REFERENCE COMMITTEE B
SUMMARY REPORT FOR THE NEW ENGLAND DELEGATION
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CONSENT CALENDAR FOR APPROVAL

BOT Report 04 Increased Use of Body-Worn Cameras by Law Enforcement Officers (Res 208-I-17). MSS asked AMA to advocate for increased funding and training for body-worn cameras by LEOs. Concerns were raised about appropriateness for AMA to address this concern so it was referred. As violence between police and public is a social determinant of health, AMA supports research into the public health effects of violent interactions and AMA has policy to address minority health issues, the BOT feels it is appropriate to support the request and recommends more directive language calling for AMA to work with medical and specialty societies to support legislation or regulation encouraging the use of and funding of body camera programs.

At A-18 the BOT report summarized the work done by AMA on EHRs and interacting with PDMPs. HOD supported the report but wanted further info on PDMPs. More entities are using PDMPs but EPCS uptake lags due to outdated DEA regulations on 2 factor authentication and currently used biometrics do not comport to rigid EPCS regulations. AMA has stressed to DEA that updates are needed in these areas to improve EPCS and PDMPs. Another barrier is that w/ over 600 EHRs it is difficult to integrate all w/PDMPs. This report provides amended policy recommendations asking for a federal study on the effectiveness of PDMPs in improving pain care and preventing misuse. It also urges EHR vendors to increase transparency of connections and costs to integrate into physicians’ practices and asks for pilot studies for best practices to integrate EHRs, PDMPs, EPCSs.

BOT Report 08 340B Drug Discount Program (Res 225-A-18 Resolve 3)
This asks to support discontinuing use of the Disproportionate Share Hospital adjustment as a determining measure for 340B program eligibility. Mixed testimony on original resolution suggested additional analysis was needed to assess which hospitals should benefit. 340B requires drugs to be sold at a discount so they can reach more low-income patients. As the 340B program has expanded the number of eligible hospitals, particularly DSHs, and patients, do low-income patients continue to benefit from the drug discounts? A 2016 study showed that the median amount of charity care provided by 340B hospitals was similar non-340B hospitals suggesting this is not the case. Multiple factors appear to limit benefits to low-income patients. The BOT recommends aligning eligibility criteria to ensure low income patients benefit from the drug discounts by supporting revised 340B eligibility formula encompassing the amount of charity care provided by a hospital and includes independent physicians being eligible.

These resolves asked to support a permit to purchase semi-automatic firearms, improve mental health reporting and tracking. Current reports to NICS records are voluntary and do not include unlicensed dealers so not possible to always identify individuals who should be disqualified from purchasing firearms. A variety of barriers limit states from providing information to the NCIS. There is no federal law licensing firearm owners and states have varied laws ie permits to purchase, license to own, firearm safety certificates, registration laws. Data show PTP states have lower firearm related deaths, homicide and suicide. Report notes that policy from A-18 requires licensing of all firearms and although PTP is a type of license it is appropriate to specifically state this so they modified current policy H-145.996 to add permitting language to licensing. Also recommends new policy encouraging laws requiring reporting to NCIS, funding to improve reporting, automate some reporting.
Reimbursement for Services Rendered During Pendency of Physician's Credentialing Application
AMA has policy calling for retroactive compensation for services rendered while getting credentialled and VA passed bill allowing retroactive payment. Asks to develop model state legislation.

Support for the Development and Distribution of HIPAA-Compliant Communication Technologies
While there are many HIPAA-compliant communication tools for physicians, over 50% of residents admit to using non-HIPAA-compliant methods. Existing technologies fall short in functionality particularly in medical training settings where workflow requires mobile, real-time messaging amongst multiple individuals with different devices. RFS asking AMA promote development and use of more optimized HIPAA-compliant technologies.

Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
There are 80-100 K children who arrived in US legally with their parents when under age 21 but when they turn 21 they are now illegal and subject to deportation. Asks to support legalization of these adults and work to allow them to attend medical school and residency until achieving legal status.

Repealing Potential Penalties Associated with MIPS
AMA has policy to improve and reduce burden of MIPS but no policy specifically asking for repeal of penalties which can be up to 9%. Asks to advocate for repeal of penalties.

Defense of Affirmative Action
Affirmative action can help ameliorate racial disparities in undergraduate education, increase minorities in medical practice in underserved areas thus improving care among this population. States that oppose affirmative action have fewer minority students in college and matriculating medical school. AMA has policy supporting undergrad education to boost medical student numbers but does not address affirmative action at the undergraduate level. Asks for new policy to oppose legislation that undermines using affirmative action. Recommend support but think this is a reaffirmation of D-200.985 #1, 8, 9 and H-350.979.

Increasing Access to Broadband Internet to Reduce Health Disparities
Residents living in rural areas tend to have less access to broadband and have less access to health care and higher likelihood of dying from leading causes of death compared w/urban residents. AMA has policy supporting telemedicine which requires broadband access. Asks AMA to advocate for expansion of broadband to all rural areas to help improve health, ease of telemedicine.

Sexual Assault Education and Prevention in Public Schools
AMA has policy re sexual assault in college but not in earlier education. 2 states require teaching about consent in high school. Supports state legislation that middle and high school curricula include information on sexual assault.

Forced Organ Harvesting for Transplantation
China is the world’s 2nd largest performer of transplants and there are concerns about several unethical practices. Multiple governmental and non-governmental organizations have positions calling for an end to these practices. Resolution asks:
1. new policy to reaffirm E-6.1.1. do we need to have policy on an existing ethical opinion
2. AMA representatives to WMA to request investigation into Chinese organ transplantation practices with a report back
3. US government to protect transplant tourists via legislation to blacklist countries that do not follow ethics and transparency as in the US

Development and Implementation of Guidelines for Responsible Media Coverage of Mass Shootings
Mass shootings increase the risk of another mass shooting ie contagion effect. In 1990s WHO and CDC developed media reporting guidelines in response to contagion effect for suicides which may lead to decrease suicide. Asks that similar guidelines be developed when covering mass shootings.

Increasing Firearm Safety to Prevent Accidental Child Deaths
There exists a variety of firearm safety features and GAO estimates 31% of accidental firearm deaths may be prevented. CAP laws in 27 states and DC encourage owners to be more conscious about storage of firearms. Most states w/CAP laws showed greater decline in unintentional deaths c/w states w/o these laws and self-inflicted firearm injuries also decreased. Asks to support CAP laws in all states or at federal level.

217 **Opposition to Medicare Part B to Part D Changes**
Current administration supports moving Part B drugs to Part D if this would achieve savings. Not enough data from several studies shows this would provide savings. Rather costs would likely increase for patients if as PBMs get involved, Part D is subject to copays, co-insurance or plans don’t cover Part D at all. Many practices rely on providing Part B drugs to treat patients and moving these to Part D jeopardize that care. Asks to oppose moving some drugs from Part B to Part D.

218 **Alternatives to Tort for Medical Liability**
Whereas’ summarize standard arguments against current system. Asks to review alternatives to current system to meet goals of fair compensation while holding dangerous professionals accountable and improve patient safety and develop new policy to replace current tort system.

223 **Permanent Reauthorization of the State Children’s Health Insurance Program**
SCHIP is funded by state and federal gov’t and provides health insurance to almost 9 million children and pregnant women improving access to care. Federal funding ran out in 2017 risking coverage and prompting medical and fiscal challenges for families. Funding was restored in 2018 for 6 years however a permanent extension would provide stability, prevent SCHIP from being used as a political football and save billions of $. Asks to amend current policy H-290-971 by adding “permanent” to wording.

224 **Fairness in the Centers for Medicare & Medicaid Services Authorized Quality Improvement Organization’s (QIO) Medical Care Review Process**
QIOs investigate complaints about medical care which are usually, but not always, done by peer-matched reviewers. Patients can request reconsideration if the initial review finds no problem. If an issue is then identified it is considered final with no recourse to the physician. The CMS manual states that this should trigger a new review but QIOs do not interpret in this way. Asks that AMA advocate for mandating opportunity for physicians to request additional review when there is a conflict b/w 2 reviewers and that QIOs reveal when reviews are not completed by a peer and to track reviews not done by peers.

225 **“Surprise” Out of Network Bills**
Legislation is being considered federally around rules for OON bills, requiring ins cos to pay for these at a percent of in-network payments. Several states have passed similar legislation. Policy H-285.904 supports network adequacy and methods for determining fair payment but doesn’t ask to advocate for legislation supporting these principles. Current proposed legislation does not address network adequacy. Asks AMA to advocate for legislation that is consistent w/policy H-285.904, applies to ERISA plans and protects state laws that do not limit payment of OON bills to a percent of Medicare or health ins fee schedule. **Recommend we support but suspect this will be reaffirmed as H-285.904 item 2 states that AMA will advocate for the principles in the policy.**

226 **Support for Interoperability of Clinical Data**
Physicians are using EHRs but have difficulty accessing information outside their own system even though this information can decrease admissions, duplicate testing and healthcare costs. Asks to review and implement appropriate recommendations from the physician-directed consensus statement on Direct Interoperability published in March which contains a list of 57 clinically desirable features and functions.

227 **CMS Proposal to Consolidate Evaluation and Management Services**
Proposed CY2019 rules plan to collapse E and M codes, cutting payment for more complex outpatient visits. Proposed add-on codes to pay for more complex care are not certain to be accepted and are unlikely to make up for the cut in payment, risking care provision for these patients. The final rule is expected in Nov and will take effect in Jan 2019. Asks for Congressional action to block implementation of consolidation of E and M codes if this moves forward.
Nonprofit Hospitals and Network Health Systems
Insurances, hospitals and health systems collaborate to limit physician networks. Consolidation raises costs, limits choice and access. Hospitals have prevented private practice physicians from obtaining privileges in nonprofit institutions which violates IRS rules. Hospitalized patients who ask to see their own physicians are redirected to network physicians and the private physician is often not notified of the patient request. This disrupts the physician’s ability to care for patients and severs the physician/patient relationship. Asks that IRS and other appropriate groups investigate if nonprofits are meeting IRS regulations relating to their tax-exempt status when restricting physicians on staff and to ensure these entities meet charitable purposes.

Reducing the Regulatory Burden in Health Care
In Jan MedPAC voted to repeal MIPS believing it cannot succeed, is burdensome, is not meaningful and will not improve value. Asks AMA to support repeal of MIPS and then oppose efforts to implement pay-for-performance programs unless the program does not increase the burdens to medical practice and have evidence to show they improve care quality. AMA has several policies on MIPS but none asking for outright repeal.

Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries
Many specialty societies have developed QCDRs to help track quality measures. CMS has proposed that to use the QCDRs to meet MIPS, they must license the registries to CMS so others can use them without a fee, violating copyrights. This reverses a CMS policy that protected the rights of registry developers. Asks to actively oppose this CMS proposal.

RESOLUTIONS FOR DISCUSSION

BOT Report 05

Exclusive State Control of Methadone Clinics (Res 211-1-17).
IN asked AMA to support complete state control of methadone clinics. Federal and state organizations have a role in regulating opioid treatment programs. SAMHSA has overall authority and other federal regulations require treatment programs be headed by a physician licensed in the jurisdiction where the program is located. States license physicians. AMA policy supports MMT and OTPs, including reducing barriers to treatment.
BOT recommends several new policies: 1. Support OTPs in any needed area 2. Encourage states to work with various groups to disseminate locations of OTPs and 3. Advocate that federal agencies consider the views of state and local stakeholders when deciding about OTP locations and policies.

Discussion: The recommendations don’t accomplish what IN asked for ie complete state control. However, given the long-standing federal jurisdiction, I do not think this ask is achievable at this time. The BOT recommendations attempt to embody the ask and increase the involvement of states where the feds currently have control, so I recommend approval.

Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings (Revised 10/31/18)
Medications can help treat OUD and prevent deaths. Brief experience in US shows successful primary care provision of methadone. AMA supports OTPs being treated no differently than other medical clinics. In revised resolution the whereas’ didn’t change. The 1st resolved was amended (Line 27) from “identify and work to remove” to “study the implications of removing” barriers to PCPs and “prescribing” to “dispensing” (Line 29) methadone as part of MAT. The 2nd resolved changed from (Line 32) “working with other federation” to “study the implications to working…” and “to provide” to “dispense” (Line 34) methadone.

Discussion: 1. change “Federation” to “federal” in line 32 or clarify which “Federation” 2. Agree with asking to study the issue but unclear why they changed prescribing to dispensing when the whereas’ discuss prescription of medication.

Restriction on IMG Moonlighting
US law prohibits moonlighting and billing for services by those with a J-1 visa. There is a projected shortage of primary care physicians and IMGs are more likely to choose primary care. Asking for legislation allowing J-1 visa holders in fellowship programs to moonlight.
**Discussion:** I think we can be supportive of moonlighting for J-1 fellows but the whereas’ don’t support the conclusion. Most PCPs don’t complete a fellowship and most moonlighting opportunities aren’t providing longitudinal primary care, so allowing moonlighting of fellows wouldn’t accomplish the stated goals.

### 211 Eliminating Barriers to Automated External Defibrillator Use
AEDs are used infrequently for several reasons including limiting labels, lack of knowledge about location of devices, variation in Good Samaritan laws. Asks:
1. update HOD policy to promote use and awareness of AED locations use mobile technology
2. remove AED labeling that only trained professionals can use them.
3. AMA support uniform legislation protecting untrained personnel using AEDs

**Discussion:** Recommend amending Resolve 2 line 23 to “…urge AED vendors and Federal Drug Administration to remove” as AEDs are considered restricted prescription devices by the FDA so would need them to change labeling ([http://www.early-defib.org/03_06_02.html](http://www.early-defib.org/03_06_02.html)).

### 214 A Public Health Case for Firearm Regulation
2nd Amendment specifies having a “well-regulated militia” and recent study showed that regulations ie stronger background checks and permit to purchase, decrease firearm homicide. Firearms are hazardous to public health. Asks to support a public health approach to evidence-based firearm laws and regulations that do not conflict with 2nd amendment and oppose barriers to firearm safety.

**Discussion:** Recommend support but it is a firearms issue and mentions the 2nd amendment.

### 215 Extending the Medical Home to Meet Families Wherever They Go
Current licensing limits ability to care for patients when outside the state and telehealth companies are usurping the role of the PCP w/inferior care given that PCPs knows the patient best. Asking AMA develop model legislation allowing PCPs in Medical Homes/NCQA certified practices to provide telehealth services when patients travel.

**Discussion:** What is the scope of problem for PCPs providing care when patients are in other states? Why limit to PCPs in Medical Homes/NCQA certified practices?

### 216 Medicare Part B Competitive Acquisition Program (CAP)
Voluntary program in 2006 allowing MDs to purchase drugs from vendors using a bidding process to lower costs which was suspended d/t lack of interest and savings. CMMI has issued call for feedback to bring this back. Asks to advocate that changes to CAP meet criteria to improve value, decrease cost of drugs while maintaining quality care.

**Discussion:** Recommend support but not clear if this is meant to replace or augment Policy H-330.886?

### 219 Promotion and Education of Breastfeeding
Science shows benefits of breastfeeding but US reps discouraged resolution to advocate a preference for breastfeeding. Asks for policies to encourage gov’t to support benefits of breastfeeding, representatives act in unbiased manner to show compromise and develop more affordable/equitable breast milk substitute and for AMA and state societies to support legislation for workplace accommodations for breastfeeding.

**Discussion:** 1. 2nd resolve seems to be reaffirmation of H-245.982 #3(d) 2. challenging for medical professionals to ask gov’t representatives to act “in an unbiased manner” when the data on breastfeeding could be argued to be clearly beneficial and thus the position should be biased in favor of supporting.

### 220 Supporting Mental Health Training Programs for Corrections Officers and Crisis Intervention Teams for Law Enforcement
Many patients with mental illness are untreated and many are in prison affording COs a role in treatment. NAMI program teaching about mental illness has reduced use of force by COs in prisons but not being used in jails. An analogous program supported by our AMA, CIT, exists for police officers and has been very successful in improving public safety and diverting people with mental illness to treatment rather than incarceration but these are underutilized. Asking to support legislation and funding for training programs for COs who work with inmates with mental illness in federal prisons.

**Discussion:** 1. consider amending resolve asking training programs to be supported for COs/police officers working in jails as well as prisons given the suggestion that NAMI programs have not had uptake in jails 2. Amend line 24 from “mentally ill populations” to “populations with mental illness”.

Regulatory Relief from Burdensome CMS "HPI" EHR Requirements
CMS does not allow HPI information to be completed by ancillary staff. Physicians should be able to make a statement about the work they did for the HPI, sign the chart and have this be acceptable documentation. Asks for regulatory relief from HPI requirements that equate “keystroking” with validating that a face-to-face encounter took place and that a physician’s e-signature is adequate verification that the HPI was reviewed. Discussion: Confusing and poorly worded whereas clauses. Not clear what the ask is or the problem that needs to be corrected. Recommend listening to testimony to flesh this out. Goal of lessening documentation burdens is good but may be a moot point when 2019 CMS guidelines are published (see Res 227).

Patient Privacy Invasion by the Submission of Fully Identified Quality Measure Data to CMS
Some quality measures reported by EHRs for MU contain personal demographic and medical information, patients do not provide consent for this to be shared and this information may be accessed illegally. Asks to advocate for regulation/legislation that require quality data be shared only in deidentified form. Discussion: Suspect that consent for the data being shared w/CMS from the EHRs is provided somewhere in fine print that a patient signs at some point in accepting Medicare or being seen in the office but if this is a gap I recommend we agree w/closing it.

Medication Assisted Treatment
Opioid deaths continue to increase and only 10% of people addicted are treated due to well-known barriers to physicians prescribing buprenorphine. Asks for AMA to advocate that MAT be covered by all payers. Discussion: The whereas statements do not mention lack of coverage for MAT as an explanation for why it is not being used. When considering the Resolved standing on it’s own, however, I recommend support but suspect this is reaffirmation of D-95.968 which asks for “legislation that eliminates barriers to, increases funding for, and requires access” for MAT.

Addressing Surgery Performed by Optometrists
AMA has specific definition of surgery but conflicting policies on who should perform surgery ie “licensed physicians” or “practitioners currently licensed by the state”. OK, KY and LA allow optometrists to perform surgery after fulfilling license requirement with 1 or 2 16 hour courses which lack practical experience. Outcomes data suggests higher rate of repeat surgeries for procedures done by optometrists compared with ophthalmologists. Asks the AMA to support and to encourage state societies and legislatures to support legislation prohibiting optometrists from performing surgery as defined in 2 existing HOD policies. Discussion: Rec we agree with preventing optometrists from doing surgery. Seems the asks could be simplified if the 2 definitions of who should perform surgery and the 3 policies could be reconciled so laser surgery is considered “surgery” and surgery should be done by “licensed physicians”.