

**REFERENCE COMMITTEE B (Legislation)**  
**SUMMARY REPORT FOR THE NEW ENGLAND DELEGATION**  
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<i>CONSENT CALENDAR FOR APPROVAL</i>
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- BOT 01      Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)**  
Extends existing AMA policy protecting DACA young adults to H4 children of legal H1B Visa holders over 21 in training/awaiting personal H1B status
- BOT 02      Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings**  
This report meets the original resolutions request to study the implications of removing barriers to provision of methadone maintenance treatment (MMT) in a primary care setting. It does not advance the ball very far, but that appears to be due to the paucity of hard data. It supports further research, provision of primary care services to those receiving MMT either at the source of methadone or in a primary care setting, and directs the Opioid Task Force to increase its educational resources on MMT.
- BOT 03      Restriction on IMG Moonlighting**  
Essentially, the report states that allowing J1 visa holders to moonlight would require definitional changes in the program that might place it at risk (particularly in the current immigration climate). No action items.
- BOT 09      Opioid Mitigation**  
This report is in response to two resolutions asking to nationally replicate specific local programs, with records of success. The report notes that, while lessons can be taken from these programs, local successes may not scale nationally, and that an effective response will need to be tailored to local factors. Some of the requested policies are variations on already existing policy. The report recommends that the AMA encourage relevant Federal agencies to evaluate and report on outcomes and best practices for innovative local strategies, that AMA update model legislation for needle exchanges, extends existing policy on “drug courts” to encourage reliance on evidence based models for those who deemed to benefit from intervention over incarceration, and urges enforcement of mental health and addiction parity laws.
- 201      Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities (MSS)**  
Asks the AMA to advocate for expansion of regulation of outpatient addiction rehab centers for patient protection. I personally favor the intent, particularly to reduce fraud and enhance patient safety, but it does ask the AMA to support more regulation. H35.983, H280.984, D480.968, H440.909, D110.987 are some recent policies where the AMA has advocated for regulation of health or health-related services for patient benefit. Minimal cost
- 203      Support Expansion of Good Samaritan Laws (MSS)**  
Asks to amend existing policy to include working with relevant groups to raise awareness of GSLs. Minimal cost
- 207      Pharmaceutical Advertising in Electronic Health Record Systems (MSS)**  
Directs the AMA to encourage the CMS to study the effects of DTP advertising at the point of care including in EMRs and directs the AMA to study the ethics of same. Fiscal note TBD
- 212      Centers for Medicare and Medicaid Services Open Payments Program (MI)**  
Modifies current policy on the Sunshine Act and CMS’ Open Payment website to seek inclusion by CMS of pharmacists and PBM’s, as, increasingly, these groups can exert significance on coverage and cost to consumers, and payments and other arrangements involving them are not publicly visible at this time. Also asks to continue AMA efforts to educate about the Open Payments Program site and the Sunshine Act. Modest cost
- 217      Promoting Salary Transparency Among Veterans Health Administration Employed Physicians (WPS)**  
Directs AMA to encourage physician salary transparency within the VA Health Administration. Modest cost.

<b>RESOLUTIONS FOR DISCUSSION</b>
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**202 Support for Veterans Courts (MSS)**

Asks the AMA to support the use of Veterans Courts for veterans who commit crimes that may be related to a neurologic or psychiatric disorder, parallel to drug courts for SUDs. TX wants to amend to “nonviolent criminal offenses. Minimal cost

**204 AMA Position on Payment Provisions in Health Insurance Policies (NY)**

Seeks to ban “anti-assignment provisions” from payer contracts and to legislate a requirement to honor patient assignment to their physician. I feel the first resolved has wording issues, and the second achieves the goal even without the first. [support legislation that requires payers to allow and honor agreements, freely reached between patients and physicians, to assign payment to the physician.] Modest cost

**205 Co-Pay Accumulators (multiple states/specialties)**

Asks for the AMA to develop model legislation incorporating third party supports provided to an enrollee (patient) during their deductible period as the same as payments by the enrollee, and count them towards the deductible. The resolved asks for a model based on a specific law passed in Virginia. The CT delegation has alternative, broader language that achieves the same goal and will be proposed as an amendment. Modest cost

**208 Net Neutrality and Public Health (MSS)**

**211 Effects of Net Neutrality on Public Health (MI)**

Res 208 directs the AMA to advocate for policy that ensures ISPs transmit healthcare data no more slowly than any other data, that our AMA collaborate with governing bodies to develop guidelines for data deserving such preservation of speed, and oppose practices that reduce market competition in the health ecosystem.

Res 211 more succinctly modifies current AMA policy to advocate for net neutrality and for [current policy] expansion of broadband service to rural and underserved areas.

I suspect these will be melded into one overarching resolution. Preservation of net neutrality is the simplest, most complete solution, but the MSS resolution may fit better into the current political milieu, and provides at least the minimum of not hampering essential medical data interchange.

**209 Federal Government Regulation and Promoting Patient Access to Kidney Transplantation (Am. Society Transplant Surgeons)**

Directs the AMA to engage US regulatory and professional organ transplant organizations to advance patient and physician-directed care for ESRD patients; to actively promote regulatory efforts to assure physician and patient involvement in the design on any ESRD federal demonstration program; and to advocate for legislative and regulatory efforts which create incentives for dialysis providers, transplant centers, organ donors and ESRD patients to increase organ donation and improve access to kidney transplantation in the US. [Evidently, the groups noted in the last request have been given significant control over kidney transplantation, and there is concern that conflicts of interest are decreasing access.] This a complex and fraught issue. Perhaps just observe. Modest cost

**210 Federal Government Regulation and Promoting Renal Transplantation (Am. Society Transplant Surgeons)**

Directs the AMA to advocate for legislative and regulatory policies that modify or eliminate “arbitrary” outcomes measures that are seen by ASTS to discourage transplantation and patient enrollment. Looking through their cited sources, I see there is evidence that can be interpreted to suggest that these outcomes measures are influencing some centers to avoid less ideal kidneys and higher risk recipients. Not sure lowering or removing quality and outcomes assessment is a fair tradeoff. This issue is fraught. I suggest watching and seeing what the experts hash out. Modest cost

**206 Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians (IMG/MAS)**

Directs the AMA to support efforts to retain and incentivize IMGs serving in Fed shortage areas to stay after the allocated period. Similar in intent to our NED resolution on retraining IMGs. Given the discussion on that resolution, it seemed appropriate to discuss this one as well Minimal cost

**213 Data Completeness and the House of Medicine (CO)**

Modifies current policy of working with states to support APCD to include the federal gov't; Directs AMA to work with interested organizations to speed the final rule regarding Schedule J by USDOL in matters related to the SCOTUS decision on *Gobeille v Liberty Mutual Insurance Company*; directs AMA to support standardized claims data submission, tying claims data submission to Schedule J processes, and support the DOL implementing a pilot project to collect APCD data in cooperation with state APCDs. The whereas's make a pretty good case for the resolutions. TX supports but wants to amend it to state that a standardized set of claims data must consider the weights of low-paying government payers such as Medicaid and Medicare that may reduce payment benchmarks. This seems not entirely germane, to my mind, and is more a function of analyzing and reporting out the data than of collecting it in a standard set.

**214 AMA Should Provide a Summary of its Advocacy Efforts on Surprise Medical Bills (NY)**

Directs the BOT to provide a detailed report on its efforts and those of allies and opponents on surprise medical bills and lists 16 specific points that should be addressed. Not sure this is the best way to get a report out of the BOT, unless they've been stonewalling. The wording seems too prescriptive but also pretty sure this wouldn't take a lot of time for the AMA staff. The thrust of this, though, publicizing the AMA's position and ensuring there is a firm stand against a watered down and weak benchmark approach dominated by the insurers is important. Perhaps a modified version would be in order. Modest cost

**215 Board Certification of Physician Assistants (multiple states/specialties)**

Modifies current policy to oppose attempts to create "board certification" for PA's and other paraprofessionals in a manner that would mislead the public to infer equivalence to medical specialty certification in two different existing policies. TX proposes deleting the word "independent" which appears in both modifications. This makes sense based on their reasoning. Minimal cost

**216 Legislation to Facilitate Corrections-to-Community Healthcare Continuity via Medicaid (Am. Association of Public Health Physicians)**

Modifies existing policy to add the Congress to a list of groups to lobby to encourage state Medicaid agencies to provide Medicaid coverage care coordination and linkages to patients up to 30 days before anticipated release from correctional facilities. TX wants to take this opportunity to rewrite the original policy to change "provide" to "allow", making the entire policy optional, and, essentially ineffective, since it is currently optional. Minimal cost.

**218 Private Payers and Office Visit Policies (ACR, AAN, AACE, ES, NANOS)**

Directs the AMA to advocate with commercial payers that are considering or enacting elimination of consult codes to hold off until final CMS updates are produced and directs the AMA to advocate for private payers to mirror the CMS guidelines if they result in increased E&M valuations. Not sure how AMA would do this nor how effective it would be. Also, given zero-sum nature of these revisions, this may be divisive. Hard to disagree with holding off on killing the consult codes, though. Modest cost.

**219 QPP and the Immediate Availability of Results in CEHRTs (Am Soc Clin Onc)**

Directs the AMA to urge CMS to create guardrails around the "immediate" availability requirement for lab, path and radiology results to allow for the physician to put the results in context for the patient. A second resolved directs the AMA to encourage EMR vendors to implement prompts to allow the physician to post results to the record or to approve and post to both record and patient portal. On the one hand, giving time to allow the physician to provide context to the patient makes good sense for care. On the other, introducing delay hampers data exchange and may affect care coordination adversely. Is there a middle ground? Modest cost