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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-14)

Report of Reference Committee G

Craig A. Backs, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 12 - Mental Health Services for School-Aged Children
2. Board of Trustees Report 16 - Pediatric Medical Orders Between States
3. Board of Trustees Report 18 - Data Transition Costs When Switching Electronic Medical Records
4. Board of Trustees Report 20 - Utilization of EHR and the Practice of "Cutting and Pasting" or Cloning
5. Board of Trustees Report 28 - Qualifications, Selection, and Role of Hospital Medical Directors and Others Providing Medical Management Services
6. Council on Medical Service Report 5 - Health Insurer Code of Conduct Principles
7. Resolution 734 – Public Reporting of Quality and Outcomes for Physician-Led Team-Based Care
8. Resolution 737 – Amendments to the AMA Principles for Physician Employment

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

9. Council on Medical Service Report 6 - Development of Models / Guidelines for Medical Health Care Teams
10. Council on Medical Service Report 8 - Clinical Data Registries
11. Resolution 701 - Medical Staff and Hospital Engagement of Community Physicians
12. Resolution 702 - Putting Price Transparency Into Practice
13. Resolution 704 - Studying Hospital-Enforced Admissions, Testing and Procedure Quotas
14. Resolution 705 - Preventive Screening and Treatment of Malnutrition in Hospital Patients
15. Resolution 707 - Grace Period
    In lieu of
    Resolution 732 - Federal Advocacy for Protection of State Law Under the 90-Day Grace Period
16. Resolution 708 - Protecting Physicians Who Are Participating in Physician Health Programs from Arbitrary Delisting by Insurance Carriers
17. Resolution 709 - Change of Coumadin Regulation by CMS

18. Resolution 712 - Verbal Admission Order Signatures
19. Resolution 718 - Improving the Handling of In-Flight Medical Emergencies

20. Substitute Resolution 719 – CMS Face-to-Face Visit Documentation
in lieu of
Resolution 730 - Payment for Centers for Medicare & Medicaid Services Mandated Services
21. Resolution 721 - Capturing Physician Sentiments of Hospital Quality
22. Resolution 723 - Integrating Physical and Behavioral Healthcare
23. Substitute Resolution 724 - Private Health Insurance Formulary Transparency
in lieu of
Resolution 716 - Pharmacy-Physician Communications Regarding Drug Formularies
24. Resolution 725 - AMA to Endorse the "Choosing Wisely" Program
25. Resolution 727 - Point of Care Availability for Blood Glucose Testing
26. Resolution 735 – The Future of Private Practice
27. Resolution 736 – Studying Physician Access to ACO Participation
28. Resolution 738 – Physician Leadership of the Patient-Centered Medical Home

RECOMMENDED FOR REFERRAL

29. Resolution 703 - Improving Home Health Care
30. Resolution 717 - Increasing Physician Efficiency

RECOMMENDED FOR NOT ADOPTION

31. Resolution 706 - High Rates of Cesarean Deliveries
32. Resolution 713 - Diagnosis Code for Excessive Reliance on Alternative Therapy

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

33. Resolution 710 - Reimbursement of Audit Requests
34. Resolution 711 - Reimbursement for Prior Approval Requirements
35. Resolution 714 - Harmonizing Quality Metric Efforts with Electronic Medical Records
36. Resolution 715 - Over-Regulation of Provider-Performed Microscopy Procedures for Ambulatory Health Care

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

- Resolution 720 – Compensation for Prior Authorization Efforts
- Resolution 722 – EHR in Post-Acute and Long-Term Care Settings
- Resolution 726 - Internet Review of Physicians
- Resolution 728 - Development of a Transparent and Fair Payment Process for ERISA Plans
- Resolution 729 – Exemption Criteria for Electronic Health Record Adoption and Cloud-Based Electronic Health Record Packages
- Resolution 731 – Requirement for Medical Insurance Companies to Provide Online Real-Time Insurance Claim Adjustment

(1) BOARD OF TRUSTEES REPORT 12 - MENTAL HEALTH SERVICES FOR SCHOOL-AGED CHILDREN

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 12 be adopted and that the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 12 adopted and the remainder of the report filed.

Board of Trustees Report 12 recommends that our AMA recognize the importance of developing and implementing school-based mental health programs that ensure at-risk children access to appropriate mental health services and support efforts to accomplish these objectives.

Board of Trustees Report 12 received uniformly supportive testimony. Your Reference Committee commends the Board of Trustees on this thorough report on mental-health disorders in school-aged children. Your Reference Committee agrees that the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry are best positioned to lead efforts to ensure that children have appropriate access to programs and resources designed to help treat mental-health disorders. As a result, your Reference Committee recommends that this report be adopted.

(2) BOARD OF TRUSTEES REPORT 16 - PEDIATRIC MEDICAL ORDERS BETWEEN STATES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 16 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 16 adopted and the remainder of the report filed.

Board of Trustees Report 16 recommends that our AMA support legislation or regulation that allows licensed and registered physicians to execute conventional medical orders for their patients who are moving out of state for a transitional period of no more than sixty days and work with interested states and specialties on legislation or regulations to allow temporary honoring of medical orders by an out-of-state physician.

Your Reference Committee, in agreement with substantial testimony, believes that Board of Trustees Report 16 provides a comprehensive overview of the issues and appropriate recommendations concerning the execution of medical orders and the transition of care for children relocating to another state. Although online testimony suggested that the report be expanded to include all patients rather than just children, your Reference Committee believes that the recommendation of the report should be

consistent with its childcare-focused content and therefore recommends that the report be adopted as written.

(3) BOARD OF TRUSTEES REPORT 18 - DATA TRANSITION COSTS WHEN SWITCHING ELECTRONIC MEDICAL RECORDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 18 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 18 adopted and the remainder of the report filed.

Board of Trustees Report 18 recommends that our AMA 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 and collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

There was supportive testimony on this report. Your Reference Committee thanks the Board for a thorough and thoughtful report, and recommends that Board of Trustees Report 18 be adopted.

(4) BOARD OF TRUSTEES REPORT 20 - UTILIZATION OF EHR AND THE PRACTICE OF "CUTTING AND PASTING" OR CLONING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendations in Board of Trustees Report 20 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 20 adopted and the remainder of the report filed.

Board of Trustees Report 20 recommends that Policy D-175.985, The CMS Electronic Medical Records Initiative Should Not Be Used to Detect Alleged Fraud by Physicians, be reaffirmed, and that our AMA engage the electronic health record (EHR) vendor community to promote improvements in EHR usability.

There was mixed testimony on this report. Many speakers expressed concern about the potential limitations of using the copy and paste function in EHRs, and presented anecdotal evidence that its use can lead to problems with patient care. Other speakers noted that copy and paste functions can be useful, and that physicians should always review their notes to ensure their quality and relevance. Your Reference Committee agrees with testimony that copy and paste functions are not problematic, per se, and

that our AMA should continue to emphasize improvements in the overall usability of EHRs. Your Reference Committee also agrees that our AMA needs to remain vigilant to ensure that payers do not automatically penalize physicians for using copy and paste or similar documentation shortcuts. The recommendations in the Board report address both of these important issues; accordingly, your Reference Committee recommends that Board of Trustees Report 20 be adopted.

(5) BOARD OF TRUSTEES REPORT 28 - QUALIFICATIONS, SELECTION, AND ROLE OF HOSPITAL MEDICAL DIRECTORS AND OTHERS PROVIDING MEDICAL MANAGEMENT SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the recommendation in Board of Trustees Report 28 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 28 adopted and the remainder of the report filed.

Board of Trustees Report 28 recommends extensive amendments to Policy H-235.981, "The Role of the Hospital Medical Director."

There was limited testimony on this report. Your Reference Committee appreciates the work of the Board in updating AMA policy to ensure its applicability to all individuals providing medical management services, and to acknowledge the overall responsibility of the medical staff for the overall quality of care provided in the hospital. Your Reference Committee recommends that the recommendations in Board of Trustees Report 28 be adopted.

(6) COUNCIL ON MEDICAL SERVICE REPORT 5 - HEALTH INSURER CODE OF CONDUCT PRINCIPLES

RECOMMENDATION:

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

HOD ACTION: Recommendation in Council on Medical Service Report 5 adopted and the remainder of the report filed.

Council on Medical Service Report 5 recommends that our AMA continue to develop resources to help physician practices address ongoing and emerging issues associated with expanding health insurance coverage under the Affordable Care Act.

There was limited testimony on this report. A member of the Council on Medical Service testified that the recommendation to support the development of new resources to help

physicians respond to emerging issues related to the Affordable Care Act, rather than update the Code of Conduct, reflects the fact that the majority of the principles in the Code were addressed by the Affordable Care Act, and are supported by over 200 AMA policies, which can guide ongoing AMA advocacy on these issues. The Council member noted that the Code had never been adopted or endorsed by any insurance company, as was the original intent, and our AMA's current approach to addressing insurance-company related challenges through the development of physician-focused resources is a more effective strategy for addressing these concerns. A question was raised about what specific resources are available to assist physicians, and your Reference Committee notes that examples of resources are highlighted on page 3 of the Council's report. Your Reference Committee also notes that the Professional Satisfaction and Practice Sustainability group is actively engaged in efforts to develop resources to help physicians navigate payment and delivery reforms. A list of existing resources from the AMA Innovator's Committee and other sources is available online at http://www.ama-assn.org/ama/pub/about-ama/strategic-focus/shaping-delivery-and-payment-models/payment-model-resources.page The Council report also notes that although the ACA did not address AMA concerns with respect to physician profiling, which were included in the original Code of Conduct, AMA advocacy efforts to address these issues are ongoing, especially in the context of advocacy related to criteria for network inclusion or tiering placement. Your Reference Committee agrees with the Council's assessment that our AMA should continue to pursue activities that help physician practices understand and manage challenges associated with expanding health insurance coverage, and recommends that Council on Medical Service Report 5 be adopted.

(7) RESOLUTION 734 - PUBLIC REPORTING OF QUALITY AND OUTCOMES FOR PHYSICIAN-LED TEAM-BASED CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 734 be adopted.

HOD ACTION: Resolution 734 adopted.

Resolution 734 asks that our AMA advocate that internal reporting of quality and outcomes of team-based care should be done at both the team and individual physician level, and that public reporting of such data should be done only at the group/system/facility level. Resolution 734 also asks that our AMA reaffirm the intent of the codified mandate in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that public reporting of quality and outcomes data for team-based care should be done at the group/system level, not at the individual physician level, and advocate that the current regulatory framework for public reporting for Meaningful Use (MU) also provide "group-level reporting" for medical groups/organized systems of care as an option in lieu of requiring MU reporting only on an individual physician basis.

There was supportive testimony on this resolution. A suggestion was made to add a recommendation stating that public reporting related to physician-led teams should adhere to our AMA Pay-for-Performance Principles and Guidelines. Your Reference Committee felt that such a statement would be beyond the scope and intent of the

resolution, which was to ensure that group level data, rather than individual data, is used for public reporting of quality and outcomes data for physician-led teams. Your Reference Committee agrees that reporting of group level data can help improve the reliability and statistical significance of the data, and recommends that Resolution 734 be adopted.

(8) RESOLUTION 737 - AMENDMENTS TO THE AMA PRINCIPLES FOR PHYSICIAN EMPLOYMENT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 737 be adopted.

HOD ACTION: Resolution 737 adopted.

Resolution 737 asks the AMA to amend Section (5)(f) of AMA Policy 225.950 to better protect physician interests following termination of an employment agreement.

Your Reference Committee heard supportive testimony for Resolution 737, which was the result of a detailed report of the Organized Medical Staff Section in consultation with AMA experts. The report properly protects physician interests during a potential termination of an employment agreement by amending our existing policy. The Reference Committee agrees that the AMA Principles for Physician Employment should be routinely updated in order to best establish the AMA position on employed physicians and finds this update to be strong. For these reasons, your Reference Committee recommends that Resolution 737 be adopted.

(9) COUNCIL ON MEDICAL SERVICE REPORT 6 - DEVELOPMENT OF MODELS / GUIDELINES FOR MEDICAL HEALTH CARE TEAMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 of Council on Medical Service Report 6 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) define "physician-led" in the context of team-based health care as the consistent use by a physician of the leadership knowledge, skills and expertise necessary to identify, engage and elicit from each team member the unique set of ~~contributions~~ training, experience, and qualifications needed to help patients achieve their care goals, and to supervise the application of these skills.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition of a new element on page 7 to read as follows (this will result in resequencing of the remaining identifiers a, b, c, etc.):

a. The patient is an integral member of the team.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition and deletion on page 7, lines 15-16, to read as follows:

a. ~~The physician team leader establishes a patient-physician relationship at the onset of care and explains each team member's role to the patient~~. A relationship is established between the patient and the team at the onset of care, and the role of each team member is explained to the patient.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition on page 7, line 17, to read as follows:

b. Patient and family-centered care is prioritized by the team and approved by the physician team leader.

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition and deletion on page 7, line 18, to read as follows:

c. Team members are expected to adhere to agreed upon ~~best~~ practice protocols.

RECOMMENDATION F:

Mr. Speaker, your Reference Committee recommends that the Patient-Centered elements of Recommendation 2 be amended by addition on page 7, line 21, to read as follows:

e. Patients' access to the team, or coverage as designated by the physician-led team, is available twenty-four hours a day, seven days a week.

RECOMMENDATION G:

Mr. Speaker, your Reference Committee recommends that the Teamwork elements of Recommendation 2 be amended by addition and deletion on page 7, line 27, to read as follows:

b. All practitioners commit ~~have a commitment~~ to working in a team-based care model.

RECOMMENDATION H:

Mr. Speaker, your Reference Committee recommends that the Teamwork elements of Recommendation 2 be amended by addition and deletion on page 7, lines 32-33, to read as follows:

g. Team members complete ~~agreed upon~~ tasks ~~autonomously,~~ according to ~~set~~ agreed upon protocols as directed by the physician leader.~~and report back to the physician team leader~~.

RECOMMENDATION I:

Mr. Speaker, your Reference Committee recommends that the Clinical Roles and Responsibilities elements of Recommendation 2 be amended by addition and deletion on page 7, lines 36-37 to read as follows:

a. Physician leaders are focused on individualized patient care~~, including the diagnosis of illnesses and complex cases~~ and the development of treatment plans.

RECOMMENDATION J:

Mr. Speaker, your Reference Committee recommends that the Clinical Roles and Responsibilities elements of Recommendation 2 be amended by addition and deletion on page 7, line 38, to read as follows:

b. Non-physician practitioners are focused on ~~routine, preventive and follow-up care~~ providing treatment within their scope of practice consistent with their education and training as outlined in the agreed upon treatment plan or as delegated under the supervision of the physician team leader.

RECOMMENDATION K:

Mr. Speaker, your Reference Committee recommends that the Practice Management elements of Recommendation 2 be amended by addition and deletion on page 7, lines 45-46, to read as follows:

b. Quality improvement processes are used and continuously evolve according to ~~improved interventions~~ physician-led team-based practice assessments.

RECOMMENDATION L:

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

HOD ACTION: Recommendations in Council on Medical Service Report 6 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 6 recommends a definition of "physician-led" in the context of team-based health care and support for specific elements that should be considered when planning a team-based care model.

There was generally supportive testimony on Council on Medical Service Report 6, with many speakers offering amendments to strengthen the report. Your Reference Committee's recommendations incorporate much of the language proposed during the hearing.

Some speakers raised concerns that the report's recommendations were too prescriptive. Your Reference Committee notes that the report outlines elements to consider when planning a team-based care model according to the needs of the specific physician practice. These elements are not mandatory.

Testimony suggested physicians be responsible for developing treatment plans and treatment recommendations. This is addressed in the Clinical Roles and Responsibilities section. In addition, this report focuses on the physician-led team and specifying around the clock access to only a physician diminishes the team-based focus.

There was a suggestion to include a recommendation that physician-led teams participate in incentive-based programs that comply with the AMA's Pay-for-Performance Principles and Guidelines. Your Reference Committee felt that this was not germane to the report, which outlines how to construct team-based models rather than why it is an optimal model.

Your Reference Committee recommends adoption of Council on Medical Service Report 6 as amended.

(10) COUNCIL ON MEDICAL SERVICE REPORT 8 - CLINICAL DATA REGISTRIES

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 8 be amended by addition on line 25 to read as follows:

1. That our American Medical Association (AMA) encourage multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Recommendation 5 in Council on Medical Service Report 8 be amended by addition and deletion on lines 5-7 to read as follows:

5. That our AMA will continue to advocate for and support initiatives that minimize the costs and maximize the benefits of ~~financial burden to~~ physician practice~~s~~ participation ~~of~~ ~~participating~~ in clinical data registries. (New HOD Policy)

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 8 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 8 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 8 makes recommendations to help maximize opportunities for clinical data registries to enhance the quality of care provided to patients.

There was supportive testimony on this report. Your Reference Committee agrees with testimony that cost is a major barrier to the development of clinical data registries, and

recommends amending Recommendation 1 to encourage multi-stakeholder efforts to develop and fund clinical data registries. Your Reference Committee also proposes amendments to Recommendation 5 that are intended to emphasize the importance of minimizing the cost to physicians of participating in clinical data registries, while also maximizing the benefits associated with data registry participation, including improved quality of care. Your Reference Committee commends the Council on a strong report and recommends the Council on Medical Service Report 8 be adopted as amended.

(11) RESOLUTION 701 - MEDICAL STAFF AND HOSPITAL ENGAGEMENT OF COMMUNITY PHYSICIANS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 701 be amended by deletion to read as follows:

RESOLVED, That our American Medical Association encourage medical staffs to develop medical staff membership categories for ~~primary care~~ physicians who provide a low volume or no volume of clinical services in the hospital ("community physicians") (New HOD Policy); and be it further

HOD ACTION: Adopted

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 701 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage medical staffs and hospitals to engage community physicians, as appropriate, in ~~medical staff and hospital~~ activities, which may include but need not be limited to: (a) ~~medical staff duties and leadership; (b) hospital governance; (c)~~ population health management initiatives; (~~d~~b) transitions of care initiatives; and (~~e~~c) educational and other professional and collegial events. (New HOD Policy)

HOD ACTION: Not Adopted

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 701 be adopted as amended.

HOD ACTION: Resolution 701 adopted as amended (per Recommendation A).

Resolution 701 asks that our AMA encourage medical staffs to develop medical staff membership categories for primary care physicians who provide a low volume or no volume of clinical services in the hospital ("community physicians"), and encourage medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities.

There was mixed testimony on this resolution. Although most speakers were supportive of the need to involve community physicians in hospital activities, several speakers disagreed with the idea that these physicians should have the opportunity to participate in leadership activities within the hospital. Your Reference Committee agrees with testimony suggesting amending the second resolve to eliminate references to governance activities, while retaining language that encourages community physician involvement in more patient-centered and professional development activities. Your Reference Committee also appreciated testimony suggesting that community physicians from all specialties, not just primary care, should be encouraged to participate in hospital activities. Your Reference Committee believes this resolution establishes important new policy for our AMA, and recommends that it be adopted as amended.

(12) RESOLUTION 702 - PUTTING PRICE TRANSPARENCY INTO PRACTICE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 702 be amended by addition to read as follows:

RESOLVED, That our American Medical Association study appropriate mechanisms through which patients and physicians will be able to obtain price data from providers, facilities, insurers and other health care entities prior to the provision of non-emergent services, and that our AMA study the barriers to this goal and serve as a leading voice in this discussion (Directive to Take Action); and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 702 be amended by deletion to read as follows:

RESOLVED, That our AMA support ~~medical education~~ efforts to enhance cost transparency as a part of undergraduate and graduate medical education, focused on the cost of the tests providers order, as well as the cost of medical equipment and facility fees (Directive to Take Action); and be it further

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 702 be adopted as amended.

HOD ACTION: Resolution 702 adopted as amended.

Resolution 702 asks that our AMA study appropriate mechanisms through which patients will be able to obtain price data prior to the provision of non-emergent services, and study barriers to this goal, in order to serve as a leading voice in this discussion. The resolution also asks that our AMA support medical education efforts to enhance cost transparency as a part of undergraduate and graduate medical education, and provide regular updates to its membership on the path toward enhancing the transparency of cost within the US health care system.

There was supportive testimony on this resolution. Your Reference Committee agrees with testimony that physicians as well as patients need access to this information, and recommends amending the first resolve to include physicians as well as patients. Your Reference Committee also agrees with testimony suggesting amending the second resolve to clarify the intent that our AMA should support broad efforts to enhance cost transparency as a part of medical education. Several speakers noted that the concept of price transparency is complex, and insurance companies, providers and patients are likely to define prices, cost and price transparency in different ways, which makes it difficult to access meaningful information about the cost of individual health care services. Although some speakers suggested that the resolution be referred because of the complexity of this issue, your Reference Committee notes that the resolution calls for a study, which will allow our AMA to develop a thorough report that examines all aspects of the price/cost transparency issue. Accordingly, your Reference Committee recommends that Resolution 702 be adopted as amended.

(13) RESOLUTION 704 - STUDYING HOSPITAL-ENFORCED ADMISSIONS, TESTING AND PROCEDURE QUOTAS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 704 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study the extent to which U.S. hospitals ~~inappropriately~~ interfere in physicians' independent exercise of medical judgment, including but not limited to the use of incentives for admissions, testing, and procedures. ~~quotas.~~

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 704 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 704 be changed to read:

STUDYING HOSPITAL INCENTIVES FOR ADMISSION, TESTING, AND PROCEDURES

HOD ACTION: Resolution 704 adopted as amended with change in title.

Resolution 704 asks that our AMA study the extent to which hospitals inappropriately interfere in physicians' independent exercise of medical judgment, including the use of admissions, testing and procedure quotas.

Testimony overwhelmingly favored adoption of Resolution 704. Your Reference Committee notes that the AMA supports protecting a physician's right to freely exercise independent medical judgment (Policy H-225.952) and believes that the proposed study may assist the AMA in protecting future attempts to infringe on this right.

Your Reference Committee believes that any interference with a physician's exercise of medical judgment to be inappropriate, therefore rendering the term redundant in this use. Additionally, studying quotas would not likely yield meaningful results, as it is improbable that hospitals would formalize a process that would effectively constitute Medicare fraud.

For these reasons, your Reference Committee recommends that Resolution 704 be adopted as amended with a change in title.

(14) RESOLUTION 705 - PREVENTIVE SCREENING AND TREATMENT OF MALNUTRITION IN HOSPITAL PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 705 be adopted.

HOD ACTION: Substitute Resolution 705 adopted.

PAYMENT FOR NUTRITION SUPPORT SERVICES

RESOLVED, That our American Medical Association recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports payment for the provision of their services.

Resolution 705 asks that our AMA support the standardization and accreditation of interdisciplinary nutrition support team services for provision of comprehensive nutritional screening, assessment, and management in hospitals; the establishment of

national registries for the sharing of information related to the performance of nutrition support teams and other preventive nutritional interventions; and the reimbursement of assessment and interventions provided by nutrition support teams where they are used to preclude or mitigate adverse health outcomes.

Resolution 705 received minimal testimony during the hearing. Your Reference Committee notes that the Joint Commission on Accreditation of Healthcare Organizations currently requires hospitals to establish criteria when in-depth nutritional assessment should be performed for patients and requires hospitals to have criteria for nutritional plans. Additionally, hospitals are required to conduct a nutritional screening within 24 hours of in-patient admission.

According to the American Society for Parenteral and Enteral Nutrition, a nutrition support team (NST) is a multi-disciplinary group of health care professionals with expertise in nutrition who aid in the provision of nutrition support. Your Reference Committee recognizes that NSTs provide the in-depth care required by the Joint Commission and that the use of NSTs is a beneficial method of providing nutritional care for hospital patients that should be paid accordingly. For these reasons, your Reference Committee recommends adoption of Substitute Resolution 705.

(15) RESOLUTION 707 - GRACE PERIOD
RESOLUTION 732 - FEDERAL ADVOCACY FOR PROTECTION OF STATE LAW UNDER THE 90-DAY GRACE PERIOD

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be <u>amended by deletion of the first resolve</u>:

~~RESOLVED, That our American Medical Association amend Policy H-185.938 such that health plans should notify providers immediately that an enrollee is in a grace period so that policy H-185.938 reads:~~

~~H-185.938 Health Insurance Exchange and 90-Day Grace Period~~
~~1. Our AMA opposes the preemption of state law by federal laws relating to the federal grace period for subsidized health benefit exchange enrollees. 2. Our AMA will advocate that health plans be required to notify physicians immediately that a patient is in the federal grace period for subsidized health benefit exchange enrollees upon an eligibility verification check by the physician. The notification must specify which month of the grace period a patient is in. Failure to notify physicians of patient grace period status would result in a binding eligibility determination upon the insurer. (Modify current HOD policy); and be it further~~

HOD ACTION: Adopted

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be amended by substitution of the second resolve to read as follows:

RESOLVED, That our AMA amend Policy H-185.938 such that health plans should pay providers for all covered services rendered during a grace period so that policy H-185.938 reads:

H-185.938 Health Insurance Exchange and 90-Day Grace Period
1. Our AMA opposes the preemption of state law by federal laws relating to the federal grace period for subsidized health benefit exchange enrollees, and will seek appropriate changes to federal law and regulations to protect state and prompt payment laws. 2. Our AMA will advocate that health plans be required to notify physicians that a patient is in the federal grace period for subsidized health benefit exchange enrollees upon an eligibility verification check by the physician. The notification must specify which month of the grace period a patient is in. Failure to notify physicians of patient grace period status would result in a binding eligibility determination upon the insurer. 3. Our AMA will continue to advocate that plans be required to pay providers for all ~~covered~~ claims for services rendered that would otherwise be covered under the contract during a grace period. (Modify current HOD policy); and be it further

HOD ACTION: Adopted as amended

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be amended by deletion of the third resolve:

~~RESOLVED, That our AMA take all possible means available to require health plans in state exchanges to notify providers immediately that an enrollee is in a grace period (Directive to take action); and be it further~~

HOD ACTION: Adopted

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be amended by addition of a new resolve to read as follows:

RESOLVED, That our AMA support the development of alternative financing solutions, such as reinsurance for unpaid premiums, for physician payments during the grace period. (Directive to Take Action)

HOD ACTION: Adopted

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Resolution 707 be adopted as amended in lieu of Resolution 732.

HOD ACTION: Resolution 707 adopted as amended in lieu of Resolution 732.

Resolution 707 asks that Policy H-185.938 be amended to advocate that insurers notify physicians immediately when an enrollee enters the grace period and that insurers be required to pay providers for all covered services provided during the grace period. Resolution 707 also asks our AMA to actively advocate for changes in the federal rule regarding pending claims during the grace period, and support state societies in their legal attempts to enforce prompt pay statutes during the grace period.

Resolution 732 asks that our AMA seek federal legislation and changes to regulations in order to prevent the preemption of state prompt pay laws by federal laws and rules related to the grace period for subsidized health benefit exchange enrollees; seek federal legislation and regulations to prevent health insurance company recoupment of payments made during the grace period when the insurer has not notified the physician the insured person is in the last two months of the grace period; and support the development of alternative financing solutions, such as reinsurance for unpaid premiums, for physician payments during the grace period.

There was support for continued AMA efforts to advocate at the state level and for changes to federal rules allowing insurers to pend claims during the 90 day grace period. Your Reference Committee recommends consolidating the resolves in Resolutions 707 and 732 into one amended resolution that will reflect the supportive testimony presented in the reference committee.

Several speakers noted that the existing language in Policy H-185.938 requiring insurers to notify physicians upon an eligibility verification check by the physician is more realistic and useful for physicians than the language proposed in the first and third resolves of Resolution 707, which would require insurance companies to notify physicians "immediately" that a patient had entered the grace period. Your Reference Committee agrees with this testimony, and accordingly recommends deletion of the first and third resolves of Resolution 707.

Your Reference Committee also agrees with testimony that advocating that failure of plans to notify physicians of a patient's grace period status should result in a binding eligibility determination, as stated in Policy H-185.938, is a strong statement of plan responsibility to provide appropriate notification to physicians, and should be retained. The second resolve of Resolution 707 recommends replacing that language with a statement that plans should pay providers for all covered services rendered during the grace period. Rather than deleting the language about binding eligibility determinations, your Reference Committee recommends amending Policy H-185.938 by adding a third section that directs our AMA to continue to advocate that plans be required to pay for all covered services provided during the grace period. Your Reference Committee believes this policy amendment is consistent with the intent of Resolutions 707 and 732, and the supportive testimony provided on these resolutions.

Your Reference Committee recommends adoption of the fourth and fifth resolves of Resolution 707 as written, and recommends adding the third resolve of Resolution 732, which would establish new policy regarding alternative financing solutions for physician payments during the grace period. The Reference Committee believes that the proposed amendments to Resolution 707 accurately reflect the testimony received on this important issue, and capture the intent of Resolutions 707 and 732.

(16) RESOLUTION 708 - PROTECTING PHYSICIANS WHO ARE PARTICIPATING IN PHYSICIAN HEALTH PROGRAMS FROM ARBITRARY DELISTING BY INSURANCE CARRIERS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 708 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That American Medical Association Policy H-285.991, Qualifications and Credentialing of Physicians in Managed Care (1) (d) be amended by addition <u>and deletion</u> as follows:

"(d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities, except in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. ~~(required p~~ Participation in a Physician Health Program in and of itself shall not count as a limit on the ability to practice medicine~~)~~. Our AMA supports the following appeals process for physicians whose health insurance contract is terminated or not renewed: (i) the specific reasons for the termination or nonrenewal should be provided in sufficient detail to permit the physician to respond; (ii) a name and address of the Director of Provider Appeals, or an individual with equivalent authority, should be provided for the physician to direct communications; (iii) the evidence or documentation underlying the proposed termination or nonrenewal should be provided and the physician should be permitted to review it upon request; (iv) the physician should have the right to request a hearing to challenge the proposed termination or nonrenewal; (v) the physician or his/her representative should be able to appear in person at the hearing and present the physician's case; (vi) the physician should be able to submit supporting information both before and at the fair hearing; (vii) the physician should have a right to ask questions of any representative of the health insurance company who attends the hearing; (viii) the physician should have at least thirty days from the date the termination or nonrenewal notice was received to request a hearing; and (ix) the hearing must be held not less than thirty days after the date the health insurer receives the physician's request for the review or hearing.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 708 be adopted as amended.

HOD ACTION: Resolution 708 adopted as amended.

Resolution 708 asks that Policy H-285.991(1)(d), be amended by addition as of the phrase: "required participation in a Physician Health Program in and of itself shall not count as a limit on the ability to practice medicine."

Your Reference Committee agrees with supportive testimony on Resolution 708. Existing AMA policy recognizes the importance of physician health programs (H-405.961) and calls on the AMA to aid in successful implementation of such services. Allowing insurance companies to disqualify any physician referred to such a program from participating in their network prevents physician health programs from successfully

rehabilitating physicians to allow them to productively care for patients. Your Reference Committee agrees with testimony calling for the removal of the addition from parentheses so as not to unintentionally lessen its perceived importance. As a result, your Reference Committee recommends that Resolution 708 be adopted as amended.

(17) RESOLUTION 709 - CHANGE OF COUMADIN REGULATION BY CMS

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 709 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~assist in the effort to change the thrombotic disease patient care discrepancy and~~ request a change in ~~this~~ Centers for Medicare and Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 709 be adopted as amended.

HOD ACTION: Resolution 709 adopted as amended.

Resolution 709 asks that our AMA assist in the effort to change the thrombotic disease patient care discrepancy and request a change in this regulation to allow a nurse to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions.

There was supportive testimony on this resolution. Your Reference Committee agrees that patients who are unable to reliably self-monitor anti-coagulation should be able to receive testing by a visiting nurse. Your Reference Committee agrees with testimony that it is important to specify that the nurse should be working under physician supervision, and recommends additional amendments to clarify the language of the resolution. Your Reference Committee recommends that Resolution 709 be adopted as amended.

(18) RESOLUTION 712 - VERBAL ADMISSION ORDER SIGNATURES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 712 be adopted.

HOD ACTION: Substitute Resolution 712 adopted.

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services to allow authentication of verbal admission orders within 30 days, rather than prior to discharge. (Directive to Take Action)

Resolution 712 asks that our AMA work with the American Hospital Association and the Centers for Medicare and Medicaid Services (CMS) to change the admission signature requirement from 48 hours to 30 days.

CMS eliminated the requirement for authentication of verbal orders within 48-hours in 2012, and now requires authentication prior to discharge. The sponsors of Resolution 712 offered the substitute language and clarified that the intent of the resolution is to request that a 30-day time-frame be given to signing admission orders, since failure to authenticate prior to discharge could result in payment denial for the whole hospital stay. Your Reference Committee agrees with supportive testimony on this substitute language, and recommends its adoption.

(19) RESOLUTION 718 - IMPROVING THE HANDLING OF IN-FLIGHT MEDICAL EMERGENCIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the first resolve of Resolution 718 be deleted.

~~RESOLVED, That our American Medical Association partner with the Aerospace Medical Association and with the American College of Emergency Physicians in supporting the development of guidelines that may be used by physicians who assist in in-flight medical emergencies~~

HOD ACTION: Adopted

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 718 be amended by addition and deletion as follows:

RESOLVED, That our AMA support ~~participate in~~ efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs.

HOD ACTION: Adopted

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 718 be adopted as amended.

HOD ACTION: Resolution 718 adopted as amended (per Recommendations A-B), plus addition of an additional resolve:

RESOLVED, That such educational course be made available "on line" as a webinar.

Resolution 718 asks that our AMA partner with the Aerospace Medical Association and with the American College of Emergency Physicians in supporting the development of guidelines that may be used by physicians who assist in in-flight medical emergencies and participate in efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs.

There was substantial testimony on Resolution 718. Your Reference Committee agrees that physicians should have resources made available to gain a greater understanding of how to care for patients during IFMEs. Compelling testimony was offered establishing that organizations such as the Aerospace Medical Association already offer this type of training and offer guidance resources. The committee notes that a seminar of this type was offered as an educational session at a the 2008 Interim Meeting. In order to enable the AMA to properly support existing training and resources for physicians, your Reference Committee recommends adoption of Resolution 718 as amended.

(20) RESOLUTION 719 - CMS FACE-TO-FACE DOCUMENTATION
RESOLUTION 730 - PAYMENT FOR CENTERS FOR MEDICARE AND MEDICAID SERVICES MANDATED SERVICES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 719 be adopted in lieu of Resolutions 719 and 730.

HOD ACTION: Substitute Resolution 719 adopted in lieu of Resolutions 719 and 730.

STUDY THE COSTS OF ADMINISTRATIVE AND REGULATORY BURDENS

RESOLVED, That our American Medical Association perform or commission an analysis of the direct and indirect costs and documented benefits associated with significant administrative and regulatory requirements imposed by the Centers for Medicare and Medicaid Services, including but not limited to face-to-face documentation requirements, the Physician Quality Reporting System, and the Meaningful Use program. (Directive to Take Action)

Resolution 719 asks that our AMA ask for data from the Centers for Medicare and Medicaid Services (CMS) regarding face-to-face forms for therapy, specifically requesting financial data regarding the cost for handling the additional forms and the cost of additional office visits required for this documentation versus any savings from decreased fraud and ask CMS to review, revise, or rescind the face-to-face documentation for therapy if there is no documented savings or other benefits.

Resolution 730 asks that our AMA perform or commission an analysis to compare official CMS estimates of direct and indirect costs attributable to the Physician Quality Reporting System (PQRS), Meaningful Use and ICD-10, and compare these estimates to the actual time and costs required to complete these mandates.

There was supportive testimony on both of these resolutions. Your Reference Committee agrees with testimony that there are many programs that represent significant administrative burdens to physicians, and recommends substitute language that would direct our AMA to take a more comprehensive approach to evaluating the costs of the multiple certification and documentation requirements that physicians are faced with today.

(21) RESOLUTION 721 - CAPTURING PHYSICIAN SENTIMENTS OF HOSPITAL QUALITY

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 721 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association foster the creation of ~~explore the possibility of creating a~~ quality measures and rating systems that incorporate~~s~~ the satisfaction and perspective of the medical staff regarding individual hospitals. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 721 be adopted as amended.

HOD ACTION: Resolution 721 adopted as amended

Resolution 721 asks that our AMA explore the possibility of creating a quality measure and rating system that incorporates the satisfaction and perspective of the medical staff regarding individual hospitals.

There was supportive testimony on this resolution. Your Reference Committee notes that the Professional Satisfaction and Practice Sustainability group is working closely with the American Hospital Association to identify ways to strengthen physician-hospital relationships and promote more productive, efficient and collaborative partnerships. Your Reference Committee believes that the amended language is consistent with this ongoing work, and recommends adoption of amended Resolution 721.

(22) RESOLUTION 723 - INTEGRATING PHYSICAL AND BEHAVIORAL HEALTH CARE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 723 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association, with interested specialty and state societies, will study and report back at the 2015 Annual Meeting on our current state of knowledge regarding integration of physical and behavioral health care, including pediatric and adolescent health care, and make ~~any~~ recommendations for further study, implementation of models of physical and behavioral health care integration, and any other tools or policies that would benefit our patients and our health care system by the integration of physical and behavioral health care. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 723 be adopted as amended.

HOD ACTION: Resolution 723 adopted as amended.

Resolution 723 asks that our AMA study issues related to integrating physical and behavioral health care.

There was supportive testimony on this resolution. The sponsor of the resolution proposed amended language that would expand the scope of the requested study to include the integration of physical and behavioral health care for children and adolescents. Your Reference Committee agrees that this is an important topic that our AMA should pursue, and recommends adoption of amended Resolution 723.

(23) RESOLUTION 724 - PRIVATE HEALTH INSURANCE FORMULARY TRANSPARENCY
RESOLUTION 716 - PHARMACY-PHYSICIAN COMMUNICATIONS REGARDING DRUG FORMULARIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Substitute Resolution 724 be adopted in lieu of Resolution 716 and Resolution 724.

HOD ACTION: Substitute Resolution 724 adopted as amended in lieu of Resolution 716 and Resolution 724.

RESOLVED, That our American Medical Association work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing (Directive to Take Action); and be it further

RESOLVED, That our AMA support legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model legislation 1) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, 2) requiring insurance carriers to make this information available to consumers by October 1 of each year and, 3) forbidding insurance carriers from making formulary deletions within the policy term. (Directive to Take Action)

RESOLVED, That our AMA promote the following insurer-pharmacy benefits manager – pharmacy (IPBMP) to physician procedural policy:

In the even that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.

RESOLVED, That drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.

Resolution 716 asks that our AMA adopt a new policy regarding pharmacy-physician communication: "In the event that a pharmacy reports back to the prescriber that a specific drug is not or is no longer on the formulary or needs prior authorization, the pharmacy shall consult the insurer for formulary alternatives, provide notice of the alternatives to the prescriber, and gather the prescriber's authorization for the substitution within 72 hours either by telephone, facsimile, or through an electronic prescribing system."

Resolution 724 asks that our AMA develop model legislation and support legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.

Testimony was somewhat divided on Resolution 716. Your Reference Committee agrees that steps should be taken to avoid patients being unable to fill prescriptions when visiting a pharmacy, but believes that addressing the issue at the time that the patient is at the pharmacist may not be the best method of addressing the issue. The most efficient method of patient drug delivery is achieved by preventing the unintended prescription of non-covered drugs. In order to achieve this efficiency, our AMA should work with pharmacies, pharmacy benefit managers, and health insurers to facilitate real-time access to formulary information and prior authorization requirements at the time of prescribing. For this reason, Resolution 716 should be considered in conjunction with Resolution 724, which seeks to improve the delivery of formulary data.

Your Reference Committee agrees with the overwhelmingly supportive testimony for Resolution 724. Your Reference Committee notes that the recommendations are largely consistent with current Medicare Part D regulations, which require plans to provide a comprehensive or abridged formulary to enrollees during enrollment in order to provide an opportunity to determine which medications are covered and whether the cost-sharing for their covered medications will change. Additionally, your Reference Committee agrees with an amendment proffered to ensure that drugs not be removed from a particular formulary while permitting the ability to add new medications as they become available.

For these reasons, your Reference Committee recommends adoption of Substitute Resolution 724 in lieu of Resolutions 716 and 724.

(24) RESOLUTION 725 - AMA TO ENDORSE THE "CHOOSING WISELY" PROGRAM

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 725 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~endorse~~ support the concepts of the American Board of Internal Medicine~~'s~~ Foundation's Choosing Wisely program. (New HOD Policy)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 725 be adopted as amended.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that the title of Resolution 725 be changed to read as follows:

SUPPORT FOR THE CONCEPTS OF THE "CHOOSING WISELY" PROGRAM

HOD ACTION: Resolution 725 adopted as amended with a change in title.

Resolution 725 asks that our AMA endorse the American Board of Internal Medicine's Choosing Wisely program.

The majority of testimony on this resolution expressed support for the concept of the Choosing Wisely initiative and its effort to increase the value of heath care delivery. However, many speakers indicated that specifically endorsing the Choosing Wisely program itself could be premature. Your Reference Committee agrees that our AMA should support the concepts of the program, and accordingly recommends that Resolution 725 be adopted as amended.

(25) RESOLUTION 727 - POINT OF CARE AVAILABILITY OF BLOOD GLUCOSE TESTING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 727 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Food and Drug Administration and the Centers for Medicare & Medicaid Services to ~~seek the maintenance of~~ maintain the Clinical Laboratory Improvement Act exempt status of point-of-care glucose testing. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 727 be adopted as amended.

HOD ACTION: Resolution 727 adopted as amended.

Resolution 727 asks that our AMA work with the Centers for Medicare and Medicaid Services (CMS) to seek the maintenance of the CLIA exempt status of point of care glucose testing.

There was supportive testimony on this resolution. Several speakers noted that the rules regarding point-of-care glucose testing have recently changed because the Food and Drug Administration (FDA) has introduced new guidelines related to blood glucose testing devices. Your Reference Committee agrees with testimony that the FDA action should not interfere with the CLIA exempt status of point of care glucose testing, which is used in a variety of clinical settings for multiple clinical purposes. Your Reference Committee believes that our AMA needs to work with both the FDA and CMS to address this issue, and recommends that Resolution 727 be adopted as amended.

(26) RESOLUTION 735 - THE FUTURE OF PRIVATE PRACTICE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that the second resolve of Resolution 735 be amended by deletion as follows:

RESOLVED, That our AMA create and maintain a reference document establishing principles for entering into and sustaining a private practice, and ~~, working with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education,~~ encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.

HOD ACTION: Adopted as amended

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 735 be adopted as amended.

HOD ACTION: Resolution 735 adopted as amended by addition and deletion (per Recommendation A), and by addition in the first resolve as follows:

RESOLVED, That our American Medical Association create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice, with a progress report to the House of Delegates at the 2015 Annual Meeting (Directive to Take Action); and be it further.

Resolution 735 asks that our AMA create, maintain, and make accessible to medical students, residents and fellows, and physicians resources to enhance satisfaction and practice sustainability for physicians in private practice; and, working with the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME), encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option.

There was significant supportive testimony for Resolution 735, with which your Reference Committee agrees. As the resolution establishes, current AMA policy recognizes the benefits of private practice and supports efforts to preserve its viability. Educating medical students about private practice and creating resources to help enhance physician satisfaction with this practice model are a worthwhile extension of

these existing policies. Your Reference Committee notes, however, that given the numerous required courses in the medical school curriculum, it is likely something that should be encouraged at the individual school level rather than pursued through the LCME and ACGME. As a result, your Reference Committee recommends that Resolution 735 be adopted as amended.

(27) RESOLUTION 736 - STUDYING PHYSICIAN ACCESS TO ACO PARTICIPATION

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 736 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study:

a. The criteria and processes by which various types of accountable care organizations (ACOs) determine which physicians will be selected to join vs. excluded from the ACO;
b. The criteria and processes by which physicians can be de-selected once they are members of an ACO;
~~b~~c. The implications of such criteria and processes for patient access to care outside the ACO; and
~~c.~~d The effect of evolving system alignments ~~on~~ and integration ~~and~~ on physician recruitment and retention ~~going forward~~.

The results of this study should be reported back to the HOD and to our AMA membership at large by the 2015 Annual Meeting. (Directive to Take Action)

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 736 be adopted as amended.

HOD ACTION: Resolution 736 adopted as amended.

Resolution 736 asks that our AMA study the criteria and processes by which accountable care organizations (ACOs) determine which physicians will be included in the ACO, the implications of such criteria for patient access to care, and the effect of evolving system alignments on integration and physician recruitment and retention.

There was supportive testimony on this resolution. Your Reference Committee agrees with testimony that the study should include an examination of de-selection criteria and processes, and proposes the amended language to reflect this important addition. The amendment also reflects a correction requested by the sponsor, as the intent was to study the effect of evolving system alignments and integration on physician recruitment and retention.

(28) RESOLUTION 738 - PHYSICIAN LEADERSHIP OF THE PATIENT-CENTERED MEDICAL HOME

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 738 be amended by deletion of the second resolve:

RESOLVED, That our AMA respond to The Joint Commission's interpretation of its primary care medical home certification standards~~, as set forth in a June 3, 2014, communication~~ addressing non-physician-led PCMHs (Directive to Take Action); and be it further

HOD ACTION: Not adopted. Second resolve amended.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 738 be adopted as amended.

HOD ACTION: Resolution 738 adopted as amended (per Recommendation A), and by deletion of the third resolve and addition of a new resolve:

~~**RESOLVED, That our AMA develop a report back at the 2015 Annual Meeting, which compares physician-led PCMHs and non-physician-led PCMHs in terms of quality of patient care, per patient total medical expenditures, total health care costs, access, and patient outcomes (Directive to Take Action)**~~

RESOLVED, That our AMA oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home or patient centered medical home (PCMH) as being anything other than MD/DO physician led (Directive to Take Action).

Resolution 738 asks that our AMA continue to support the concept of physician-led teams within the patient-centered medical home, respond to the Joint Commission's interpretation of its primary care medical home certification standards related to non-physician-led medical homes, and develop a report comparing physician-led and non-physician led medical homes.

There was strong supportive testimony on this resolution. Several speakers noted that our AMA has aggressively advocated that The Joint Commission (TJC) require physician leadership of a patient-centered medical home, and our AMA will continue to respond to TJC actions that weaken the physician's leadership role. In addition, our AMA continues its broader advocacy campaign related to state scope of practice laws, which TJC cite as

justification for maintaining flexibility regarding leadership of medical homes. The Chair of the Board of Commissioners of TJC testified that a report comparing quality and costs in physician-led and non-physician led medical homes, as called for in the third resolve, would provide useful information to TJC. Your Reference Committee recommends deleting the second resolve of Resolution 738, as AMA communication with TJC on these issues is ongoing, and recommends that Resolution 738 be adopted as amended.

(29) RESOLUTION 703 - IMPROVING HOME HEALTH CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 703 be referred.

HOD ACTION: Resolution 703 referred.

Resolution 703 asks that our AMA support the establishment of state-based certification for home health care workers and regulatory oversight of home health agencies.

Testimony on Resolution 703 was mixed. Your Reference Committee supports proper oversight of home health care. However, considerable testimony raised concerns over the specific type of home care that may require certification and oversight. The term home health care can apply to a wide array of services and workers, each of which may require drastically different levels of oversight. As a result, the specific type of care warranting certification and regulation must be defined before a position can be adequately determined.

Additionally, your Reference Committee agreed with concerns over the financial implications of worker and agency certification and regulation. With a growing number of Americans reaching an age that often requires some form of home-care, it is important not to introduce fiscal barriers that may prevent those in need from receiving care. Accordingly, your Reference Committee recommends that Resolution 703 be referred.

(30) RESOLUTION 717 - INCREASING PHYSICIAN EFFICIENCY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 717 be referred.

HOD ACTION: Resolution 717 referred

Resolution 717 asks that our AMA encourage the integration of dictation systems into electronic medical record (EMR) systems.

There was mixed testimony on this resolution. Although some speakers agreed that the ability to integrate dictation systems into electronic medical records would be helpful, others indicated that dictation systems are not always the most effective or efficient way of maximizing the value of EMRs. In addition, there is the potential that including

dictation systems as a standard feature in EMRs could raise their cost. Your Reference Committee believes this is a complex issue that merits further study, and recommends that Resolution 717 be referred.

(31) RESOLUTION 706 - HIGH RATES OF CESAREAN DELIVERIES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 706 not be adopted.

HOD ACTION: Resolution 706 not adopted.

Resolution 706 asks that our AMA support the American College of Obstetricians and Gynecologists' (ACOG's) recommendation of vaginal delivery over cesarean section in the absence of maternal or fetal indications and encourage appropriate entities to study the indications for cesarean section in order to achieve a greater degree of standardization in their use.

Testimony on Resolution 706 was mixed. Your Reference Committee notes that the American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice opinion offers perspective and considerations for obstetricians and gynecologists to consider in developing birth plans. While such a specified recommendation is a useful resource, its focus makes it more appropriately covered by experts in the field. As a result, the development and furtherance of policy and guidance on childbirth protocol is best left to specialties, such as ACOG. For these reasons, your Reference Committee recommends that Resolution 706 not be adopted.

(32) RESOLUTION 713 - DIAGNOSIS CODE FOR EXCESSIVE RELIANCE ON ALTERNATIVE THERAPY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 713 not be adopted.

HOD ACTION: Resolution 713 not adopted.

Resolution 713 asks that our AMA propose development of a diagnosis code for excessive reliance on alternative therapy to the extent that it interferes with care or the patient-physician relationship.

There was limited and mixed testimony on this resolution. Your Reference Committee notes that our AMA continues to express concerns about the complexity of ICD-10, and is reluctant to encourage the creation of any new codes at this time. Your Reference Committee believes that the existing diagnosis codes related to patient non-compliance could effectively address the concerns raised in this resolution. Accordingly, your Reference Committee recommends that Resolution 713 not be adopted.

(33) RESOLUTION 710 - REIMBURSEMENT OF AUDIT REQUESTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that AMA Policies H-285.943, H-335.980, and H-315.992 be reaffirmed in lieu of Resolution 710.

HOD ACTION: AMA Policies H-285.943, H-335.980, and H-315.992 reaffirmed in lieu of Resolution 710.

Resolution 710 asks that our AMA develop a methodology for physician reimbursement from insurance companies to compensate for the medical practice expenses of completing audits.

There was mixed testimony on this resolution. Your Reference Committee agrees that health plan audits present an often frustrating interruption in physicians' time that would otherwise be spent caring for patients. Accordingly, physician time spent conducting the administrative tasks related to audits should be fairly compensated by health plans, as is currently recommended in AMA Policies H-285.943, H-335.980, and H-315.992. Additionally, Current Procedural Terminology code 99080 is a methodology of billing for such tasks. However, as expressed by the Chair of the CPT Editorial Panel, insurance companies often do not recognize some codes. Additionally, your Reference Committee notes that ongoing AMA efforts, including a model bill currently under development and testimony provided at the National Committee on Vital Health Statistics have focused on standardizing the format and limiting the circumstances in which plans can audit providers (http://www.ama-assn.org/resources/doc/psa/x-pub/ncvhs-audit-forms-testimony-2011.pdf).

Ultimately, your Reference Committee believes that AMA Policies H-285.943, H-335.980, and H-315.992 sufficiently addresses the concerns raised in the resolution and therefore recommend reaffirmation in lieu of Resolution 710.

H-285.943 Payment for Managed Care Administrative Services
Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers. (CMS Rep. 13, I-97; Appended: Res. 806, I-99; Reaffirmation A-04; Reaffirmation I-08; Reaffirmation I-09; Reaffirmed in lieu of Res. 912, I-09; Reaffirmation A-10)

H-335.980 Payment For Copying Medical Records

It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided. (Res. 161, I-90; Appended by Res. 819, A-98; Reaffirmation A-08)

H-315.992 Copying Records for Audits
Our AMA supports taking appropriate action to ensure that the financial responsibility for producing or copying patient records at the request of any regulatory agency having the authority to do so shall be borne entirely by the requesting agency and the request for said records shall be made at least 30 days in advance of any deadline. (Res. 75, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11)

(34) RESOLUTION 711 - REIMBURSEMENT FOR PRIOR APPROVAL REQUIREMENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that AMA Policies H-385.951, H-285.943, and H-385.948 be reaffirmed in lieu of Resolution 711.

HOD ACTION: AMA Policies H-385.951, H-285.943, and H-385.948 reaffirmed in lieu of Resolution 711.

Resolution 711 asks that our AMA develop a methodology for physician reimbursement from insurance companies to compensate for the medical practice expenses of completing prior approval requirements.

There was mixed testimony on this resolution. Your Reference Committee notes that Resolution 711 was originally placed on the Reaffirmation Consent Calendar, and the committee continues to believe existing policy adequately supports ongoing efforts in this area. Physician time spent conducting the administrative tasks related to prior authorization should be fairly compensated by health plans, as is currently recommended in AMA Policies H-385.951, H-285.943, and H-385.948. As with audit charges, the development of a methodology does not necessarily beget payment, as insurance contracts often do not allow payment for prior authorization.

Your Reference Committee notes ongoing AMA efforts to reduce the burden that prior authorizations place on physicians. The AMA has created a whitepaper outlining the costs and workflow inefficiencies of the current process (http://www.ama-assn.org/resources/doc/psa/x-pub/standardization-prior-auth-whitepaper.pdf), has created a model workflow to promote efficiency (http://www.ama-assn.org/resources/doc/psa/x-pub/pa-approach-summary.pdf), and has advocated extensively on this issue, including a recent presentation given to the National Committee for Vital and Health Statistics (http://www.ama-assn.org/resources/doc/psa/x-pub/ncvhs-prior-authorization.pdf). Additionally, the AMA has developed model

legislation that aims to reduce the administrative burdens and increase insurer transparency in the prior authorization process.

Ultimately, your Reference Committee believes that AMA policies H-385.951, H-285.943, and H-385.948 sufficiently addresses the concerns raised in the resolution and therefore recommend reaffirmation in lieu of Resolution 711.

H-385.951 Remuneration for Physician Services
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols. 2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work. 3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly. (Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11)

H-285.943 Payment for Managed Care Administrative Services
Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers. (CMS Rep. 13, I-97; Appended: Res. 806, I-99; Reaffirmation A-04; Reaffirmation I-08; Reaffirmation I-09; Reaffirmed in lieu of Res. 912, I-09; Reaffirmation A-10)

H-385.948 Reasonable Charge for Preauthorization
The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients. (Res. 815, A-97; Reaffirmation A-04; Reaffirmation A-10; Reaffirmed: CMS Rep. 4, I-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11)

(35) RESOLUTION 714 - HARMONIZING QUALITY METRIC EFFORTS WITH ELECTRONIC MEDICAL RECORDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-450.946 and H-450.966 be reaffirmed in lieu of Resolution 714.

HOD ACTION: Policies H-450.946 and H-450.966 reaffirmed in lieu of Resolution 714.

Resolution 714 asks that our AMA work with agencies to explore and validate a uniform set of data metrics, including quality, payment and utilization data, and publish guidelines associated with these findings and report back to the House of Delegates.

There was supportive testimony on this resolution and the need to streamline and align quality metrics and reporting requirements to help increase their utility for physicians and reduce administrative burdens associated with meeting multiple quality reporting requirements. A member of the Council on Legislation testified that our AMA's advocacy with the Centers for Medicare and Medicaid Services and the Office of the National Coordinator for Health Information Technology emphasizes the importance of alignment across quality reporting programs and the need for standards that facilitate the capture and exchange of quality data information in electronic medical records. Your Reference Committee notes that this resolution was originally placed on the Reaffirmation Consent Calendar, and believes that existing policy provides a strong foundation for continued AMA advocacy in this area. Accordingly, your Reference Committee recommends that the following policies be reaffirmed in lieu of Resolution 714:

H-450.946 Ensuring Quality in Health System Reform
Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed upon principles. (Sub. Res. 703, I-93; Reaffirmation A-01; Renumbered: CMS Rep. 7, I-05; Reaffirmed in lieu of Res. 704, A-12)

H-450.966 Quality Management

The AMA: (1) continues to advocate for quality management provisions that are consistent with AMA policy; (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures; (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures; (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; (5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and (6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured. (BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaf: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13)

(36) RESOLUTION 715 - OVER-REGULATION OF PROVIDER-PERFORMED MICROSCOPY PROCEDURES FOR AMBULATORY HEALTH CARE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Policies H-220.946 and H-180.973 be reaffirmed in lieu of Resolution 715.

HOD ACTION: Resolution 715 referred for report back at I-14.

Resolution 715 asks that our AMA demand recognition of current certification systems that are in place without placing financial and temporal barriers to care and oppose

overregulation of professional practitioners without clear demonstration of harm under current regulations or policies.

There was limited testimony on this resolution. Your Reference Committee notes that the resolve clauses express general statements calling for our AMA to oppose duplicative certification requirements and overregulation of professional practitioners. Policies H-220.946 and H-180.773 address these issues. These broad statements would apply to the over-regulation of provider-performed microscopy procedures, as well as other clinical procedures or situations in which physicians may be burdened by over regulation. Accordingly, your Reference Committee recommends reaffirmation of the following policies in lieu of Resolution 715:

> H-220.946 Unreasonable Burden of The Joint Commission Standards and Surveys
> The AMA requests The Joint Commission to study and consider the ability of small hospitals, particularly in rural areas, to bear the burden of the increasing demands on staff and financial resources in the implementation of the current and proposed standards; and urges The Joint Commission to eliminate standards that increase health care costs without demonstrably improving the quality of care. (Res. 834, A-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)
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> H-180.973 The "Hassle Factor"
> Our AMA will greatly intensify its efforts (including support of HR 2695) to reduce the burden of government and third party regulation on medical practice and its intrusion into the physician-patient relationship and doctor patient time. (Res. 276, A-92; Reaffirmation A-00; Reaffirmation A-01; Modified: CLRPD Rep. 1, A-03; Reaffirmation I-07; Reaffirmation I-09)

Mr. Speaker, this concludes the report of Reference Committee G. I would like to thank Peter C. Amadio, MD, Thomas M. Anderson, Jr., MD, Dana Block-Abraham, DO, Stephen N. Clay, MD, Kenneth M. Louis, MD, Stephen J. Rockower, MD, and all those who testified before the Committee.

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