

Reference Committee B

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* contained in Handbook Addendum

REPORT 2 OF THE BOARD OF TRUSTEES (I-16)
AMA Support for State Medical Societies' Efforts to Implement MICRA-type Legislation
(Resolution 214-I-15)
(Reference Committee B)

EXECUTIVE SUMMARY

Resolution 214-I-15, which was introduced by the Tennessee Delegation and referred to the Board of Trustees, asks “that our AMA engage its leadership and staff, those of the national medical specialty societies, and other stakeholder organizations to provide resources and technical assistance to efforts throughout the Federation to defeat no fault medical liability legislation.”

No-fault liability or Patient Compensation Systems (PCS) propose compensating patients for any suboptimal medical outcome, regardless of whether negligence has occurred. Essentially, PCS proposals would replace the current medical liability system in a state with a system modeled on workers' compensation programs.

While individual proposals differ from state to state, generally, a PCS would operate as follows. Patients dissatisfied with their medical care would file a claim to a panel including individuals such as physicians, patient advocates, hospital administrators, and attorneys. Based on interviews and a medical record review, the panel would make a prima facie determination of whether a medical injury occurred. The panel would not be required to make a determination of whether medical negligence occurred. If the panel finds that a medical injury occurred, the claim will go to a compensation department for the determination of compensation based on a fee schedule for each type of injury and the severity of the injury. Appeals could be made based only on the process itself and not the size of the award.

This report summarizes no-fault medical liability legislation, analyzes available analyses pertaining to such legislation, recommends reaffirmation of longstanding AMA policy in support of MICRA-style reforms, and recommends that the AMA support the efforts of interested state medical associations to defeat efforts to replace state medical liability systems with no-fault liability or Patient Compensation Systems.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-I-16

Subject: AMA Support for State Medical Societies' Efforts to Implement MICRA-type
Legislation
(Resolution 214-I-15)

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 INTRODUCTION

2
3 Resolution 214-I-15, which was introduced by the Tennessee Delegation and referred to the Board
4 of Trustees, asked “that our American Medical Association continue to support state medical
5 societies’ efforts to implement MICRA-type legislation,” and “that our AMA engage its leadership
6 and staff, those of the national medical specialty societies, and other stakeholder organizations to
7 provide resources and technical assistance to efforts throughout the Federation to defeat no fault
8 medical liability legislation.” This report summarizes no-fault medical liability legislation and
9 analyzes available evidence pertaining to such legislation, and recommends new policy and
10 reaffirmation of existing policy.

11 12 BACKGROUND

13
14 No-fault liability or Patient Compensation Systems (PCS) propose compensating patients for any
15 suboptimal medical outcome, regardless of whether negligence has occurred. Essentially, PCS
16 proposals would replace the current medical liability system in a state with a system modeled on
17 workers’ compensation programs or more limited systems like neurologic birth injury funds.

18
19 While individual proposals differ from state to state, generally, a PCS would operate as follows.
20 Patients dissatisfied with their medical care would file a claim to a panel including individuals such
21 as physicians, patient advocates, hospital administrators, and attorneys. Based on interviews and a
22 medical record review, the panel would make a prima facie determination of whether a medical
23 injury occurred. The panel would not be required to make a determination of whether medical
24 negligence occurred. If the panel finds that a medical injury occurred, the claim will go to a
25 compensation department for the determination of compensation based on a fee schedule for each
26 type of injury and the severity of the injury. Appeals could be made based only on the process itself
27 and not the size of the award.

28
29 PCS proponents claim that the system will “dramatically reduce the practice of defensive medicine,
30 thereby reducing health care costs, increasing the number of physicians practicing in a state,
31 improving patient safety, and providing patients fair and timely compensation without the expense
32 and delay of the court system.”¹

33
34 PCS opponents question these claims, including the assumptions made about the impact on
35 defensive medicine, and counter that the PCS system will compensate patients where no negligence

1 has occurred, increase the number of claims filed, increase reporting to the National Practitioner
2 Data Bank (NPDB), increase costs for physicians and other clinicians, and otherwise undermine
3 medical liability reforms at the state and federal levels.

4
5 PATIENT COMPENSATION SYSTEM LEGISLATION

6
7 To date, PCS bills have been filed in about half a dozen states. To date, none of these bills has
8 passed the respective state legislature. This report will focus on legislation filed in one state –
9 Georgia – as representative of other state experiences.

10
11 *Georgia Senate Bill 141 (2013) and subsequent bills*

12
13 During the 2013 – 2014 legislative session, the Georgia General Assembly considered Senate Bill
14 (S.B.) 141 and its companion bill, House Bill (H.B.) 662, both called the “Patient Injury Act.”
15 Neither bill passed out of committee. The following is a summary of the PCS structure the bills
16 proposed.

17
18 PCS administration and governance

19
20 The PCS would have been governed by an 11-member board representing the medical, legal,
21 patient, and business communities, and would be appointed by the governor, the lieutenant
22 governor, and the speaker of the House of Representatives. The Board would employ staff
23 including an executive director, advocacy director, chief compensation officer, chief financial
24 officer, chief medical officer, and chief quality officer. The chief medical officer’s office would
25 manage medical review, with the authority to administer oaths, take depositions, issue subpoenas,
26 compel the attendance of witnesses and the production of evidence, and obtain patient records
27 pursuant to the patient’s release of protected health information.

28
29 The board would also establish committees, including a medical review committee composed of
30 two physicians and one other board member, with the authority to convene an independent medical
31 review panel to evaluate whether an application constitutes a medical injury. The panel would be
32 composed of an odd number of at least three panelists chosen from a list of panelists recommended
33 by the medical review committee and approved by the board.

34
35 The board would also establish a compensation committee responsible for recommending a
36 compensation schedule for damage payments to the board.

37
38 Health care professionals included in a PCS

39
40 The following health care professionals and entities would have been included in a PCS pursuant to
41 S.B. 141:

- 42
43
- 44 • Hospitals and health care facilities, including nursing homes and skilled nursing facilities
 - 45 • Pharmacists and pharmacies
 - 46 • Chiropractors
 - 47 • Professional counselors, social workers, and marriage and family therapists
 - 48 • Dentists, dental hygienists, and dental assistants
 - 49 • Dieticians
 - 50 • Nurses, including advanced practice nurses
 - 51 • Nursing home administrators
 - Occupational therapists

- 1 • Optometrists
- 2 • Physical Therapists
- 3 • Physicians
- 4 • Acupuncturists
- 5 • Physician assistants
- 6 • Cancer and glaucoma treatment practitioners, respiratory care, clinical perfusionists, and
- 7 orthotics and prosthesis practitioners
- 8 • Podiatrists
- 9 • Psychologists
- 10 • Speech language pathologists and audiologists

11

12 Other versions of PCS bills have applied to:

13

- 14 • Physicians, hospitals, health systems or persons licensed or otherwise authorized to provide
- 15 health care services²
- 16 • Only physicians³
- 17 • Only primary care physicians⁴

18

19 Notably, after facing opposition from many of the categories of health care professionals included,
20 more recent versions of Georgia's PCS legislation – now coined the “Patient Compensation Act” –
21 were pared down to apply only to physicians.

22

23 Provider taxes

24

25 According to S.B. 141, the PCS would be administered by the Department of Community Health,
26 with an independent budget not controlled by the Department. The PCS' administrative costs
27 would be supported by a tax on health professionals. The following are a sample of the taxes
28 proposed.

29

- 30 • Dentists, dental hygienists, dental assistants, and nurses (except nurse anesthetists): \$100
- 31 per licensee
- 32 • Hospitals and ambulatory surgery centers: \$200 per bed
- 33 • Physician assistants and nurse anesthetists: \$250 per licensee
- 34 • Physicians and chiropractors: \$500 per licensee
- 35 • Other providers: \$2,500 per registration or license

36

37 A report by Aon Risk Solutions, prepared for Patients for Fair Compensation, the main proponent
38 of the PCS system, estimated that the total contribution for a PCS more expansive than that
39 proposed by S.B. 141 could be \$43.9 million annually from hospitals, nursing homes and assisted
40 care facilities, medical and osteopathic practice, nurses, dentistry/dental hygiene/dental labs and
41 other providers.⁵ Physician contributions from PCS taxes would account for approximately \$8.7
42 million of this total estimate.⁵

43

44 Notably, this estimate was taken from a longer list of health care professionals⁶ than was included
45 in S.B. 141. The estimated tax on physicians from S.B. 141 is not known. Further, while
46 subsequent PCS legislation significantly narrowed the list of health professionals potentially
47 subject to the system, as is noted above, the Board is not aware of an estimate of what the tax on
48 physicians would be with these more limited bills.

1 What is a medical injury?

2
3 S.B. 141 defines a medical injury as “a personal injury or wrongful death due to medical treatment,
4 including a missed diagnosis, which reasonably could have been avoided: (i) with care provided by
5 an individual practitioner, under the care of an experienced specialist or by an experienced general
6 practitioner practicing under the same or similar circumstances, or (ii) with care provided in a
7 system of care, if rendered within an optimal system of care under the same or similar
8 circumstances.”

9
10 Consideration of whether a medical injury could have been avoided shall only, per S.B. 141,
11 include “consideration of an alternate course of treatment if the injury could have been avoided
12 through a different but equally effective manner with respect to the treatment of the underlying
13 condition.” This consideration shall also only include “consideration of information that would
14 have been known to an experienced specialist or readily available to an optimal system of care at
15 the time of treatment.”

16
17 A medical injury, as defined by S.B. 141, does not include “an injury or wrongful death caused by
18 a product defect in a drug or device.”

19
20 More recent versions of PCS legislation⁷ in Georgia have defined medical injury as follows: A
21 personal injury or wrongful death due to medical treatment, including a missed diagnosis, where all
22 the following criteria exist:

- 23
24 • The provider performed a medical treatment on the applicant;
25 • The applicant suffered a medical injury with damages;
26 • The medical treatment was the proximate cause of the damages; and
27 • Based on the facts at the time of medical treatment, one or more of the following:
28 ○ An accepted method of medical services was not used for treatment; or
29 ○ An accepted method of medical services was used for treatment, but executed in a
30 substandard fashion.

31
32 The definition still excludes an injury or wrongful death caused by a product defect in a drug or
33 device.⁷

34
35 Process

36
37 To obtain compensation for a medical injury, a patient or his or her legal representative would file
38 an application with the PCS, including a brief statement of the facts and circumstances surrounding
39 the medical injury that gave rise to the application, as well as an authorization for the release of
40 protected health information potentially relevant to the application. Within 10 days of receipt of the
41 application, the office of medical review would determine whether the application on its face
42 constitutes a medical injury.

43
44 If the office determines that the application *does not*, on its face, constitute a medical injury, the
45 office must send a rejection to the applicant that informs the applicant of a right of appeal.

46
47 If the office determines that the application *does*, on its face, constitute a medical injury, the office
48 must notify each provider named in the application and his or her insurer. The provider then has 15
49 days to “support the application” or elect not to support the application. It is unclear from the plain
50 language of S.B. 141 what “supporting the application” would entail.

1 If the provider does support the application, and the office of medical review finds that the
2 application is valid, then the office of compensation shall determine a compensation award in
3 accordance with a compensation schedule, and offset by any past and future collateral source
4 payments. Periodic payment would be allowed.

5
6 If the provider does not support the application, the office then undertakes a 60-day investigation
7 conducted by a “multidisciplinary team with relevant clinical experience.” This investigation can
8 include document review and interviews. If the review panel determines that a medical injury has
9 occurred, the office of compensation must determine a compensation award in accordance with the
10 compensation schedule and the panel’s findings.

11
12 Both provider and patient have the opportunity to appeal the office’s determinations to an
13 administrative law judge, though the judge’s determinations are limited to whether the
14 requirements and rules of the PCS system were followed.

15 RESEARCH ON NO-FAULT MEDICAL LIABILITY PROPOSALS

16
17
18 A 2012 analysis by Aon Risk Solutions,⁸ prepared for Patients for Fair Compensation, estimates the
19 claims cost impact of a change from the fault-based liability system in Georgia to a PCS. Based on
20 the Aon work, claims cost (measured by indemnity payments and adjusted loss expenses) would
21 increase by 13 percent.

22
23 A subsequent independent actuarial analysis⁹ by TowersWatson of the Aon estimates suggests that
24 the cost increase could be much larger than 13 percent. TowersWatson finds that small changes in
25 Aon’s assumptions have a large impact on cost.

26
27 These two analyses being the primary evidence of the potential impact of PCS proposals on the
28 medical liability system, they are worth reviewing in more detail.

29 *Aon calculations*

30
31
32 In order to better understand Aon’s estimate it is important to look at the steps involved in their
33 analysis and the assumptions that they made.

- 34
35
- 36 • As a first step in estimating the additional claims cost of a PCS, Aon needed to know how
37 many claims are indemnified (paid) under the current system. Aon estimates that 864
38 claims are paid annually in Georgia. Because state-level claims data are not publically
39 available in the state, Aon bases this estimate (864 claims annually) on an internal
40 database.
 - 41 • Also important is the total number of patients in Georgia who seek indemnification (file
42 claims) in the current system. This metric is important because it forms the basis for the
43 number of claims that would be brought under a PCS. Again, because of a lack of data,
44 Aon had to estimate that number. Using the previous estimate of 864 paid claims, and an
45 assumption that 30 percent of patients who seek indemnification receive payment, Aon
46 estimates that 2,880 (864 / 0.30) patients per year file claims in Georgia under the current
47 system.
 - 48 • A key point of consideration in changing from a fault-based system to a PCS is the effect
49 on the number of patients who seek indemnification. Aon assumes the number who seek
50 indemnification would increase by 67 percent, with almost all of that increase occurring for
51 lower-cost claims: for example, Aon assumes there would be a 1,000 percent increase in
the number of patients seeking indemnity for insignificant injury under a PCS, from 133

1 patients annually to 1,468 patients annually. Taken together, Aon estimates that the number
2 of patient claims will increase from 2,880 to roughly 4,800 (2,800 x 1.67) annually under a
3 PCS.

- 4 • Aon also had to make an assumption about how many of those patients would be
5 indemnified under the PCS. Aon assumes that 40 percent of the 4,880 (about 1,920) would
6 receive payment under a Georgia PCS.
- 7 • Finally, Aon assumes that average indemnity payments in Georgia within each of the nine
8 injury severity categories would be 6.3 percent lower under the PCS than under the current
9 system.

10
11 Aon combines those estimates and assumptions with data on claim costs from an internal database
12 and data from PIAA. Aon's work suggests that in Georgia, claims cost would increase from \$423
13 million to \$478 million – a 13 percent increase. Further, the number of paid claims would more
14 than double, and for some categories of injury, increase even more dramatically – up to 1,730
15 percent for insignificant injury.

16
17 Further, an individual analysis by TowersWatson demonstrates that the Aon estimates are subject
18 to a greater deal of uncertainty than is present in usual actuarial calculations. As demonstrated
19 below, small changes in each of the assumptions have a large impact on the estimated cost impact.

20 21 *TowersWatson analysis*

22 23 Changing the assumption about the indemnification ratio in the current system

24
25 As discussed, one concern with moving to a PCS is that the number of patients filing claims would
26 greatly increase. Complicating the estimation process is that in many states there is not a good
27 measure of how many patients file claims in the current system, including in Georgia. Aon
28 estimates that 2,880 patients per year seek payment under the current system. They arrive at this
29 estimate using the 864 paid claims and an assumption that 30 percent of patients seeking indemnity
30 under the current system receive payment ($864 / 0.30 = 2,880$).

31
32 TowersWatson explored the cost impact if a 25 percent indemnification ratio were used instead of
33 30 percent. With 864 paid claims and an indemnification ratio of 25 percent, the number of patients
34 seeking indemnification would be higher ($864 / 0.25 = 3456$). Keeping the other assumptions that
35 Aon made the same, this modification would yield a claims cost increase of
36 35 percent rather than 13 percent.

37 38 Changing the assumption about the increase in the number of patients seeking indemnification

39
40 TowersWatson also analyzed the effect of the cost increase if more patients were to seek
41 indemnification under the PCS than Aon estimates. Aon assumes the number of patients filing
42 claims would increase by 67 percent, with almost all of that increase occurring in the lower-cost
43 injury categories. TowersWatson modifies that assumption to an increase of 105 percent of patients
44 filing claims, and allows more of that increase to occur within the higher-cost categories. With that
45 modification – and using the 25 percent rather than the 30 percent indemnification ratio in the
46 current system – the cost increase is 68 percent rather than the 13 percent given by the Aon
47 analysis.

1 Changing the assumption about the indemnification ratio in the PCS

2
3 TowersWatson also calculated the effect on costs, were the PCS to indemnify far more patients
4 than Aon assumed. Aon assumes that the indemnification ratio would be 40 percent under a PCS.
5 When TowersWatson modifies this to 50 percent (resulting in more claims paid) on top of the
6 changes to the other assumptions, the cost increase is 108 percent.

7
8 With these assumptions, the cost of a PCS would be more than twice that of the current system.

9
10 RELEVANT AMA POLICY

11
12 The AMA remains fully committed to the enactment of proven MLR laws, such as those modeled
13 after the California Medical Injury Compensation Reform Act of 1975 (MICRA) (Policy
14 H-435.967, “Report of the Special Task Force and the Advisory Panel on Professional Liability”).
15 Caps on non-economic damages, such as those enacted in California and Texas, have proven to be
16 successful at maintaining a stable state liability climate. A large and growing body of research
17 shows that caps on non-economic damages lead to improved access to care for patients, lower
18 medical liability premiums and lower health care costs. In addition to the cap on non-economic
19 damages, the other reforms contained in MICRA (attorney contingency fee limits, collateral source
20 reform and periodic payment of future damages), have helped to stabilize premiums in California
21 and to stabilize California’s medical liability climate as whole. As such, the AMA continues to
22 press for relief from the current medical liability system for physicians at both the federal and state
23 levels through the enactment of these traditional reforms.

24
25 At the same time, the AMA generally calls for the implementation and evaluation of innovative
26 reforms to see if they are able to improve the nation’s medical liability climate. These reforms
27 could either complement traditional MLR provisions, such as caps, or they may be able to improve
28 the liability climate in a state that is not able to enact traditional MLR provisions for political or
29 judicial reasons.

30
31 The AMA has called for federal funding for pilot projects to test such concepts as health courts,
32 liability safe harbors for the practice of evidence-based medicine, early disclosure and
33 compensation models, expert witness guidelines and affidavits of merit, to name some of the more
34 promising options.

35
36 The AMA Principles for Health Courts, which the AMA House of Delegates adopted in 2007, are
37 particularly relevant here (Policy H-435.951, “Health Court Principles”). These principles are
38 particularly relevant because the AMA believes that administrative liability systems such as those
39 established by hospitals or insurers – or in this case, the state – should include many of the same
40 requirements that the AMA supports for a health court established within a jurisdiction’s standard
41 judicial system (Policy H-435.951, “Health Court Principles”). Reasoning dictates that the PCS
42 should similarly include many of these requirements. However, a close examination of the PCS
43 demonstrates that many key facets are not aligned with AMA policy and principles.

44
45 *Standard of proof*

46
47 The PCS would lower the standard of proof required for a judgment against a physician. To prove
48 medical liability based on negligence, a plaintiff must establish four elements: (1) a duty by the
49 physician to act according to the applicable standard of care; (2) a breach of that standard of care;
50 (3) injury or harm to the plaintiff; and (4) a causal connection between the breach of the standard of
51 care and the injury or harm. The PCS would skip step (2) and find judgment against a physician by

1 focusing only on step (3) – injury or harm to the patient – and not requiring a determination of
2 whether the physician breached the standard of care, and whether that breach of the standard of
3 care caused the injury or harm. Recent PCS proposals focus on “whether an accepted method of
4 medical treatment” was used, while earlier proposals focus simply on whether the injury could
5 have been avoided.

6
7 In other alternative medical liability reform systems such as health courts, the AMA has insisted
8 that negligence must be proven for a patient to recover (Policy H-435.951, “Health Court
9 Principles”). A PCS system would lower this standard of proof, and thus, is contrary to AMA
10 policy.

11 *Expert witnesses and judges*

12
13
14 AMA principles recommend that health court judges have specialized training in the delivery of
15 medical care that qualifies them for serving on a health court. In addition, qualified experts should
16 be utilized to assist a health court in reaching a judgment (Policy H-435.951, “Health Court
17 Principles”). AMA policy provides guidance on what the standards for those experts should be. At
18 minimum, statutory requirement for qualification as an expert witness in medical liability cases
19 should provide that the witness have:

- 20
- 21 • Comparable education, training, and occupational experience in the same field as the
- 22 defendant or specialty expertise in the disease process or procedure performed in the case;
- 23 • Occupational experience that includes active medical practice or teaching experience in the
- 24 same field as the defendant;
- 25 • Active medical practice or teaching experience within five years of the date of the
- 26 occurrence giving rise to the claim; and
- 27 • Certification by a board recognized by the American Board of Medical Specialties or the
- 28 American Osteopathic Association or by a board with equivalent standards (Policy H-
- 29 265.994, “Expert Witness Testimony”).
- 30

31 In cases brought before health courts, AMA policy further recommends that:

- 32
- 33 • The health court task force maintain a list of qualified medical experts who meet the same
- 34 qualifications as the medical experts who testify on behalf of the party in the lawsuit, from
- 35 which a judge may select to help clarify or interpret medical testimony; and
- 36 • Party expert witnesses be a doctor of medicine or osteopathy who meets the same
- 37 requirements outlined in AMA policy on expert witnesses (Policy H-435.951, “Health
- 38 Court Principles”).
- 39

40 PCS cases would be decided by a panel of “individuals with relevant clinical expertise,” though
41 what that expertise consists of is not specified. There is no requirement that the medical experts
42 have the same or similar expertise, training, qualifications, or specialty certification as the
43 defendant. Moreover, there is no standard at which to hold those experts who testify to the
44 appropriateness of care provided. For these reasons, the PCS lowers – or at minimum, does not
45 specify – standards for expert witnesses and decision makers, and goes against the high standards
46 AMA policy expects for expert witnesses in medical liability cases.

47 *Damages*

48
49
50 AMA policy supports a fee structure system for damage awards based on type or severity of injury,
51 or to have non-economic damages linked to the amount of economic damages included in the

1 judgment. The underlying principle is that consistent injuries should result in consistent non-
2 economic damage awards based on the schedule. At the same time, economic damages should not
3 be limited; injured parties should be fully compensated for their economic losses. Punitive
4 damages, if allowed, should not be awarded unless the party alleging such damages meets the
5 burden of producing clear and convincing evidence of oppression, fraud, malice, or the opposing
6 party's intent to do harm (Policy H-435.951, "Health Court Principles"). With these considerations
7 in mind, the fee structure system the PCS proposes is aligned with AMA policy.

8
9 *National Practitioner Data Bank*

10
11 PCS legislation commonly includes a provision stating that a physician who is the subject of an
12 application shall not be found to have committed medical negligence and shall not be automatically
13 reported to the state medical board. The PCS will only share with the medical board for
14 disciplinary action information from those applications in which the department has determined
15 that the provider represents an imminent risk of harm to the public. However, the plain language of
16 PCS bills does not specify what standard the department should use to make this determination of
17 risk of harm to the public.

18
19 Further, while PCS proponents commonly claim that PCS systems will not trigger reporting to the
20 National Practitioner Data Bank (NPDB), the Board believes this assertion is debatable.

21
22 According to the NPDB Guidebook, "[e]ach entity that makes a payment for the benefit of a health
23 care practitioner in settlement of or, in satisfaction in whole or in part of, a written claim or
24 judgment for medical malpractice against that practitioner must report the payment information to
25 the NPDB.... Medical malpractice payments are limited to exchanges of money and must be the
26 result of a written complaint or claim demanding monetary payment for damages. The written
27 complaint or claim must be based on a practitioner's provision of or failure to provide health care
28 services. A written complaint or claim can include, but is not limited to, the filing of a cause of
29 action based on the law of tort in any State or Federal court or other adjudicative body, such as a
30 claims arbitration board."¹⁰

31
32 The NPDB interprets the written claim requirement "to include any form of writing, including pre-
33 litigation communications."¹⁰ The NPDB, not any other entity, determines whether a written claim
34 has occurred for purposes of filing a report. Unless the PCS system is to be entirely verbal, it seems
35 possible that the NPDB would consider payments made as a result of a PCS system judgment to be
36 reportable events. The issue whether a "medical malpractice" payment, for the purposes of the
37 NPDB, requires wrongful conduct by the physician.

38
39 Given the findings of the Aon and TowersWatson estimates that claims made to the PCS system
40 would dramatically increase in comparison to the current liability system, it is possible that reports
41 to the NPDB would increase dramatically as well.

42
43 AMA policy opposes legislative or administrative efforts to expand the NPDB reporting
44 requirements for physicians, such as the reporting of a physician who is dismissed from a medical
45 liability lawsuit without any payment made on his or her behalf, or to expand the entities permitted
46 to query the NPDB such as public and private third party payers for purposes of credentialing or
47 reimbursement (Policy H-355.975, "Opposition to the National Practitioner Data Bank").

48
49 Because of the potential for the PCS to dramatically increase claims to the NPDB – including
50 claims in which there has been no finding of negligence – the PCS system goes against
51 longstanding AMA policy regarding reporting to the NPDB.

1 DISTINGUISHING PCS PROPOSALS FROM NEUROLOGIC INJURY FUNDS

2
3 Several states, including Florida and Virginia, have funds established to pay for the care of infants
4 born with certain neurological injuries. While these systems share the no-fault nature of PCS
5 proposals, they differ in that utilization of neurologic injury programs is an exclusive remedy,
6 providing absolute immunity from medical liability for participating health care professionals.
7 Because injury claims adjudicated by neurologic injury tribunals do not depend upon medical
8 liability, decisions do not need to be reported to the NPDB. Similarly, standard of care and expert
9 witness considerations are not present with neurologic injury funds as they are with PCS proposals.
10 Even so, neurologic injury programs continue to be a subject of debate.

11
12 CONCLUSION

13
14 Medical liability remains a continuing concern for physicians. It affects both how and where they
15 practice. The ramifications of the current liability system are wide-ranging, from patients who now
16 have limited access to health care to the financial implications on the health care system as a
17 whole. The AMA remains at the forefront on this issue by advocating at both the federal and state
18 levels and conducting research to improve the liability system. The AMA remains committed to
19 advocating for proven reforms – such as caps on non-economic damages – to fix the problem. At
20 the same time, the AMA will continue advocating for innovative reforms, such as health courts,
21 safe harbors for the practice of evidence-based medicine and early disclosure and compensation
22 models, as a way to complement traditional reforms and to solve this issue for both physicians and
23 patients.

24
25 Though some aspects of PCS proposals are consistent with AMA policy, significant aspects of the
26 proposals to date are inconsistent with AMA Health Court Principles and AMA medical liability
27 reform policy, including policies on the standard of care for medical liability cases, expert witness
28 requirements, and reporting to the NPDB. Moreover, analyses of PCS proposals – even those
29 prepared on behalf of PCS advocates – demonstrate the potential for a PCS to vastly increase the
30 cost of a state’s medical liability system. These shortcomings are deeply concerning to the Board of
31 Trustees.

32
33 Given the AMA’s in-house expertise and the ongoing MLR-related advocacy, the Board of
34 Trustees believes that support for a Patient Compensation System is not warranted.

35
36 RECOMMENDATION

37
38 The Board of Trustees recommends that the following be adopted in lieu of Resolution 214-I-15
39 and that the remainder of the report be filed.

- 40
41 1. That our American Medical Association (AMA) reaffirm Policy H-435.967, “Report of the
42 Special Task Force and the Advisory Panel on Professional Liability.” (Reaffirm HOD Policy)
43
44 2. That our AMA support the efforts of interested state medical associations to defeat efforts to
45 replace a state medical liability system with a no-fault liability or Patient Compensation
46 System. (Directive to Take Action)

Fiscal Note: Less than \$2500.

REFERENCES

- ¹ Georgia Senate Bill 141 (2013-2014 Regular Session).
- ² Maine L.D. 1311 (127th Legis. 2015).
- ³ Florida Senate Bill 1308 (2016 Session).
- ⁴ Vermont House 35 (2013-2014 Regular Session).
- ⁵ Aon Risk Solutions. Georgia Rating Model for the Implementation of a Patients Compensation System. Prepared for Patients for Fair Compensation. June 21, 2012.
- ⁶ Abortion clinics, acupuncture, assisted care facilities, athletic trainers, chiropractic medicine, clinical laboratories, clinical laboratory personnel, dentistry, dental hygiene, dental laboratories, dietetics, nutritional practice, electrolysis, HMOs, hospitals, maternal and child health, medical practice, medical transportation service – EMT, midwifery, multiphasic health testing, naturopathic, nursing, nursing home administration, nursing homes and related health care, occupational therapy, optometry, orthotics, prosthetics, pedorthics, osteopathic medicine, pharmacy, physical therapy, podiatric medicine, radiological, respiratory therapy, speech language pathology, and audiology.
- ⁷ Georgia Senate Bill 86 (2015-2016 Regular Session)
- ⁸ Aon Risk Solutions. An Evaluation of the Impact to Direct Medical Malpractice Costs in the State of Georgia Related to the Implementation of a Patients Compensation System. Prepared for Patients for Fair Compensation. October 10, 2012.
- ⁹ TowersWatson analysis of 2012 Aon Risk Solutions reports for Patients for Fair Compensation. August 9, 2013.
- ¹⁰ U.S. Department of Health and Human Resources, Health Resources and Services Administration. NPDB Guidebook. Rockville, Maryland. U.S. Department of Health and Human Services, 2015. A payment made as a result of a suit or claim solely against an entity (for example, a hospital, clinic, or group practice) that does not identify an individual practitioner should not be reported to the NPDB. See also, Wakefield memo to Sebelius regarding Appropriate Medical Malpractice Payment Reporting to the National Practitioner Data Bank (NPDB) in Light of Recent Medical Malpractice Reforms in Massachusetts and Oregon (May 20, 2014).

REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-16

Subject: Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing (Resolution 222-I-15)

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee B (Ann R. Stroink, MD, Chair)

1 INTRODUCTION

2
3 At the 2015 Interim Meeting, the House of Delegates referred Resolution 222-I-15, “Model State
4 Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid
5 Prescribing,” introduced by the Virginia Delegation, which asked:

6
7 That our American Medical Association develop model state legislation that improves
8 workflow for using state based prescription monitoring programs by enhancing information
9 available including automated alert notification of doctor shopping, real time EHR-PMP
10 integration, and e-prescribing of schedule II and III drugs which should be essential parts of a
11 state based risk mitigation strategy with identification and correction of any workflow or
12 technological barriers a high priority; and

13
14 That Stage 3 of the federal government’s meaningful use program should be delayed until the
15 following are accomplished: a) real time integration of EHRs and state based PMPs, and b)
16 electronic prescribing of schedule II and III drugs are available for meaningful use certified
17 EHR’s in the United States.

18
19 Reference committee testimony broadly supported the concept of prescription drug monitoring
20 program (PDMP) integration with electronic health records (EHRs). There was concern, however,
21 about how well PDMPs and EHRs are integrated in actual practice. Testimony noted that in clinical
22 situations where PDMPs and EHRs work well together, there are positive benefits to data retrieval
23 and information that can help with clinical decision making. On the other hand, testimony also
24 noted that not all PDMPs currently have the ability to provide real-time data or are effectively
25 integrated into clinical workflow systems. In addition, testimony noted that EHR integration into
26 PDMPs varies greatly, and there are considerable technological and practical challenges to such
27 integration.

28
29 The reference committee cited work being done by several medical societies as well as the AMA
30 Task Force to Reduce Opioid Abuse in support of physicians registering for and using PDMPs.
31 When PDMPs contain relevant, real-time data that can be accessed as part of a physician’s
32 workflow, physicians often have important information that can help improve patient care and
33 make more informed prescribing decisions. This report will discuss issues surrounding automated
34 alerts of so-called “doctor shopping,” which raise several questions, including who should receive
35 the alerts and what action(s) should be taken based on those alerts. In addition, it is not clear how

1 state legislation, by itself, could improve the technological functionality of a PDMP, but such
2 legislation could be a factor in requirements of using PDMPs. This includes tying such
3 requirements to when PDMPs and EHRs may be, in fact, integrated. In addition, this report will
4 provide a brief update on electronic prescribing of controlled substances and an update on relevant
5 issues concerning Stage 3 of the federal government's Meaningful Use program.

6
7 This report will recommend that existing policy be reaffirmed and recommends new policies be
8 adopted to guide AMA advocacy.

9
10 AUTOMATED ALERTS IN A PRESCRIPTION DRUG MONITORING PROGRAM

11
12 Proponents of automated alerts to prescribers using PDMPs frequently cite the ability of such alerts
13 to provide information about "doctor shopping." While not a legal term of art or clinical
14 description, "doctor shopping" generally—and often pejoratively—seeks to define individuals who
15 seek to fraudulently obtain a prescription¹ or who seek multiple prescriptions for controlled
16 substances from multiple prescribers and/or pharmacies in a short time frame. State laws and
17 regulation define the parameters differently. Being deemed a "doctor shopper" typically means that
18 the patient has received one or more prescriptions for a controlled substance from 3-5 prescribers
19 and filled it at 3-5 pharmacies within a 30-90 day time frame. This also is referred to as a Multiple
20 Prescription Event (MPE). Many states and other stakeholders have touted their PDMPs as being
21 able to reduce the number of MPEs. Commonly cited examples are New York and Tennessee,
22 which have reported significant reductions in MPEs.²

23
24 The Board supports efforts to identify individuals who use fraudulent means to obtain controlled
25 substances from prescribers and dispensers either for their own use or for diversion to others. It is
26 not a straightforward issue, however, to separate: (1) patients who unintentionally receive multiple
27 prescriptions that may represent dangerous drug combinations from; (2) patients with substance use
28 disorders who are seeking more controlled substance prescriptions than would generally be
29 prescribed for their medical condition; or from (3) individuals who misrepresent their health
30 conditions in order to obtain controlled substance prescriptions for purposes of misuse or diversion.
31 For this reason, the broad application of criteria for identifying MPEs may not meet the goal of
32 reducing opioid misuse, overdose or diversion. For example, if a patient sees multiple physicians
33 for multiple conditions, and each physician prescribes a controlled substance—and the patient fills
34 each prescription at a different pharmacy, then technically that patient may be flagged as a "doctor
35 shopper." The automated alert in the PDMP may be set to highlight that patient in yellow, red or
36 some other distinctive color. The technology and functionality for communicating these types of
37 alerts vary by state, but there is little discussion about what the physician is supposed to do when
38 the PDMP identifies a patient as having an MPE.

39
40 If it becomes clear that an individual is fraudulently seeking prescriptions for nonmedical use or
41 diversion, these efforts should be resisted and denied and potentially referred to law enforcement.
42 Patients seeking more controlled substances than their health condition warrants may need to be
43 screened, assessed for a possible opioid use disorder, and counseled and/or referred for treatment.

44
45 Patients who are unintentionally receiving dangerous drug quantities or combinations need better
46 care coordination. If, for example, the patient is receiving an opioid analgesic, a benzodiazepine
47 and a muscle relaxant from three different physicians, the combination could be deadly. Depending
48 on how the PDMP allows a physician to set up an alert—or if the PDMP default is to flag such an
49 MPE—when a patient is flagged as a potential doctor shopper, what should the physician do in
50 such a situation?

1 As stated by E-10.01, “Fundamental Elements of the Patient-Physician Relationship,” “the
2 physician has an obligation to cooperate in the coordination of medically indicated care with other
3 health care providers treating the patient.” Yet, to prescribe a controlled substance to this patient
4 raises the practical concern whether that prescription will be seen by regulatory bodies, law
5 enforcement or others as contributing to further MPEs. Even if the physician documents the
6 reasons why the patient is not a “doctor shopper,” it is unlikely that the PDMP has the
7 sophistication to distinguish between patients. All the PDMP (and others who have access to the
8 PDMP) know is that the physician continued to prescribe controlled substances to an alleged
9 “doctor shopper.”

10
11 Ethical policy E-10.01 further states that “the physician may not discontinue treatment of a patient
12 as long as further treatment is medically indicated, without giving the patient reasonable assistance
13 and sufficient opportunity to make alternative arrangements for care.” In an MPE situation,
14 physicians and pharmacists are under intense pressure to reduce the number of MPEs. The balance
15 is ensuring that the PDMP alert does not create a barrier to care. Therefore, the Board recommends
16 that the AMA advocate to key stakeholders, including the National Association of State Controlled
17 Substances Authorities, the National Association of Boards of Pharmacy, and the National
18 Governors Association, to ensure that efforts to reduce MPEs are done in a manner that supports
19 continuity of care and does not adversely affect the patient-physician relationship.

20 21 INTEGRATION OF PDMPs AND EHRs

22
23 There are many benefits to integrating PDMP data into EHRs in a seamless manner. A seamless
24 integration process would allow physicians to have a patient’s prescription history as part of the
25 medical record, eliminate having to sign in to separate systems, improve workflow, and other
26 benefits that could improve patient care.

27
28 The AMA supports this type of technological improvement. For example, Policy H-95.945,
29 “Prescription Drug Diversion, Misuse and Addiction,” provides a recommendation “that PDMPs be
30 designed such that data is immediately available when clinicians query the database and are
31 considering a decision to prescribe a controlled substance.” PDMPs, while they vary on whether
32 data is input by pharmacists from within 24 hours to a week or more, arguably contain helpful
33 information for physicians and other health care professionals about a patient’s controlled
34 substances prescription history.

35
36 In addition, a 2016 AMA national survey found that, when asked “what would make PDMPs more
37 effective and useful,” the number one response (66 percent of respondents) was “integration with
38 EHR/EMR.”³ Such integration, moreover, has been studied in several pilot programs by the
39 federal Office of the National Coordinator across multiple states and in clinical settings ranging
40 from the emergency department to ambulatory settings to pharmacies and opioid treatment
41 programs.⁴ This is consistent with AMA policy and its considerable support for the interoperability
42 of EHRs and other systems. This includes D-478.972, “EHR Interoperability,” D-478.994, “Health
43 Information Technology,” and D-478.996, “Information Technology Standards and Costs.”

44 45 UPDATE ON EPCS AND MEANINGFUL USE

46
47 Electronic prescribing of controlled substances (EPCS) has not become a major component of the
48 U.S. health care system. Although all states allow for EPCS, according to Sure Scripts,
49 approximately 6.0 percent of physicians and other health care providers are enabled for EPCS.⁵
50 New York has the highest percentage (37 percent)—almost certainly due to the fact that as of
51 March 27, 2016, New York requires mandatory electronic prescribing for all prescriptions.⁶

1 As the AMA wrote to the U.S. Drug Enforcement Administration in 2015, “a well-designed
2 electronic medication prescription (eRx) system adds value to [physicians’] practice of medicine
3 and supports better patient care. We believe expanding the utility of EPCS to match that of current
4 eRx capabilities will benefit physicians and patients alike.”⁷

5
6 A number of reasons continue to limit the ability of those physicians, however, who would like to
7 prescribe controlled substances electronically, including the DEA “two-factor authentication”
8 requirement, verification requirements, vendor incompatibility and readiness, technological and
9 workflow barriers and other reasons, whose full discussion are beyond the scope of this report. If
10 these issues can be resolved, however, then it is hopeful that EPCS can truly become a helpful
11 component of risk mitigation strategies at the clinical, systems-wide and state-based levels.
12

13 Yet, significant barriers remain. With CMS’ release of the Stage 3 Meaningful Use proposed rule
14 in 2015, CMS signaled their intent to increase the complexity of the program and to further
15 physicians’ burden on the interoperability of electronic health information. While the majority of
16 the Stage 3 objectives and measures were recycled from Stage 2, the proposed rule increased the
17 bar for physician success and set a high initial threshold for all new objectives. Many health care
18 systems and state and medical associations, including the AMA, provided CMS detailed comments
19 focused on reducing the physician reporting burden and methods to increase flexibility in the
20 program.
21

22 Specifically relating to the electronic prescription of medications, the AMA asked CMS to allow
23 physicians the option to include or exclude controlled substances in the calculation of Meaningful
24 Use electronic prescribing measure. In the final Stage 3 rule CMS accepted AMA’s comments,
25 stating:
26

27 After consideration of the public comments received, we are finalizing changes to the
28 language to continue to allow providers the option to include or exclude controlled
29 substances in the denominator where such medications can be electronically
30 prescribed. For the purposes of this objective, we are adopting that prescriptions for
31 controlled substances may be included in the definition of permissible prescriptions
32 where the electronic prescription of a specific medication or schedule of medications
33 is permissible under state and federal law.⁸
34

35 While a number of suggested changes by the AMA were adopted, CMS stated that further program
36 adjustments could be made in future rulemaking. For many in the industry, the forthcoming
37 MACRA proposed rule in early 2016 was seen as an opportunity for CMS to rethink Stage 3
38 requirements.
39

40 Health IT development is largely guided by federal certification and reporting requirements. Prior
41 to commenting on CMS’ Stage 3 proposed rule, the AMA provided detailed comments to ONC on
42 their 2015 Edition Health IT Certification—with a focus on improving EHR interoperability and
43 usability. By taking a two-pronged approach of reducing prescriptive federal reporting demands
44 while seeking a more focused health IT certification, the AMA, along with many other
45 organizations, believes physician EHR satisfaction and participation in new payment models will
46 increase. However, due to the EHR development timeline, even before a Stage 3 final rule was
47 released, health IT developers began working on new EHRs. Although the MACRA proposed rule
48 incorporated many aspects of Meaningful Use through the Advancing Care Information (ACI)
49 component of MIPS, CMS has acknowledged health IT must improve and adapt to the needs of
50 physicians and patients.⁹

1 The AMA views MACRA as an opportunity to align the development of health IT with the
2 evolving demands of health care. Value-based reimbursement models will require physicians to
3 have at their disposal a robust health IT toolbox. While the EHR will still play a major role going
4 forward, physicians and patients must have the ability to optimize care using both certified and
5 non-certified technology. CMS has already identified 2015 Edition health IT products as one
6 component for successful participation in MIPS; however, requirements on the use of EHRs will
7 not be finalized until late 2016.

8
9 Additionally, CMS has proposed a flexible approach to the use of EHRs in APMs. The AMA
10 views the proposed APM requirements as a logical starting point for MIPS. The AMA has supplied
11 detailed and constructive feedback outlining how physicians can optimize the use of EHRs while
12 achieving success in multiple MIPS components.¹⁰ This holistic approach to CMS' quality
13 payment program provides the flexibility physicians will need to successfully participate in MIPS,
14 and may also act as a glide path for those who wish to migrate to APMs. Furthermore, because this
15 approach focuses less on the process and more on patient outcomes, health IT developers will
16 benefit by increased development freedom—focusing less on federal reporting demands and
17 creating tools that better integrate with physician workflows.

18
19 2015 Edition EHRs are already in development and some have already been certified. Many health
20 IT developers will have products in the market by mid-2017. Advanced functionality like real-time
21 integration between EHRs and PDMPs is not included in certification, nor are EHR vendors
22 incentivized to focus on this type of functionality. Furthermore, there are no national standards for
23 EHR-PDMP communication, and each state has established their own requirements around PDMP
24 interoperability. While this capability is highly desirable by physicians, health IT developers are
25 driven to meet federal certification requirements before developing other functionality.

26
27 Going forward, CMS and ONC must create a way to better incorporate feedback from physicians
28 into the development of their programs. By restructuring CMS programs to focus on outcomes and
29 focusing ONC certification on testing for product safety, security, usability, and interoperability—
30 including with PDMPs—a physicians will encounter greater choice and better functioning products
31 in health IT going forward.

32 33 RECOMMENDATIONS

34
35 The Board of Trustees recommends that the following be adopted in lieu of Resolution 222-I-15,
36 and that the remainder of the report be filed.

- 37
38 1. That our American Medical Association (AMA) support the ability of prescription drug
39 monitoring programs (PDMPs) to have the capability for physicians to know when their
40 patients have received a prescription for controlled substances from multiple prescribers or
41 multiple pharmacies within a short time frame; (New HOD Policy)
42
43 2. That our AMA advocate to key stakeholders, including the National Association of State
44 Controlled Substances Authorities, the National Association of Boards of Pharmacy, and the
45 National Governors Association, to ensure that efforts to reduce Multiple Provider Events
46 (MPEs) are done in a manner that supports continuity of care; (Directive to Take Action)
47
48 3. That our AMA work with the Centers for Disease Control and Prevention (CDC), Substance
49 Abuse and Mental Health Services Administration (SAMHSA) and other relevant federal
50 agencies, to better understand the factors that lead to MPEs and develop medically and
51 ethically appropriate strategies for reducing them; (Directive to Take Action)

- 1 4. That our AMA support the interoperability of state PDMPs with electronic health records
2 (EHRs); (New HOD Policy)
3
- 4 5. That Policies D-478.972, "EHR Interoperability," D-478.994, "Health Information
5 Technology," and D-478.996, "Information Technology Standards and Costs," be reaffirmed;
6 (Reaffirm HOD Policy)
7
- 8 6. That our AMA advocate for the Centers for Medicaid and Medicare Services (CMS) and
9 Office of the National Coordinator for Health Information Technology (ONC) to better
10 incorporate feedback from physicians to focus on outcomes and focusing ONC certification on
11 testing for product safety, security, usability, and interoperability. (New HOD Policy)

Fiscal Note: Less than \$2,500.

REFERENCES

- ¹ For a good discussion of statutory and regulatory requirements related to fraud, misrepresentation and other illicit means of obtaining a prescription, see “Doctor Shopping Laws” from the Public Health Law Program in the Office for State, Tribal, Local and Territorial Support at the Centers for Disease Control and Prevention. Available at <https://www.cdc.gov/phlp/docs/menu-shoppinglaws.pdf>
- ² Mandating PDMP participation by medical providers: current status and experience in selected states Prescription Drug Monitoring Program Center of Excellence at Brandeis COE Briefing states States, Prescription Drug Monitoring Program Center of Excellence at Brandeis COE Briefing. Revision 1, February 2014. Available at http://www.pdmpeccellence.org/sites/all/pdfs/COE%20briefing%20on%20mandates%20revised_a.pdf
- ³ Physician perceptions and practices on opioid prescribing, education, barriers to care, naloxone. AMA national survey conducted by TNS Global Research, Nov. 13–23, 2015. The survey had 2,130 respondents who are practicing U.S. physicians who provide a minimum of 20 hours per week in direct patient care, have a current DEA license to prescribe Schedule II controlled substances, and prescribe opioids on a weekly, or more frequent, basis. See more at <http://www.ama-assn.org/ama/pub/news/news/2016/2016-02-18-barriers-non-opioid-therapy.page>
- ⁴ See “Connecting for Impact: Linking Potential Prescription Drug Monitoring Programs (PDMPs) to Patient Care Using Health IT,” available at <https://www.healthit.gov/PDMP>
- ⁵ EPCS Provider Enablement by State. <http://surescripts.com/products-and-services/e-prescribing-of-controlled-substances>
- ⁶ See New York State Department of Health website: http://www.health.ny.gov/professionals/narcotic/electronic_prescribing/ which also lists exceptions to the mandate.
- ⁷ August 11, 2015 letter from AMA CEO James L. Madara, MD, to Barbara J. Boockholdt, Chief, Regulatory Section, U.S. Drug Enforcement Administration Office of Diversion Control. <http://www.ama-assn.org/resources/doc/washington/x-pub/2015-8-11-ama-letter-dea-epcs.PDF>
- ⁸ CMS. Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017. October 2015. Accessed August 2016 from: <https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications>
- ⁹ Acting CMS Administrator Andy Slavitt. Remarks by Andy Slavitt, CMS Acting Administrator before the American Medical Association 2016 Annual Meeting Chicago, IL. June 2016. Accessed August 2016 from: <https://blog.cms.gov/2016/06/13/remarks-by-andy-slavitt-cms-acting-administrator-before-the-american-medical-association-2016-annual-meeting-chicago-il/>
- ¹⁰ AMA comments to CMS on the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models; Proposed Rule (CMS–5517–P). June 2016. Accessed August 2016 from: <https://download.ama-assn.org/resources/doc/washington/ama-macra-comments-27june2016.pdf>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-16)

Introduced by: Medical Student Section

Subject: Removing Restrictions on Federal Funding for Firearm Violence Research

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, Firearm violence is responsible for over 32,000 deaths and 84,000 injuries annually,
2 is one of the top three causes of death in American youth, and costs the U.S. at least \$174
3 billion annually;^{1,2,3,4,5} and
4

5 Whereas, The federal budgetary law, “Congressional Appropriations Act,” has effectively barred
6 the CDC, NIH, and other federal agencies from conducting necessary research on firearm
7 violence since 1996; for example, CDC funding for firearm injury prevention fell 96% in 1996 to
8 only \$100,000 annually;^{1,6,7,8,9} and
9

10 Whereas, Our AMA, along with over 100 other medical organizations, recently sent a joint letter
11 to Congress urging federal funding for research on firearm violence;¹⁰ and
12

13 Whereas, Pursuant to AMA policy H-145.975, our AMA supports federal and state research on
14 firearm-related injuries and deaths and increased funding for and the use of state and national
15 firearms injury databases, including the expansion of the National Violent Death Reporting
16 System to all 50 states and U.S. territories, to inform state and federal health policy; and
17

18 Whereas, Existing AMA policy urges the Centers for Disease Control and Prevention to
19 research firearm violence from a public health standpoint (H-145.997, D-145.999) and at the
20 2016 Annual Meeting, our House of Delegates adopted policy to actively lobby Congress to lift
21 the gun violence research ban (D-145.995); therefore be it

¹ Taichman DB and Laine C. (2015). Reducing Firearm-Related Harms: Time for Us to Study and Speak Out. *Ann Intern Med*, 162(7), 520.

² McCarthy M. (2013). Reviving research into US gun violence. *BMJ*. 346:f980. Available at <http://www.bmj.com/content/346/bmj.f980>.

³ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2015). Web-based Injury Statistics Query and Reporting Systems: Fatal Injury Reports. Available at http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html.

⁴ Siegel M, Ross CS, King C. (2014). Examining the relationship between the prevalence of guns and homicide rates in the USA using a new and improved state-level gun ownership proxy. *Injury Prevention*, 20(6), 424-426.

⁵ Children’s Safety Network. (2012). “The Cost of Firearm Violence.” Available at <https://www.childrenssafetynetwork.org/publications/cost-firearm-violence>.

⁶ Centers for Disease Control & Prevention (CDC) FY 2013 Budget Request Summary, CDC, <http://1.usa.gov/13sPK4Y>.

⁷ S. H.R.2029, 114th Cong. (2015) (enacted).

⁸ Frankel TC. (2015). “Why the CDC still isn’t researching gun violence, despite the ban being lifted two years ago.” Available at <https://www.washingtonpost.com/news/storyline/wp/2015/01/14/why-the-cdc-still-isnt-researching-gun-violence-despite-the-ban-being-lifted-two-years-ago/>.

⁹ Anglemeyer A, Horvath T, Rutherford G. (2014). The Accessibility of Firearms and Risk for Suicide and Homicide Victimization Among Household Members. *Ann Intern Med*, 160(2), 101-110.

¹⁰ Doctors for America. (2016). “Over 100 Medical and Public Health Organizations Call for Federal Gun Research.” Available at http://files.www.drsoforamerica.org/blog/blogs-from-dc-climate-change-and-health-at-the-white-house/CDC_letter_4-6_FINAL.pdf.

1 RESOLVED, That our American Medical Association provide an informational report on recent
2 and current organizational actions taken on our existing AMA policies (e.g. H-145.997)
3 regarding removing the restrictions on federal funding for firearms violence research, with
4 additional recommendations on any ongoing or proposed upcoming actions. (Directive to Take
5 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 08/29/16

RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Citation: (Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13)

AMA Campaign to Reduce Firearm Deaths H-145.988

The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Citation: (Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13)

Physicians and the Public Health Issues of Gun Safety D-145.997

Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

Citation: (Res. 410, A-13)

Guns in Hospitals H-215.977

1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present

Citation: BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm

safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16

Data on Firearm Deaths and Injuries H-145.984

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Citation: (Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13)

Gun Control H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Citation: (Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)

Firearm Availability H-145.996

Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers; (2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun control legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Citation: (Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07)

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Citation: (Res. 171, A-89; Reaffirmed: BOT Rep.50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. Citation: (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

- (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
 - (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18;
 - (c) the imposition of significant licensing fees for firearms dealers;
 - (d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
 - (e) mandatory destruction of any weapons obtained in local buy-back programs.
- (2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

Citation: (BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14)

Restriction of Assault Weapons H-145.993

Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon.

Citation: (Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07)

Guns in School Settings H-60.947

Our AMA recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment.

Citation: (Res. 402, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; and (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children.

Citation: (Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)

Preventing Firearm-Related Injury and Morbidity in Youth D-145.996

Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.

Citation: (Res. 216, A-15)

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976

Our AMA: (1) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (2) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (3) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

Citation: (Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13)

Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989

It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns.

Citation: (Res. 423, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)

Control of Non-Detectable Firearms H-145.994

The AMA supports a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices.

Citation: (Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

Firearm Availability H-145.996

Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers; (2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16

School Violence H-145.983

The AMA encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property.

Citation: (Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Preventing Firearm-Related Injury and Morbidity in Youth D-145.996

Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.

Citation: (Res. 216, A-15)

Workplace Violence Prevention H-215.978

Our AMA: (1) supports the efforts of the International Association for Healthcare Security and Safety, the AHA, and The Joint Commission to develop guidelines or standards regarding hospital security issues and recognizes these groups' collective expertise in this area. As standards are developed, the AMA will ensure that physicians are advised; and (2) encourages physicians to: work with their hospital safety committees to address the security issues within particular hospitals; become aware of and familiar with their own institution's policies and procedures; participate in training to prevent and respond to workplace violence threats; report all incidents of workplace violence; and promote a culture of safety within their workplace.

Citation: BOT Rep. 16, A-94; Reaffirmation I-99; Reaffirmation I-03; Modified: CSAPH Rep. 1, A-13; Modified: CSAPH Rep. 07, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-16)

Introduced by: Resident and Fellow Section

Subject: Inclusion of Sexual Orientation and Gender Identity Information in Electronic Health Records

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, The Institute of Medicine¹ and The Joint Commission² have recommended that
2 health care professionals ask patients about their sexual orientation and gender identity (SOGI)
3 status in clinical settings and including such data in Electronic Health Records (EHRs);³ and
4
5 Whereas, SOGI data collection is increasingly viewed as a critical step toward systematically
6 documenting and addressing health disparities affecting lesbian, gay, bisexual, and
7 transgender (LGBT) people;⁴ and
8
9 Whereas, New rules from the Centers for Medicare & Medicaid Services and the Office of the
10 National Coordinator of Health Information Technology require all electronic health record
11 systems (EHRs) certified under Stage 3 of the Meaningful Use program to allow users to
12 record, change, and access structured data on sexual orientation and gender identity; and
13
14 Whereas, An Institute of Medicine report, “The Health of Lesbian, Gay, Bisexual, and
15 Transgender People: Building a Foundation for Better Understanding,” aptly points out
16 “Although a modest body of knowledge on LGBT health has been developed, these
17 populations, stigmatized as sexual and gender minorities, have been the subject of relatively
18 little health research”; and
19
20 Whereas, Research supports the use of a two-question process in collecting gender identity
21 data by asking sex assigned at birth and current gender;^{5,6,7} and
22
23 Whereas, Within standardized nomenclature there are a variety of terminology standards (e.g.
24 Systematized Nomenclature of Medicine - Clinical Terms⁸) that do not provide for gender
25 identity to be collected as a two-step process; therefore be it

¹ Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities; Board on the Health of Select Populations; Institute of Medicine (2011) The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding. Washington, DC: National Academies Press. Available: http://www.nap.edu/catalog.php?record_id=13128. Accessed 2015 Oct 14.

² The Joint Commission (2011) Advancing effective communication, cultural competence, and patient- and family-centered care for the lesbian, gay, bisexual, and transgender community: A field guide. Oakbrook Terrace, IL: The Joint Commission.

³ U.S. Department of Health and Human Services (29 June 2011) Affordable Care Act to improve data collection, reduce health disparities. News release.

⁴ U.S. Department of Health and Human Services (no date) Healthy People 2020. Lesbian, gay, bisexual and transgender health. Available: <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25>. Accessed 2015 Oct 14.

⁵ The GenIUSS Group. (2014). Best Practices for Asking Questions to Identify Transgender and Other Gender Minority Respondents on Population-Based Surveys. J.L. Herman (Ed.). Los Angeles, CA: The Williams Institute

⁶ Bradford, J.B., Cahill, S., Grasso, C., Makadon, H.J. Policy Focus: How to Gather Data on Sexual Orientation and Gender Identity in Clinical Settings. The Fenway Institute. 2012

⁷ National LGBT Health Education Center. Collecting Sexual Orientation and Gender Identity Data in Electronic Health Records: Taking the Next Steps. The Fenway Institute. August 2015

⁸ Wikipedia contributors. SNOMED CT. Wikipedia, The Free Encyclopedia. March 23, 2016, 17:46 UTC. Available at: https://en.wikipedia.org/w/index.php?title=SNOMED_CT&oldid=711567365. Accessed April 29, 2016.

- 1 RESOLVED, That our American Medical Association advocate for inclusion of sexual
- 2 orientation and gender in electronic health records (EHRs). (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/12/16

RELEVANT AMA POLICY

PROSPECTIVE PATIENTS E-1.1.2

As professionals dedicated to protecting the well-being of patients, physicians have an ethical obligation to provide care in cases of medical emergency. Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care. Nor may physicians decline a patient based solely on the individual's infectious disease status. Physicians should not decline patients for whom they have accepted a contractual obligation to provide care.

However, physicians are not ethically required to accept all prospective patients. Physicians should be thoughtful in exercising their right to choose whom to serve.

A physician may decline to establish a patient-physician relationship with a prospective patient, or provide specific care to an existing patient, in certain limited circumstances:

(a) The patient requests care that is beyond the physician's competence or scope of practice; is known to be scientifically invalid, has no medical indication, or cannot reasonably be expected to achieve the intended clinical benefit; or is incompatible with the physician's deeply held personal, religious, or moral beliefs in keeping with ethical guidelines on exercise of conscience.

(b) The physician lacks the resources needed to provide safe, competent, respectful care for the individual. Physicians may not decline to accept a patient for reasons that would constitute discrimination against a class or category of patients

(c) Meeting the medical needs of the prospective patient could seriously compromise the physician's ability to provide the care needed by his or her other patients. The greater the prospective patient's medical need, however, the stronger is the physician's obligation to provide care, in keeping with the professional obligation to promote access to care.

(d) The individual is abusive or threatens the physician, staff, or other patients, unless the physician is legally required to provide emergency medical care. Physicians should be aware of the possibility that an underlying medical condition may contribute to this behavior.

AMA Principles of Medical Ethics: I,VI,VIII,X

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations H-65.976

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement.

Res. 414, A-04 Modified: BOT Rep. 11, A-07 Modified: Res. 08, A-16

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education H-295.878

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender,

gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients.

Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16

Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families D-65.995

Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children. (Res. 445, A-05; Modified: CSAPH Rep. 1, A-15)

National Health Survey H-440.885

Our AMA supports a national health survey that incorporates a representative sample of the U.S. population of all ages (including adolescents) and includes questions on sexual orientation, gender identity, and sexual behavior. (CSA Rep. 4, A-03; Modified: BOT Rep. 11, A-07)

Goal of Health Care Data Collection H-406.999

The AMA (1) continues to advocate that health care data collected by government and third party payers be used for education of both consumers and providers; and (2) believes that government, third party payers and self-insured companies should make physician-specific utilization information available to medical societies.

BOT Rep. W, A-92 Reaffirmed: Res. 719, A-93 BOT Rep. Y, I-85 Reaffirmed CLRPD Rep. 2, I-95 CMS Rep. 10, A-96 Reaffirmed: CMS Rep. 8, A-06 Reaffirmed: CMS Rep. 01, A-16

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.(Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15)

Health Information Technology D-478.994

Our AMA will:

- (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT);
- (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT;
- (3) support initiatives to ensure interoperability among all HIT systems; and
- (4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.(Res. 723, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed: Res. 726, A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed: Res. 205, A-11; Appended: Res. 220, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 228, I-13; Reaffirmation A-14)

Patient Information in the Electronic Medical Record H-315.971

AMA Guidelines for Patient Access to Physicians' Electronic Medical Record Systems:

- (1) Online interactions are best conducted over a secure network, with provisions for privacy and security, including encryption.
- (2) Physicians should take reasonable steps to authenticate the identity of correspondent(s) in electronic communication and to ensure that recipients of information are authorized to receive it. Physicians are encouraged to follow the following guidelines for patient authentication: (a) Have a written patient authentication protocol for all practice personnel and require all members of the physician's staff to understand and adhere to the protocol. (b) Establish minimum standards for patient authentication when a patient is new to a practice or not well known. (c) Keep a written record, electronic or paper, of each patient authenticated.
- (3) Prior to granting a patient access to his or her EMR, informed consent should be obtained regarding the appropriate use of and limitations to access of personal health information

contained in the EMR. Physicians should develop and adhere to specific guidelines and protocols for online communications and/or patient access to the EMR for all patients, and make these guidelines known to the patient as part of the informed consent process. Such guidelines should specify mechanisms for emergency access to the EMR and protection for and limitation of access to, highly sensitive medical information.

(4) If the patient is allowed to make annotations to his or her EMR (i.e., over-the-counter drug treatments, family medical history, other health information), the annotation should be indicated as authored by the patient with sourcing information (i.e., date and time stamp, login and IP address if applicable). A permanent record of all allowed annotations and communications relevant to the ongoing medical care of the patient should be maintained as part of the patient's medical record.

(5) Physicians retain the right to determine which information they do and/or do not import from a PHR into their EHR/EMR and to set parameters based on the clinical relevance of data contained within personal health records.

(6) Any data imported into a physician's EMR/EHR from a patient's personal health record (PHR) must preserve the source information of the original data and be further identified as to the PHR from which it was imported as additional source information to preserve an accurate audit trail.

(7) In order to maintain the legitimate recording of clinical events, patients should not be able to delete any health information in the record. Rather, in order to maintain the forensic nature of the record, patients should only be able to add notations when appropriate.

(8) Disclosures of Personal Health Information should comply with all applicable federal and state laws, privileges recognized in federal or state law, including common law, and the ethical requirements of physicians.(BOT Rep. 19, A-07; Modified: BOT Rep. 16, A-10)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-16)

Introduced by: Resident and Fellow Section

Subject: Universal Prescriber Access to Prescription Drug Monitoring Programs

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, The United States has been facing a rise in the number of opioid-related deaths over
2 the past several years a phenomenon known as “the opioid epidemic”, with over 47,000
3 overdose deaths nationwide in 2014 compared to roughly 17,400 in 2000;^{1,2} and
4

5 Whereas, Our AMA recognizes the role prescribing practices play in contributing to drug abuse,
6 and supports training in appropriate practices to students and residents (AMA Policy H-95.990);
7 and
8

9 Whereas, Prescription drug monitoring programs (PDMPs) are state-run programs that can
10 allow prescribers to securely see a patient’s recently filled prescriptions for controlled
11 substances; and
12

13 Whereas, In an otherwise highly fragmented healthcare system, PDMPs are central databases
14 that allow prescribers to better monitor for inappropriate medication doses, abuse of controlled
15 substances, or diversion of controlled substances for street sale; and
16

17 Whereas, Our AMA supports the creation and voluntary use of state-run PDMPs by physicians
18 (H-95.945), and our AMA and AMA-RFS support the creation of a national PDMP; and
19

20 Whereas, PDMPs exist in 49 states, though the structure and administration of the programs
21 differ throughout the country; and
22

23 Whereas, Resident and fellow physicians made up roughly 10.9% of the physician workforce in
24 2014 and can write prescriptions for controlled substances in most states;³ and
25

26 Whereas, Midlevel providers including nurse practitioners and physician’s assistants can also
27 write prescriptions for controlled substances; and
28

29 Whereas, Resident physicians routinely prescribe controlled substances for their patients
30 including opioid pain medications, yet they do not universally have access to their state’s
31 PDMP;⁴ and

¹ Centers for Disease Control and Prevention. CDC Grand Rounds: Prescription Drug Overdoses—A US Epidemic. Atlanta, GA: Centers for Disease Control and Prevention; 2012. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm>. Accessed March 30, 2016.

² Center for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Mortality File. (2015). Number and Age-Adjusted Rates of Drug-poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 2000–2014. Atlanta, GA: Center for Disease Control and Prevention. Available at http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving_OA_Heroin_US_2000-2014.pdf. Accessed April 26, 2016.

³ American Association of Medical Colleges. 2015 State Physician Workforce Data Book. Washington, D.C. 2015. Available at: <https://www.aamc.org/data/workforce/reports/442830/statedataandreports.html>. Accessed March 30, 2016.

⁴ Freyer, F. “Doctors in training gain access to prescription database.” Boston Globe. Boston, MA. December 14, 2015. Available at: <https://www.bostonglobe.com/metro/2015/12/13/medical-residents-gain-access-prescription-database/uqrbMC9kfsZX5SjAU8Snck/story.html>. Accessed April 26, 2016.

1 Whereas, Many of the existing 49 state laws responsible for the creation of PDMPs do not
2 explicitly grant resident physicians access to PDMPs; therefore be it
3

4 RESOLVED, That our American Medical Association support legislation and regulatory action
5 that would authorize all prescribers of controlled substances, including residents, to have
6 access to their state prescription drug monitoring program. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/12/16

RELEVANT AMA POLICY

Drug Abuse Related to Prescribing Practices H-95.990

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:

A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.

B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:

A. promotes physician training and competence on the proper use of controlled substances;

B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;

C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and

D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.

4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 907, I-11; Appended: Res. 219, A-12; Reaffirmation A-15; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15)

Prescription Drug Diversion, Misuse and Addiction H-95.945

Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from

the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths. (Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16)

Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939

Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines. (BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16)

Prescription Drug Monitoring Program Confidentiality H-95.946

Our AMA will: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred. (Res. 221, A-1; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-16)

Introduced by: New York

Subject: Seamless Conversion of Medicare Advantage Programs

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, The Centers for Medicare and Medicaid Services is permitting a process of "seamless
2 conversion," wherein seniors are transitioned from traditional Medicare insurance products into
3 Medicare Advantage options with seniors having little understanding of the implications, the
4 opting out process, or informed consent; and
5
6 Whereas, Many of the Medicare Advantage plans have select narrow provider panels which
7 may disrupt a patient's established doctor/patient relationship and adversely affect the patient's
8 healthcare delivery and financial wellbeing; and
9
10 Whereas, This practice of seamless conversion is projected to augment for the January 2017
11 enrollment period; and
12
13 Whereas, There is little time in the upcoming enrollment period to appropriately educate seniors
14 on these efforts and assist them in making appropriate choices for their healthcare and financial
15 needs; therefore be it
16
17 RESOLVED, That our American Medical Association collaborate with senior groups, including
18 AARP, to raise awareness among physicians and seniors regarding the implications of the
19 practice of "seamless conversion" (Directive to Take Action); and be it further
20
21 RESOLVED, That our AMA immediately begin to advocate with Congress and the Centers for
22 Medicare and Medicaid Services to implement an immediate moratorium on the practice of
23 seamless conversion. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/21/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-16)

Introduced by: District of Columbia
Subject: AMA Study of the Affordable Care Act
Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, The Patient Protection and Affordable Care Act (PPACA or ACA) was supported by
2 our AMA; and
3
4 Whereas, The ACA has not achieved many of the goals it intended to accomplish; and
5
6 Whereas, Only 16 states and the District of Columbia created state-based exchanges. Of that
7 number, four have failed (Hawaii, New Mexico, Nevada and Oregon) -- and Kentucky's will be
8 dismantled or shuttered next year. (The Oregon exchange received \$350 million in federal
9 funds, but never created a functional website or enrolled a single person in private insurance
10 online); and
11
12 Whereas, Premium costs in the exchanges increased about 12% nationwide from 2015 to 2016,
13 and current estimates are that the increase from 2016 to 2017 will double that; and
14
15 Whereas, Deductible costs and pharmaceutical costs are rising at alarming rates; and
16
17 Whereas, Insurers are increasingly fleeing--1/3 of counties in the U.S. will have only one option
18 in the exchanges next year, and the populace is not finding the exchanges attractive; and
19
20 Whereas, Millions of Americans remain without health insurance, or were pushed into struggling
21 Medicaid rosters; and
22
23 Whereas, Our AMA has a considerable volume of resolutions and reports pertinent to the
24 matter, and this extensive HOD Policy could guide the public debate; and
25
26 Whereas, Our AMA with its Federation is the most qualified entity to advise the health care
27 industry and Congress on what can be done to improve the current ACA model; therefore be it
28
29 RESOLVED, That our American Medical Association study, and using our extensive HOD
30 policy, identify what needs to be changed/fixed with the ACA (Directive to Take Action); and be
31 it further
32
33 RESOLVED, That our AMA compile a policy compendium of AMA HOD Policy or links to that
34 policy, to provide to legislators, think tanks, and the public with reliable accurate ideas and
35 knowledge (Directive to Take Action); and be it further
36
37 RESOLVED, That a comprehensive report on how to change and improve the ACA be
38 presented back to the House of Delegates at the 2017 Annual Meeting. (Directive to Take
39 Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.
Received: 09/27/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-16)

Introduced by: Medical Student Section

Subject: Advocacy and Studies on Affordable Care Act Section 1332
(State Innovation Waivers)

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, Despite improvements in access to health insurance, it is projected that
2 approximately 31 million people will remain without adequate health insurance, even with the full
3 implementation of the Affordable Care Act (ACA);¹ and
4

5 Whereas, Many patients with health insurance purchased through the ACA state and federal
6 healthcare exchanges continue to encounter difficulties in access and affordability of care due to
7 rising co-pays, deductibles, out-of-pocket costs and narrow provider networks;² and
8

9 Whereas, Section 1332 of the ACA allows states³ to apply for waivers to be exempt from some
10 of the requirements of the legislation so that they may introduce their own innovations, which
11 they believe would better provide healthcare benefits, access and affordability for the residents
12 of their states;⁴ and
13

14 Whereas, One of the statutory criteria of qualifying for a Section 1332 waiver is that innovations
15 be “deficit-neutral” and, as per federal guidance, “a waiver that increases the deficit in any given
16 year is less likely to meet the deficit neutrality requirement”;⁵ and
17

18 Whereas, The Federal guidance reducing likelihood of waiver approval based on one-year
19 deficit neutrality will likely impair states’ abilities to obtain waivers and pursue innovations that
20 will have initial costs in any particular year but still achieve deficit neutrality through long-term
21 cost savings;⁶ and
22

23 Whereas, The National Governor’s Association (NGA) issued recommendations to the
24 Department of Health and Human Services and the Department of Treasury recommending that
25 “Section 1332 waiver applications be part of state efforts to innovate in Medicaid and reach
26 additional populations”;^{7,8} and

¹ Effects of the Affordable Care Act on Health Insurance Coverage – Baseline Projections,” ed. Congressional Budget Office (2014)

² “State variation in narrow networks on the ACA marketplaces” Leonard Davis Institute of Health Economics. Aug 2015. Web. 20 Apr 2016. <<http://ldi.upenn.edu/sites/default/files/rte/state-narrow-networks.pdf>>

³ California, Colorado, New Mexico, Minnesota, Arkansas, Kentucky, Ohio, Hawai’i, Rhode Island, Massachusetts, and Vermont have taken steps to apply for a Section 1332 Innovation Waiver.

⁴ “SECTION 1332: STATE INNOVATION WAIVERS.” Centers for Medicare & Medicaid Services. Web. 12 Feb. 2016.

⁵ “Waivers for State Innovation.” Federal Register. Web. 12 Feb. 2016. <<https://www.federalregister.gov/articles/2015/12/16/2015-31563/waivers-for-state-innovation#p-44>>.

⁶ Howard, H. and Meuse, D. New Section 1332 Guidance A Mixed Bag for States. <http://healthaffairs.org/blog/2016/02/29/new-section-1332-guidance-a-mixed-bag-for-states/>

⁷ “NGA Recommendations Regarding 1332 State Innovation Waivers” National Governors Association. 2015. Web, April 2016 <<http://www.nga.org/files/live/sites/NGA/files/pdf/2015/1510LtrHHSTreasuryAttachment.pdf>>

⁸ “States May Find Health Reform’s Escape Hatch Is Too Small.” Modern Healthcare. Web. 21 Apr. 2016. <<http://www.modernhealthcare.com/article/20151215/NEWS/151219919>>

1 Whereas, Existing AMA policies (e.g. D-290.979, H-165.856, and H-290.965) support state-
2 based innovations to improve healthcare benefits, access and affordability; therefore be it
3

4 RESOLVED, That our American Medical Association advocate that the “deficit-neutrality”
5 component of the current HHS rule for Section 1332 waiver qualification be considered only on
6 long-term, aggregate cost savings of states’ innovations as opposed to having costs during any
7 particular year, including in initial “investment” years of a program, reduce the ultimate likelihood
8 of waiver approval (New HOD Policy); and be it further
9

10 RESOLVED, That our AMA study reforms that can be introduced under Section 1332 of the
11 Affordable Care Act in isolation and/or in combination with other federal waivers to improve
12 healthcare benefits, access and affordability for the benefit of patients, healthcare providers and
13 states, and encourages state societies to do the same. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/29/16

RELEVANT AMA POLICY

Medicaid Expansion D-290.979 - Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded. Res. 809, I-12

Health Insurance Market Regulation H-165.856 - Our AMA supports the following principles for health insurance market regulation: (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan; (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection; (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges; (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium; (5) Insured individuals should be protected by guaranteed renewability; (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices; (7) Guaranteed issue regulations should be rescinded; (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and

permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

CMS Rep. 7, A-03 Reaffirmed: CMS Rep. 6, A-05 Reaffirmation A-07 Reaffirmed: CMS Rep. 2, I-07 Reaffirmed: BOT Rep. 7, A-09 Appended: Res. 129, A-09 Reaffirmed: CMS Rep. 9, A-11 Reaffirmed in lieu of Res. 811, I-11 Reaffirmed in lieu of Res. 109, A-12 Reaffirmed in lieu of Res. 125, A-12 Reaffirmed: Res. 239, A-12 Reaffirmed: CMS Rep. 9, A-14

Medicaid Waivers for Managed Care Demonstration Projects H-290.987 - (1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.

BOT Rep. 24, A-95 Reaffirmation A-99 Reaffirmation A-00 Reaffirmation I-04 Modified: CMS Rep. 1, A-14

Medicaid Expansion Options and Alternatives H-290.966 - 1. Our AMA encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap. 2. Our AMA encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations. 3. Our AMA encourages the Centers for Medicare & Medicaid Services to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults. 4. Our AMA advocates that states be required to develop a transparent process for monitoring and evaluating the effects of their Medicaid expansion plans on health insurance coverage levels and access to care, and to report the results annually on the state Medicaid web site.

CMS Rep. 5, I-14 Reaffirmed: CMS Rep. 02, A-16

Medicaid Waivers and Maintenance of Effort Requirements H-290.969 - Our AMA opposes any efforts to repeal the Medicaid maintenance of effort requirements in the ACA and American Recovery and Reinvestment Act (ARRA), which mandate that states maintain eligibility levels for all existing adult Medicaid beneficiaries until 2014 and for all children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019.

CMS Rep. 5, I-11 Reaffirmation A-14

Monitoring Medicaid Managed Care H-290.985 - As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists

upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries.

CMS Rep. 5 A-96 Reaffirmed and Appended: Sub. Res. 704, I-97 Reaffirmation A-00
Reaffirmation I-04 Reaffirmed: CMS Rep. 1, A-14

AMA Advocacy for Health System Reform H-165.835 - 1. Our AMA will advocate for modification of the Patient Protection and Affordable Care Act through legislation, regulation or judicial action to remove or oppose any components of the Act that are not consistent with existing AMA policy. 2. Our AMA will identify the major flaws in the Patient Protection and Affordable Care Act and advocate repair of those flaws. 3. Our AMA will educate the physicians of these United States in the details and implementation of the PPACA legislation. Res. 214, A-10 Appended: Sub. Res. 222, I-10 Appended: Res. 203, A-12 Reaffirmed in lieu of Res. 215, A-15

Affordable Care Act Medicaid Expansion H-290.965 - 1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access. 2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models. 3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries. 4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents. 5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care. 6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs. 7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care. 8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services. 9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS. 10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016. 11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists. 12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches. 13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits. CMS Rep. 02, A-16

Redefining AMA's Position on ACA and Healthcare Reform D-165.938 - 1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform: A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines; B. Repeal and appropriate replacement of the SGR; C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines; D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting"); E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations; F. Repeal the non-physician provider non-

discrimination provisions of the ACA. 2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals. 3. There will be a report back at each meeting of the AMA HOD. Res. 231, A-13 Reaffirmed in lieu of Res. 215, A-15

Health Insurance Affordability H-165.828 - 1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA). 2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage. 3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy. 4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability. CMS Rep. 8, I-15 Reaffirmed in lieu of: Res. 121, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-16)

Introduced by: New Jersey

Subject: Limitation on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

-
- 1 Whereas, The purpose of legislation establishing the National Practitioner Data Bank (NPDB)
2 was to create a record of physicians whose medical treatment of a patient resulted in harm; and
3
4 Whereas, The regulations and NPDB Guidebook interpreting when a report should be filed have
5 expanded beyond the goal and intended purpose of the legislation to include reports by
6 malpractice carriers of physicians who were not involved in patient care; and
7
8 Whereas, Medical malpractice carriers may err on the side of reporting to the NPDB because of
9 the penalties that may be levied for failure to report; and
10
11 Whereas, Reports to the NPDB are damaging to a physician's reputation, employment status,
12 hospital medical staff privileges, and future employment opportunities; therefore be it
13
14 RESOLVED, That our American Medical Association formally request that the Health
15 Resources and Services Administration (HSRA) clarify that reports of medical malpractice
16 settlements by physicians are contingent upon treatment, the provision of or failure to provide
17 healthcare services, of the plaintiff (Directive to Take Action); and be it further
18
19 RESOLVED, That our AMA formally request that HSRA audit the National Practitioner Data
20 Bank (NPDB) for reports on physicians who were not involved in the treatment of a plaintiff, but
21 were reported as a result of a healthcare entity's settlement of a claim that included the name of
22 the physician in his/her administrative role at the entity (Directive to Take Action); and be it
23 further
24
25 RESOLVED, That HSRA should be compelled to remove the name of any physician from the
26 NPDB who was reported by a medical malpractice carrier as the result of the settlement of a
27 claim by a healthcare entity where the physician was not involved in the treatment of the
28 plaintiff. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/29/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-16)

Introduced by: Indiana
Subject: MIPS and MACRA Exemptions
Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, The new payment system, merit-based incentive payment system (MIPS) and
2 Medicare Access and Chip Reauthorization Act of 2015 (MACRA), will be implemented in 2019
3 to replace the current fee-for-service systems; and
4
5 Whereas, MACRA picks a handful of screening tests and calls this a measure of quality; and
6
7 Whereas, There are no measures in MACRA for making a timely and accurate diagnosis, a core
8 expectation of primary care; and
9
10 Whereas, Eighty-seven percent of solo practices will face negative adjustments in year one of
11 MACRA (*Medical Economics*, May 25, 2015, Vol. 93 No. 10); and
12
13 Whereas, Electronic medical records are not designed for population management, a
14 requirement of MACRA; and
15
16 Whereas, Most small practices will not be able to comply with these guidelines; therefore be it
17
18 RESOLVED, That our American Medical Association support an exemption from the merit-
19 based incentive payment system (MIPS) and Medicare Access and Chip Reauthorization Act of
20 2015 (MACRA) for small practices since these rules will hasten the demise of small private
21 practice in the U.S. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/29/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-16)

Introduced by: Indiana
Subject: Affordable Care Act Revisit
Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, The Affordable Care Act (ACA) has and will worsen government deficit spending, in
2 spite of significant taxation under the plan and promises that it would save federal tax dollars;
3 and
4
5 Whereas, The ACA has not substantially decreased the number of uninsured; total insured
6 under the plan recently dropped below 12 million; and
7
8 Whereas, The ACA expands bureaucratization of an already over-regulated sector of the U.S.
9 economy; and
10
11 Whereas, The ACA, through its requirements related to demonstration of meaningful use,
12 transition to electronic medical records and a myriad of "red tape" rules and regulations has
13 interfered with physician productivity and satisfaction, as well as patient access; and
14
15 Whereas, The ACA infringes on religious liberties and morality through its coverage of abortion
16 on some plans and the potential for heavy fines for insurers who do not comply with the rules on
17 birth control; and
18
19 Whereas, The ACA interferes with free-market competition that would have helped lower costs
20 and improve efficiencies; and
21
22 Whereas, The ACA is limiting choice and savings through the ongoing loss of multiple
23 exchanges, co-ops and insurance plans across the country; and
24
25 Whereas, Cuts to Medicare under the ACA are unsustainable and will decrease access and
26 increase cost to seniors in the future; and
27
28 Whereas, The ACA, through its policy standardization and restrictions on policy variations, has
29 resulted in obscene premiums, deductibles and co-pays for some individuals, with most ACA
30 insureds seeing increased premiums every year; and
31
32 Whereas, The ACA largely usurps the state's authority over health insurance regulation; and
33
34 Whereas, The ACA wastes federal dollars through numerous exemptions, loopholes, subsidies
35 and other schemes; therefore be it

1 RESOLVED, That our American Medical Association House of Delegates no longer support the
2 Affordable Care Act (ACA) in its current form and to work for replacement or substantial revision
3 of the act to include these changes:

- 4
- 5 - Allowing health insurance to be sold across state lines
 - 6 - Allowing all businesses to self-insure and to purchase insurance through business health
7 plans or association health plans
 - 8 - Improving the individual mandate with a refundable tax credit that would be used to
9 purchase health insurance
 - 10 - Improving health-related savings accounts so as to help ACA insureds afford their higher
11 deductibles and co-pays
 - 12 - Reversing cuts to traditional Medicare and Medicare Advantage programs
 - 13 - Encouraging states to develop alternatives to Medicaid by using federal funds granted
14 under provisions of the ACA
 - 15 - Eliminating all exemptions, loopholes, discounts, subsidies and other schemes to be fair to
16 those who cannot access such breaks in their insurance costs (New HOD Policy); and be
17 it further

18
19 RESOLVED, That our AMA maintain the following provisions to the ACA if it is replaced:

- 20
- 21 - Full coverage of preventive services
 - 22 - Family insurance coverage of children living in a household until age 26
 - 23 - Elimination of lifetime benefit caps
 - 24 - Guaranteed insurability (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/29/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-16)

Introduced by: Indiana

Subject: Automatic Enrollment into Medicare Advantage

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, With Medicare's specific approval, a health insurance company can enroll a member
2 of its commercial plan into its Medicare Advantage Plan when the individual becomes eligible for
3 Medicare; and
4
5 Whereas, This "seamless conversion" is an opt out program; and
6
7 Whereas, Patients many times are unaware that they were automatically enrolled into a
8 Medicare Advantage plan and may end up with big bills when they get admitted to out of
9 network hospitals; therefore be it
10
11 RESOLVED, That our American Medical Association work to make seamless conversion
12 enrollment into a Medicare Advantage Plan an opt-in rather than an opt-out process. (Directive
13 to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/29/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-16)

Introduced by: Indiana
Subject: Electronic Health Records
Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, The electronic health record (EHR) in the present form has been prematurely
2 mandated by the government for the medical profession with emphasis on billing (electronic
3 billing record or EBR); and
4
5 Whereas, Physicians are more vulnerable to malpractice lawsuits by:
6 - Clicking items with more detail than their usual examination
7 - Choosing a code, by mandate, that may not really reflect the true diagnosis
8 - An inability to review voluminous consultant's notes that may lead to missing important
9 recommendations; and
10
11 Whereas, Current EHR systems require too much time for the mandated useless documentation
12 causing dissatisfaction between doctors and patients and anger that is very obviously felt in
13 most waiting rooms of doctors' offices; therefore be it
14
15 RESOLVED, That our American Medical Association support federal legislation that will replace
16 current meaningful use with common sense meaningful use developed by the medical
17 profession that is user friendly and practical. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/29/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-16)

Introduced by: Medical Student Section

Subject: Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, There are an estimated 700,000 transgender individuals in America, not accounting
2 for individuals who may identify with a non-conforming gender identity, who face unique
3 obstacles to receiving healthcare;^{1,2} and
4

5 Whereas, A lack of healthcare worker awareness and sensitivity regarding different sexual
6 orientation/gender identity (SO/GI) and/or patient intake forms that fail to accurately record a
7 patient's preferred name, appropriate pronoun, sex, and gender identity can cause transgender
8 individuals to delay or not seek out care at all;³ and
9

10 Whereas, The inclusion of SO/GI options with open-ended questions on patient forms validates
11 patients' identities,² allows for a more inclusive medical environment, encourages patient
12 disclosure leading to more complete and accurate patient health information, and recognizes
13 that biological sex, gender identity, and sexual orientation are separate facets of a patient's
14 identity;^{4,5} and
15

16 Whereas, Accurate SO/GI information will help physicians establish a more complete social
17 history for all patients,^{6,7} screen for gender and lifestyle-specific disease,⁶ and identify what
18 organs an individual may or may not have that may require preventative health screenings;⁸ and
19

20 Whereas, The Department of Health and Human Services has ruled that "providers participating
21 in the EHR Incentive Programs will need to have certified health IT with the capability to capture
22 SO/GI to meet the CEHRT definition in 2018 and subsequent years" and that "certification does
23 not require that a provider collect this information, only that certified Health IT Modules enable a
24 user to do so;"⁹ and

¹ Makadon H. Ending LGBT invisibility in health care: The first step in ensuring equitable care. *Cleve Clin J Med.* 2011; 78: 220-224.

² Gates, G. J. (2011) "How Many People are Lesbian, Gay, Bisexual, and Transgender?" The Williams Institute. Available at: <http://williamsinstitute.law.ucla.edu/research/census-lgbt-demographics-studies/how-many-people-are-lesbian-gay-bisexual-and-transgender/>

³ Mizock, L., & Lewis, T. (2008). Trauma in Transgender Populations: Risk, Resilience, and Clinical Care. *Journal of Emotional Abuse*, 8(January 2015), 335–354. <http://doi.org/10.1080/10926790802262523>

⁴ Gay and Lesbian Medical Association. Guidelines of Care for Lesbian, Gay, Bisexual, and Transgender (LGBT) Patients. New York. January 2006.

⁵ American Psychological Association. (2011). "Definition of Terms: Sex, Gender, Gender Identity, Sexual Orientation." Available at: <https://www.apa.org/pi/lgbt/resources/sexuality-definitions.pdf>

⁶ "How to Gather Data on Sexual Orientation and Gender Identity in Clinical Settings." Policy Brief by the Fenway Institute. January 09, 2012.

⁷ "Why Gather Data on Sexual Orientation and Gender Identity in Clinical Settings." Policy Brief by the Fenway Institute. January, 09, 2012.

⁸ Deutsch, M. B., Green, J., Keatley, J., Mayer, G., Hastings, J., & Hall, A. M. (2013). Electronic Medical Records and the Transgender Patient: Recommendations from the World Professional Association for Transgender Health EMR Working Group. *Journal of the American Medical Informatics Association : JAMIA*, 20(4), 700–703. <http://doi.org/10.1136/amiajnl-2012-001472>

⁹ "2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition, and ONC Health IT Certification Program Modifications." Office of the Federal Register. Available at: <https://www.federalregister.gov/articles/2015/10/16/2015-25597/2015-edition-health-information-technology-health-it-certification-criteria-2015-edition-base#h-46>

1 Whereas, Pursuant to existing AMA policy H-160.991, our AMA believes that the physician's
2 nonjudgmental recognition of sexual orientation and behavior enhances the ability to render
3 optimal patient care in health as well as in illness; therefore be it
4
5 RESOLVED, That our American Medical Association support the inclusion of a patient's
6 biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and
7 (if applicable) surrogate identifications in medical documentation and related forms in a
8 culturally-sensitive and voluntary manner (New HOD Policy); and be it further
9
10 RESOLVED, That our AMA advocate for collection of patient data that is inclusive of sexual
11 orientation/gender identity for the purposes of research into patient health. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/30/16

RELEVANT AMA POLICY

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991 - 1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients; (iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity. 2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases. 3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues. 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people. CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16

Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients H-65.967 - 1. Our AMA supports policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care. 2. Our AMA: (a) supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates; and (b) supports that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventive care. Res. 4, A-13 Appended: BOT Rep. 26, A-14

Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families D-65.995 - Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children. Res. 445, A-05 Modified: CSAPH Rep. 1, A-15

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations D-65.996 - Our AMA will encourage and work with state medical societies to provide a sample printed nondiscrimination policy suitable for framing, and encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity." Res. 414, A-04 Modified: BOT Rep. 11, A-07 Modified: Res. 08, A-16

Nondiscriminatory Policy for the Health Care Needs of LGBT Populations H-65.976 - Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement. Res. 414, A-04 Modified: BOT Rep. 11, A-07 Modified: Res. 08, A-16

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980 - The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity. Res. 178, A-88 Reaffirmed: Sub. Res. 101, I-97 Reaffirmed: CMS Rep. 9, A-07 Modified: BOT Rep. 11, A-07

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education H-295.878 - Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients. Res. 323, A-05 Modified in lieu of Res. 906, I-10 Reaffirmation A-11 Reaffirmation A-12 Reaffirmation A-16

Strategies for Enhancing Diversity in the Physician Workforce H-200.951 - Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities; (2) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. CME Rep. 1, I-06 Reaffirmed: CME Rep. 7, A-08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16

National Health Survey H-440.885 - Our AMA supports a national health survey that incorporates a representative sample of the U.S. population of all ages (including adolescents) and includes questions on sexual orientation, gender identity, and sexual behavior. CSA Rep. 4, A-03 Modified: BOT Rep. 11, A-07

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-16)

Introduced by: Michigan
Subject: SOAP Notes and Chief Complaint
Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, SOAP (Subjective, Objective, Assessment, and Plan) or routine visit notes start with a
2 subjective portion; and
3
4 Whereas, There are typically three key components when selecting the appropriate level of
5 evaluation and management (E/M) service provided--history, examination, and medical decision
6 making; and
7
8 Whereas, The chief complaint (CC) is a required element of history and is described in the
9 Medicare Learning Network's *Evaluation and Management Services Guide* as "a concise
10 statement that describes the symptom, problem, condition, diagnosis, or reason for the patient
11 encounter"; and
12
13 Whereas, The Medicare Learning Network's *Evaluation and Management Services Guide* states
14 that the CC may be listed as separate elements of history or they may be included in the
15 description of the history of the present illness; and
16
17 Whereas, It should be the physician's decision as to how to describe the CC or reason for the
18 patient's visit; and
19
20 Whereas, Physicians are subject to federal auditing initiatives including recovery audits
21 performed by Recovery Audit Contractors (RAC) whose primary task is to review Medicare
22 claims data and determine if a claim was appropriately paid; and
23
24 Whereas, Physician colleagues have reported the denial of visits due to the absence of specific
25 "key" words within the CC portion of the history, even though the note itself provides adequate
26 documentation of the reason for the visit and the actual services performed; therefore be it

1 RESOLVED, That our American Medical Association amend AMA Policy D-320.991, Creating a
2 Fair and Balanced Medicare and Medicaid RAC Program, by addition to read as follows:
3

4 1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit
5 Contractor (RAC) practices and recovery statistics and continue to encourage the
6 Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which
7 will impose penalties against RACs for abusive practices.

8 2. Our AMA will continue to encourage CMS to adopt new regulations which require
9 physician review of all medical necessity cases in post-payment audits, as medical
10 necessity is quintessentially a physician determination and judgment.

11 3. Our AMA will encourage CMS to discontinue the denial of payments or imposition
12 of negative action during a RAC audit due to the absence of specific words in the
13 chief complaint when the note provides adequate documentation of the reason for the
14 visit and services rendered.

15 ~~3.~~ 4. Our AMA will assist states by providing recommendations regarding state
16 implementation of Medicaid RAC rules and regulations in order to lessen confusion
17 among physicians and to ensure that states properly balance the interest in
18 overpayment and underpayment audit corrections for Recovery Contractors.

19 ~~4.~~ 5. Our AMA will petition CMS to amend CMS' rules governing the use of
20 extrapolation in the RAC audit process, so that the amended CMS rules conform to
21 Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of
22 Extrapolation; and insists that the amended rules state that when an RAC initially
23 contacts a physician, the RAC is not permitted to use extrapolation to determine
24 overpayment amounts to be recovered from that physician by recoupment, offset, or
25 otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of
26 Health and Human Services has already determined, before the RAC audit, either
27 that (a) previous, routine pre- or post-payment audits of the physician's claims by the
28 Medicare Administrative Contractor have found a sustained or high level of previous
29 payment errors, or that (b) documented educational intervention has failed to correct
30 those payment errors.

31 ~~5.~~ 6. Our AMA, in coordination with other stakeholders such as the American Hospital
32 Association, will seek to influence Congress to eliminate the current RAC system and
33 ask CMS to consolidate its audit systems into a more balanced, transparent, and fair
34 system, which does not increase administrative burdens on physicians.

35 ~~6.~~ 7. Our AMA will: (A) seek to influence CMS and Congress to require that a
36 physician, and not a lower level provider, review and approve any RAC claim against
37 physicians or physician-decision making, (B) seek to influence CMS and Congress to
38 allow physicians to be paid any denied claim if appropriate services are rendered, and
39 (C) seek the enactment of fines, penalties and the recovery of costs incurred in
40 defending against RACs whenever an appeal against them is won in order to
41 discourage inappropriate and illegitimate audit work by RACs.

42 ~~7.~~ 8. Our AMA will advocate for penalties and interest to be imposed on the auditor
43 and payable to the physician when a RAC audit or appeal for a claim has been found
44 in favor of the physician. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/30/16

RELEVANT AMA POLICY

Member Education on Medicare Recovery Audit Contractors H-335.963

Our AMA: (1) will educate our membership about the effect of the program's safeguard contractor activity and Recovery Audit Contractor (RAC) audits on individual physician practices, expansion of the RAC program, and assistance that may be available through our AMA; and (2) will actively support the legislation currently before Congress to require an immediate moratorium on the expansion of the RAC program, and will seek the introduction of subsequent legislation that would limit or exclude physician billings from the authority of RAC audits altogether.

Citation: (Sub. Res. 226, A-08)

RAC Audits of E&M Codes D-330.915

1. Our AMA opposes Recovery Audit Contractor audits of E&M codes with the Centers for Medicare & Medicaid Services (CMS) and will explain to CMS and Congress why these audits as currently conducted are deleterious to the provision of care to patients with complex health needs.

2. If our AMA is unsuccessful in reversing the audits, our AMA will urge CMS and elected Washington officials to require physician reimbursement for time and expense of appeals.

3. Our AMA will urge CMS and elected Washington officials to provide statistical data regarding the audits, including the specialties most affected by these audits, and the percentage of denied claims for E&M codes which, when appealed, are reversed on appeal.

Citation: (Res. 224, I-12)

Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991

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 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.

4. 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 a 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.

5. 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.

6. 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.

7. 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.

Citation: Res. 215, I-11; Appended: Res. 209, A-13; Appended: Res. 229, A-13; Appended: Res. 216, I-13; Reaffirmed: Res. 223, I-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-16)

Introduced by: Michigan

Subject: Firearm-Related Injury and Death: Adopt a Call to Action

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, Deaths and injuries related to firearms constitute a major public health problem in the
2 United States; and
3

4 Whereas, In response to firearm violence and other firearm-related injuries and deaths, an
5 interdisciplinary, inter-professional group of leaders from eight national health professional
6 organizations and the American Bar Association, representing the official policy positions of
7 their organizations, advocate a series of measures aimed at reducing the health and public
8 health consequences of firearms; and
9

10 Whereas, The eight national health professional organizations include the American Academy
11 of Family Physicians, American Academy of Pediatrics, American College of Emergency
12 Physicians, American Congress of Obstetricians and Gynecologists, American College of
13 Physicians, American College of Surgeons, American Psychiatric Association, and American
14 Public Health Association; and
15

16 Whereas, The American Medical Association is prominently absent; and
17

18 Whereas, The specific recommendations of this inter-disciplinary group include universal
19 background checks of gun purchasers, elimination of physician “gag laws,” restricting the
20 manufacture and sale of military-style assault weapons and large-capacity magazines for
21 civilian use, research to support strategies for reducing firearm-related injuries and deaths,
22 improved access to mental health services, and avoidance of stigmatization of persons with
23 mental and substance use disorders through blanket reporting laws; and
24

25 Whereas, The American Bar Association, acting through its Standing Committee on Gun
26 Violence, confirms that none of these recommendations conflict with the Second Amendment or
27 previous rulings of the U.S. Supreme Court; therefore be it
28

29 RESOLVED, That our American Medical Association endorse the specific recommendations
30 made by an interdisciplinary, inter-professional group of leaders from the American Academy of
31 Family Physicians, American Academy of Pediatrics, American College of Emergency
32 Physicians, American Congress of Obstetricians and Gynecologists, American College of
33 Physicians, American College of Surgeons, American Psychiatric Association, American Public
34 Health Association, and the American Bar Association in the publication “Firearm-Related Injury
35 and Death in the United States: A Call to Action From 8 Health Professional Organizations and
36 the American Bar Association,” which is aimed at reducing the health and public health
37 consequences of firearms and lobby for their adoption. (Directive to Take Action)

Reference:

1. Annals of Internal Medicine 7 April 2015, Vol 162, No.7 "Firearm-Related Injury and Death in the United States" - <http://annals.org/article.aspx?articleid=2151828>

Fiscal Note: Minimal - less than \$1,000.

Received: 09/30/16

RELEVANT AMA POLICY

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976

Our AMA: (1) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (2) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (3) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

Citation: (Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13)

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.

Citation: (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)

Data on Firearm Deaths and Injuries H-145.984

The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

Citation: (Res. 811, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-13)

Increasing Toy Gun Safety H-145.974

Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.

Citation: (Res. 406, A-15)

AMA Campaign to Reduce Firearm Deaths H-145.988

The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Citation: (Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13)

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; and (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children.

Citation: (Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)

Control of Non-Detectable Firearms H-145.994

The AMA supports a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices.

Citation: (Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

Waiting Period Before Gun Purchase H-145.992

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Citation: (Res. 171, A-89; Reaffirmed: BOT Rep.50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)

Firearm Availability H-145.996

Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers; (2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and

(3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

School Violence H-145.983

The AMA encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property.

Citation: (Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the

United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;

(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18;

(c) the imposition of significant licensing fees for firearms dealers;

(d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and

(e) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

Citation: (BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14)

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and

(2) will actively lobby Congress to lift the gun violence research ban.

Citation: Res. 1011, A-16;

Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989

It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns.

Citation: (Res. 423, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11)

Restriction of Assault Weapons H-145.993

Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon.

Citation: (Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07)

Gun Control H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Citation: (Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)

Ban Realistic Toy Guns H-145.995

The AMA supports (1) working with civic groups and other interested parties to ban the production, sale, and distribution of realistic toy guns; and (2) taking a public stand on banning realistic toy guns by various public appeal methods.

Citation: (Sub. Res. 140, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

- (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
- (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
- (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
- (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
- (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)

Guns in Hospitals H-215.977

1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present

Citation: BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16

Preventing Firearm-Related Injury and Morbidity in Youth D-145.996

Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.

Citation: (Res. 216, A-15)

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun control legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

Citation: (Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-16)

Introduced by: Missouri
Subject: Parental Leave
Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, The United States has one of the shortest parental leave periods in the world and is
2 the only developed country not to mandate that the leave period is both paid and protected; and
3
4 Whereas, Only 46% of private sector employees qualify for unpaid parental leave under the
5 Family and Medical Leave Act of 1993, which only covers individuals who work for employers
6 with at least 50 employees within 75 miles and who have worked more than 1250 hours in the
7 past 12 months; and
8
9 Whereas, Paid leave better facilitates parents taking a longer leave and is associated with
10 significantly greater improvements in infant mortality compared to unpaid leave; and
11
12 Whereas, Longer use of parental leave improves health outcomes for the child by decreasing
13 infant mortality by 10%, increasing the likelihood of vaccination, increasing the likelihood of the
14 child having routine medical check-ups, and increasing cognitive and behavioral scores in early
15 childhood; and
16
17 Whereas, Longer use of parental leave reduces the risk of maternal depressive symptoms and
18 improves the physical health status of both mothers and fathers; therefore be it
19
20 RESOLVED, That our American Medical Association study the health implications among
21 patients if the United States were to modify one or more of the following aspects of the Family
22 and Medical Leave Act (FMLA):
23 - a reduction in the number of employees from 50 employees;
24 - an increase in the number of covered weeks from 12 weeks; and
25 - creating a new benefit of paid parental leave (Directive to Take Action); and be it
26 further
27
28 RESOLVED, That our AMA study the effects of FMLA expansion on physicians in varied
29 practice environments. (Directive to Take Action)

Fiscal Note: Estimated cost of \$31,000 to implement resolution.

Received: 09/30/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-16)

Introduced by: Florida

Subject: Ending Medicare Advantage "Auto-Enrollment"

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

- 1 Whereas, The Centers for Medicare and Medicaid Services now allows commercial healthcare
2 insurers to “auto-enroll” their insured into that carrier’s Medicare Advantage Plan with a single
3 letter of notification during that insured’s pre-Medicare enrollment period; and
4
5 Whereas, During the pre-Medicare enrollment period each individual will receive dozens of
6 communications from multiple healthcare insurers regarding a wide variety of Medicare
7 insurance products that many Medicare-eligible individuals find confusing; and
8
9 Whereas, The insured receiving notification by their healthcare carrier of “auto-enrollment” in
10 that carrier’s Medicare Advantage Plan must actively “opt-out” of that plan within 60 days or lose
11 their ability to enroll in traditional Medicare for a year; therefore be it
12
13 RESOLVED, The our American Medical Association work with the Centers for Medicare and
14 Medicaid Services and/or Congress to end the procedure of “auto-enrollment” of individuals into
15 Medicare Advantage Plans. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 10/05/16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-16)

Introduced by: American Society of Ophthalmic Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Facial Plastic and Reconstructive Surgery
American Society for Aesthetic Plastic Surgery
American Society of Cataract and Refractive Surgery
American Society of Retinal Specialists
American Society of Plastic Surgeons

Subject: The Rights of Patients, Providers and Facilities to Contract for Non-Covered Services

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

-
- 1 Whereas, Blepharoplasty and blepharoptosis repair are distinct surgical procedures directed at
2 correcting different pathology of the upper eyelids; and
3
4 Whereas, Each may be performed for medically necessary (functional) or aesthetic indications;
5 and
6
7 Whereas, These distinctions are dictated by coverage rules of third party payers regarding
8 medical necessity; and
9
10 Whereas, In 2009, NCCI bundled payments for blepharoplasty and ptosis repair and the
11 bundling applied to procedures that met medical necessity criteria but aesthetic procedures
12 would be performed per agreement between patients, surgeons and facilities in accordance with
13 current practice and regulations; and
14
15 Whereas, In May, 2016, CMS issued a guidance that interpreted the bundles to include all
16 ptosis procedures and all functional and aesthetic aspects of blepharoplasty (CMS MLN Matters
17 Number M9658); and
18
19 Whereas, This guidance makes it a violation of policy for aesthetic surgery to be done on the
20 same eyelid, at the same time as functional surgery or at any time by the initial surgeon or by a
21 second surgeon at the same time or at any future time; and
22
23 Whereas, This prohibits the rights of a patient to contract with a surgeon to obtain aesthetic
24 surgery involving an eyelid once any functional surgery has been performed on that lid at the
25 time of the functional surgery or at any time in the future by the same or any surgeon; and
26
27 Whereas, Medical third party payers are not obligated to pay for procedures that do not meet
28 their medical necessity criteria but DO NOT have authority to regulate choices made by patients
29 and providers regarding procedures that do not meet their criteria for medical necessity and
30 decisions regarding non-covered benefits are to be made by agreement between patients,
31 providers and facilities (AMA Policy D-380.997); and

1 Whereas, CMS Matter Number MM9658 violates the rights of patients, facilities and providers to
2 privately contract for non-covered services; and
3

4 Whereas, This regulation sets a bad precedent for future CMS guidance that could affect private
5 contracting between patients and providers in any area of medicine; therefore be it
6

7 RESOLVED, That our American Medical Association reaffirm Policy D-380.997 and any other
8 applicable policies (Reaffirm HOD Policy); and be it further
9

10 RESOLVED, That our AMA engage in efforts to convince the CMS to rescind the CMS guidance
11 that bundled all blepharoptosis procedures with all functional and aesthetic aspects of
12 blepharoplasty and to abstain from bundling other situations in which functional and aesthetic
13 considerations should be able to be considered separately (Directive to Take Action); and be it
14 further
15

16 RESOLVED, That our AMA actively oppose further regulations that would interfere with the
17 rights of patients, providers, and facilities to privately contract for non-covered services. (New
18 HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 10/13/16

RELEVANT AMA POLICY

Private Contracting by Medicare Patients D-380.997

1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry.

2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997.

3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare.

CMS Rep. 6, A-99 Reaffirmation A-04 Reaffirmation A-08 Reaffirmation I-13 Modified: CMS Rep. 1, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-16)

Introduced by: American Academy of Orthopaedic Surgeons, North American Spine Society, American Association for Hand Surgery, American Orthopaedic Foot and Ankle Society, American Congress of Obstetricians and Gynecologists, American Association of Hip and Knee Surgeons, Kansas

Subject: Support for Prescription Drug Monitoring Programs

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

-
- 1 Whereas, State prescription drug monitoring programs (PDMPs) have been established to
2 collect and monitor prescribing and dispensing data of controlled substances; and
3
4 Whereas, PDMPs are currently established in 49 states, the District of Columbia, and Guam;
5 and
6
7 Whereas, Data from PDMPs help physicians to assess risks of abuse or diversion of controlled
8 substances; and
9
10 Whereas, Patients may acquire controlled substances from health care providers and/or
11 pharmacies in more than one state; and
12
13 Whereas, State-based PDMPs currently are not interactive across state lines, limiting the data
14 to which physicians have access, thereby limiting their ability to determine individual patients'
15 risks for addiction or diversion; and
16
17 Whereas, The National All Schedules Prescription Electronic Reporting Act (NASPER) was first
18 passed by Congress in 2005 and last re-authorized in the Comprehensive Addiction and
19 Recovery Act of 2016; and
20
21 Whereas, NASPER contains the initial mandate that PDMPs be interactive between states; and
22
23 Whereas, NASPER does not remain fully funded; and
24
25 Whereas, Our AMA has been supportive of full appropriations for NASPER; therefore be it
26
27 RESOLVED, That our American Medical Association continue to encourage Congress to assure
28 that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar
29 programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to
30 remain viable and active (New HOD Policy); and be it further
31
32 RESOLVED, That our AMA work to assure that interstate operability of PDMPs in a manner that
33 allows data to be easily accessed by physicians and does not place an onerous burden on their
34 practices. (Directive to Take Action)

¹ <http://www.pdmassist.org/content/prescription-drug-monitoring-frequently-asked-questions-faq>
² <https://www.govtrack.us/congress/bills/109/hr1132/summary>

Fiscal Note: Minimal - less than \$1,000.

Received: 10/11/16

RELEVANT AMA POLICY

Prescription Drug Monitoring Program Confidentiality H-95.946

Our AMA will: (1) advocate for the placement and management of state-based prescription drug monitoring programs with a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial; (2) encourage all state agencies responsible for maintaining and managing a prescription drug monitoring program (PDMP) to do so in a manner that treats PDMP data as health information that is protected from release outside of the health care system; and (3) advocate for strong confidentiality safeguards and protections of state databases by limiting database access by non-health care individuals to only those instances in which probable cause exists that an unlawful act or breach of the standard of care may have occurred.

Res. 221, A-12 Reaffirmed: BOT Rep. 12, A-15 Reaffirmed: BOT Rep. 5, I-15

Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939

Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.

BOT Rep. 12, A-15 Reaffirmed: BOT Rep. 5, I-15 Reaffirmation A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-16)

Introduced by: American Academy of Allergy, Asthma and Immunology

Subject: Protect Individualized Compounding in Physicians' Offices
as Practice of Medicine

Referred to: Reference Committee B
(Ann R. Stroink, MD, Chair)

1 Whereas, The AMA has adopted policy that encourages the United States Pharmacopeia (USP)
2 to retain special rules for compounding in physician offices for allergen immunotherapy and
3 potentially other kinds of small-volume physician office-based compounding, including engaging
4 with the U.S. Congress and the Food and Drug Administration (FDA); that the AMA shall form a
5 coalition of specialties impacted by rules related to physician in-office compounding; that
6 regulation of physician in-office compounding should be regulated by state medical boards
7 rather than state pharmacy boards; and that the AMA supports current 2008 USP General
8 Chapter <797> sterile compounding rules as pertaining to allergen extracts; and
9

10 Whereas, AMA Washington office staff have recently convened medical specialties affected by
11 recent proposed actions by the USP and FDA as they relate to physician office compounding
12 and are initiating a survey of the potential impact of proposed requirements on each specialty,
13 as well as assisting with outreach regarding broad concerns on this issue; and
14

15 Whereas, The USP's revisions to Chapter <797> are not anticipated until at least 2018; and
16

17 Whereas, In August 2016, the FDA issued a draft guidance entitled "Insanitary Conditions at
18 Compounding Facilities" that effectively circumvents the USP Chapter <797> revision process
19 by indicating that states should enforce a set of standards for compounding facilities, including
20 considering to be insanitary any compounded material not mixed under those standards, and
21 specifically including physician in-office compounding in its definition of "compounding facilities";
22 and
23

24 Whereas, The draft guidance specifically cites the 60 tragic deaths and 750 fungal meningitis
25 infections in 2012 resulting from contaminated products produced by a compounding pharmacy
26 and indicates that other adverse events have resulted from contaminated drug products
27 produced in commercial compounding facilities, but as yet the FDA has not provided evidence
28 or indication of any adverse events resulting from individually compounded medications
29 produced in physician offices; and specifically the FDA has not produced any data that allergen
30 extract compounding in physician offices has resulted in any infectious complications in
31 patients; and
32

33 Whereas, Any physician in the practice of Allergy/Immunology would have to consider
34 immediately halting treatment already underway for patients on allergen immunotherapy,
35 including those in treatment for allergies with a significant risk of life threatening anaphylaxis,
36 under threat of potential recourse by states implementing these standards as soon as a finalized
37 guidance might be issued, thereby putting these patients at serious risk of physical harm; and

1 Whereas, Allergen immunotherapy, which has been provided in the U.S. for more than 100
2 years with no known documented adverse infectious events, requires the allergist to compound
3 not only initial individualized treatment sets, but sometimes also to make modifications to a
4 patients' allergen extract over the course of this highly personalized treatment; and this
5 generally would not be possible under the standards suggested in the draft guidance, therefore
6 creating a significant barrier to the physician's ability to practice evidence based medicine; and
7

8 Whereas, The FDA's draft guidance, if made final, would thus have significant detrimental
9 impact on patients' access to optimal individualized care by limiting their physicians' ability to
10 practice medicine; and
11

12 Whereas, There is no known evidence that this effort by the FDA to expand compounding
13 pharmacy-level precautionary measures is indicated or necessary for small-volume physician in-
14 office compounding, and if FDA has such evidence that has not been shared then it is acting
15 without sufficient transparency for such an extraordinary regulatory over-reach; therefore be it
16

17 RESOLVED, That our American Medical Association strongly request that the US Food and
18 Drug Administration (FDA) withdraw its draft guidance "Insanitary Conditions at Compounding
19 Facilities" and that no further action be taken by the agency until revisions to the USP Chapter
20 <797> on Sterile Compounding, have been finalized (Directive to Take Action); and be it further
21

22 RESOLVED, That our AMA work with the US Congress to adopt legislation that would preserve
23 physician office-based compounding as the practice of medicine and codify in law that
24 physicians compounding medications in their offices for immediate or subsequent use in the
25 management of their patients are not compounding facilities under the jurisdiction of the FDA.
26 (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 10/13/16