlone, Kristin Schleiter, Kai Sternstein, and George Cox.

Vijayalakshmi Appareddy, MD
American Association of Physicians of Indian Origin

Gary J. Price, MD (Alternate)
Connecticut

E. Rawson Griffin, III, MD (Alternate)
Florida

Sharon Richens, MD
Utah

Kristina Novick, MD (Alternate)
American Society of Clinical Oncology

Stephen J. Rockower, MD
Maryland

Ann R. Stroink, MD
Congress of Neurological Surgeons
Chair