RESOLUTION 11-20

Title: Fentanyl Patch for Patch Exchange Program

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Sandy Dettmann, MD, and Gerald Lee, MD

Referred To:

House Action:

Whereas, fentanyl is a powerful synthetic opioid analgesic and 50-100 times more potent than morphine, and

Whereas, fentanyl is a Schedule II prescription drug, and it is typically used to treat patients with severe pain or to manage pain after surgery, and

Whereas, roughly 28,400 people died from overdose of synthetic opiates, other than methadone, in 2017 alone, and

Whereas, Michigan's overdose rate of 21.2 per 100,000 is above the national average of 14.6 per 100,000, and

Whereas, synthetic opioids, mainly fentanyl, overdose deaths have increased in Michigan from 72 in 2012 to 1,368 in 2017, and

Whereas, Ontario, Canada, has instituted a successful patch for patch (P4P) exchange program, and

Whereas, a key component of the Ontario P4P program includes the labeling of a new fentanyl prescription as a first prescription, and

Whereas, this action will result in a onetime return of 9 out of 10 patches, and

Whereas, the returned patches should be stuck to a sheet of paper and turned into the pharmacist when getting a new prescription, and

Whereas, if a pharmacy receives a prescription for fentanyl patches but does not collect all used patches or collects fewer than the quantity to be dispensed, the pharmacy must contact the prescriber, and

Whereas, this enables the pharmacist, together with the prescriber, to make an assessment, consider the circumstances, and determine the best course of action and the quantity to be dispensed, and

Whereas, it is the responsibility of the pharmacist to properly store and dispose of used patches, as well as contacting appropriate law enforcement if there is suspected counterfeiting, misuse, and/or tampering; therefore be it

RESOLVED: That MSMS supports and shall propose a fentanyl "patch for patch" (P4P) exchange program in the state of Michigan modeled after the successful P4P program implemented in Ontario, Canada; and be it further

RESOLVED: That MSMS advocate the Michigan Legislature adopt a fentanyl "patch for patch" exchange program in Michigan modeled after the successful P4P program implemented in Ontario, Canada.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:

Prescription Drug Abuse
MSMS supports the following AMA position on "Curtailing Prescription Drug Abuse While Preserving Therapeutic Use – Recommendations for Drug Control Policy:"

"Our AMA (1) opposes expansion of multiple-copy prescription programs to additional states or classes of drugs because of their documented ineffectiveness in reducing prescription drug abuse, and their adverse effect on the availability of prescription medications for therapeutic use; (2) supports continued efforts to address the problems of prescription drug diversion and abuse through physician education, research activities, and efforts to assist state medical societies in developing proactive programs; and (3) encourages further research into development of reliable outcome indicators for assessing the effectiveness of measures proposed to reduce prescription drug abuse.

Relevant AMA Policy:

Curtailing Prescription Drug Abuse While Preserving Therapeutic Use - Recommendations for Drug Control Policy H-95.979 (see language above)

RESOLUTION 12-20

Title: Non-Stigmatizing Verbiage

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Sandy Dettmann, MD, DABAM, FASAM

Referred To:

House Action:

Whereas, we are in the midst of the largest manmade epidemic in the history of the United States, and

Whereas, drug overdose is the most common cause of death in Americans under the age of 50, and

Whereas, addiction is a medical disease with effective, evidence-based medical treatment available, and

Whereas, persons who suffer from the disease of addiction are frequently referred to as "drug addicts," and

Whereas, the verbiage "drug addict" conjures up a somewhat negative image in the minds of most people, and

Whereas, in reality, addiction is an "equal opportunity destroyer;" therefore be it

RESOLVED: That MSMS encourages the use of clinically accurate, non-stigmatizing, person first terminology when referring to persons with the disease of addition and shall incorporate such terminology in future communications and publications, as well as update existing policies during the normal process of updating the MSMS Policy Manual; and be it further

RESOLVED: That MSMS believes an individual with the disease of addiction should be accurately referred to as a "person with the disease of addiction" instead of "drug addict" or other stigmatizing verbiage.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:

Communication, Documentation, and Professionalism
MSMS endeavors to educate physicians and other health care providers about the importance of careful and accurate verbal discussions and written documentation of care provided.

MSMS encourages physicians to demonstrate and maintain high ethical standards to avoid inadvertently discrediting other physicians or other health care providers; thereby, leading by example so that resident physicians and medical students can learn in a supportive environment while providing excellent care for our mutual patients.

Relevant AMA Policy:

Destigmatizing the Language of Addiction H-95.917
Our AMA will use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty.

Destigmatizing the Language of Addiction D-95.966
Our AMA and relevant stakeholders will create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities.

RESOLUTION 20-20

Title: Michigan State Medical Society Judicial Commission

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Jayne E. Courts, MD, FACP

Referred To:

House Action:

Whereas, the Judicial Commission serves to review any concern about the conduct of a physician member that is potentially in violation of the American Medical Association (AMA) Code of Ethics, and

Whereas, concerns may originate from patients or other people and may include, but are not limited to, inappropriate behavior, sexual harassment, or issues of gender identity, and

Whereas, the MSMS Judicial Commission serves as the disciplinary body within MSMS, and

Whereas, the Judicial Commission works through the component county medical societies, often in a slow and potentially inequitable process, and

Whereas, the Official Procedures of the Judicial Commission allow determination of appropriate disciplinary action of a physician member, including possible censure, suspension, or expulsion from MSMS membership, and

Whereas, clear and concise approaches to the judicial and disciplinary process would improve timeliness, consistency, equity, and protection due to standardized processes and expedited decisions; therefore be it

RESOLVED: That the MSMS Board of Directors consider making the Judicial Commission a Committee of the Board so the Committee may perform its function in a more efficient and equitable manner; and be it further

RESOLVED: That the MSMS Board of Directors study the structure and function of the Judicial Commission and recommend Constitution and Bylaws changes that will be brought to the 2022 MSMS House of Delegates for first reading.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions to form or join task forces (internal or external) - $5,000+

Relevant MSMS Policy:

Judicial Commission Complaint Process

1. MSMS staff receive inquires from patients or physicians about filing a complaint for a physician, nurse, hospital, or any other healthcare facility.
2. If the complaint is about a physician, the staff member verifies that the physician is a MSMS member. If the physician is a member, the staff member explains that the Judicial Commission process is a peer review process which starts with the county society peer review committee. We encourage the complainant to personally discuss the issue with the physician. Finally, the staff member explains that the MSMS Judicial Commission does not have jurisdiction to award money damages, revoke, restrict or limit a physician's license.
3. Many times, when the complainant realizes it is a peer review process only, they decide not to proceed. If they decide to proceed, the staff member sends a complaint form to gather further information. The complainant has 30 days to submit the form with the detailed information.
4. Once the form is received by MSMS, the MSMS staff member determines the appropriate county medical society (CMS) who should review the complaint and forwards the information to that CMS. If there is not an active county medical society, the MSMS Judicial Commission reviews the complaint.
5. Each CMS has their own process for reviewing a complaint. The MSMS staff member stays in touch with the CMS staff member asking for updates.
6. Once the CMS peer review process makes their determination, they send information about the final decision to the MSMS staff member.
7. The MSMS staff member notifies the Judicial Commission chair about the decision. The Chair decides how the full Commission will be notified of the complaint.

Statistics on Complaints

Year	Forms Mailed	Forms Received	Full Complaint Process
2016	2	0	0
2017	1	1	1
2018	3	0	0
2019	1	0	0
2020	3	2	2

Relevant AMA Policy:

Conflicts of Interest H-140.967
Our AMA calls on state and county medical societies to seek out and to respond to complaints of significant violations of the Council on Ethical and Judicial Affairs' guidelines, and it reminds those societies of the AMA's pledge to stand behind and to provide financial support for any society enforcing in good faith and under approved disciplinary procedures AMA's code of ethics.

Source:
1. Michigan State Medical Society. Constitution and Bylaws, Supplement: Official Procedures for the MSMS Judicial Commission, 2015 edition.

RESOLUTION 23-20

Title: Signage Balancing Patient Safety, Quality of Care, and Patient Dignity

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Jayne E. Courts, MD, FACP

Referred To:

House Action:

Whereas, patients who reside in a skilled nursing facility (SNF), either for sub-acute rehabilitation (SAR) or long-term care (LTC), often have safety or care needs that need to be addressed by the health care team at the SNF, and

Whereas, included in these patient care needs are often simple, but important, care plan concerns such as the number needed for assist due to the fall risk, the need to follow a dysphagia diet (with thickened liquids), or the need to follow a fluid restriction, and

Whereas, SNF staff are trained to respond to call lights as quickly as possible, including responding to call lights of any residents who require assistance, even if the patient has not been assigned to that staff member, and

Whereas, a staff member may provide assistance to a patient with whom he/she is not familiar, including lack of familiarity with the care plan, and

Whereas, in the inpatient setting or in the acute rehabilitation setting, patients at risk for falls often wear wristbands clearly indicating this potential risk in an effort to reduce falls and the possible adverse consequences for the patient, and

Whereas, this readily visible reminder is seen as a patient safety and quality of care measure that benefits the patient and helps to reduce the number of fall "never events," and

Whereas, the regulatory environment in the SNF setting is determined by the Centers for Medicare and Medicaid Services (CMS), and

Whereas, CMS's interpretive guidelines require that an environment must be maintained in which there are no signs posted in residents' rooms or in staff work areas able to be seen by other residents and/or visitors that include confidential clinical or personal information (though signage in non-visible, non-readily seen locations such as the inside of a cupboard door in the resident's room is permissible), and

Whereas, any publicly visible identification of residents with a fall risk such as a wristband is deemed to be a violation of patient dignity requirements, rather than as a potential method of ensuring the patient's safety and provision of quality of care, and

Whereas, this requirement to ensure information is not viewable by the public doesn't even allow a colored dot on the room number by the door to alert SNF staff members to patient care needs such as a dysphagia diet, fluid restrictions, or other patient safety and quality concerns, and

Whereas, non-adherence to this regulatory approach, believed to preserve the dignity of the patient, will result in a citation which may include plan of correction requirements, education of the staff, and monetary infractions, including but not limited to denial of payment until the CMS 7 surveyors have resurveyed the SNF and have determined that the regulatory guidelines have been met through the plan of correction, and

Whereas, CMS citations may result in a reduction in the SNF's five-star rating which may affect reimbursement rates and the SNF's reputation and possible referral rates until the five-star rating has improved, and

Whereas, identification of patients at risk for falls in the inpatient setting or the acute rehabilitation setting is not considered to be an infringement on the patient's dignity, but is viewed instead as a safety concern for the protection of the patient; therefore be it

RESOLVED: That MSMS work with appropriate stakeholders to review the rationale for the Centers for Medicare and Medicaid Services' patient dignity regulations applicable to long-term care facilities and determine acceptable indicators or markers with better visibility to indicate patients with an increased fall risk or other health care risk concerns; and be it further

RESOLVED: That MSMS work with the appropriate stakeholders to develop and advocate for recommended changes to the Centers for Medicare and Medicaid Services' patient dignity regulations applicable to long-term care facilities so that discrete, but readily visible, indicators or markers of a patient's health care risk concerns may be used for the benefit and safety of patients without triggering a citation; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with the Centers for Medicare and Medicaid Services (CMS) to review the rationale for CMS's patient dignity regulations applicable to long-term care facilities and determine acceptable indicators or markers with better visibility to indicate patients with an increased fall risk or other health care risk concerns; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with the Centers for Medicare and Medicaid Services (CMS) to change the patient dignity regulations applicable to long-term care facilities so that discrete, but readily visible, indicators or markers of a patient's health care risk concerns may be used for the benefit and safety of patients without triggering a citation.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:
None

Relevant AMA Policy:

Residential Facility Regulations H-280.984
Our AMA advocates for patients in long-term care, group home and other residential settings and will: (1) strive to see that enhanced quality of care results from any new proposed state or federal regulations; (2) attempt to ensure that appropriate and necessary physician involvement be maintained for patients; (3) urge state regulatory bodies and HHS to seek consultation and advice from the AMA and other professional medical societies when developing rules and regulations that affect medical care; (4) support cooperative efforts with appropriate groups for the purpose of developing mutually supported positions regarding medical care regulations; (5) support efforts to monitor federal and state legislation and regulations which affect physicians involved in long-term, group home or other residential setting care, and provide testimony and information about appropriate medical management of patients to regulatory and/or licensing bodies; and (6) support actions to establish better understanding and cooperation among federal and state health agencies as they formulate health and safety standards.

RESOLUTION 24-20

Title: Prescription Medication Pill Size

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Michelle M. Condon, MD and David Whalen, MD

Referred To:

House Action:

Whereas, dosing of medication frequently requires a patient to cut pills in half to achieve the proper dose recommended by their physician, and

Whereas, these medication types requiring alteration in pill tab size may be to limit the dose of controlled substances which is an advantage to many patients, and

Whereas, these dosage adjustments may be difficult for patients with limited dexterity to cut on their own; therefore be it

RESOLVED: That MSMS ask the Michigan Board of Pharmacy to pursue pill medication size to be no smaller than six mm in diameter or other size found by research to be best suited for pill cutting by elderly or disabled patients; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to request pharmaceutical companies to manufacture pills larger than five mm in diameter for medications most likely to be prescribed to elderly and disabled persons, especially those consisting of controlled substances, to better allow pill cutting to help control dosages, unless research shows this to be unnecessary in this group of patients.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 25-20

Title: Limit Copay on Emergency Department Visits

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Michelle M. Condon, MD, FACP

Referred To:

House Action:

Whereas, some insurance products require a patient to pay an extra or larger co-pay or deductible if an emergency department evaluation does not lead to a hospital admission, and

Whereas, these patients may have waited to confer with their private physician until office hours are open, but are instructed by that physician to go to the emergency department for evaluation; therefore be it

RESOLVED: That MSMS advocate that insurance companies waive the imposition of higher co-pays or deductibles when a patient is directed by their primary care physician to seek treatment for an acute problem in the emergency department, even if the patient is not admitted to the hospital.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 28-20

Title: ICD-10-CM Code for 'Statin Refusal'

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Rose Ramirez, MD

Referred To:

House Action:

Whereas, we are moving from a fee-for-service payment model to a value-based payment model, and

Whereas, measuring and reporting quality metrics by providers has continued to increase, and

Whereas, the Centers for Medicare and Medicaid Services (CMS) Medicare Stars program requires insurers to also meet and report on quality metrics, and

Whereas, because of HEDIS measures and the CMS Medicare Stars program, there is a very strong push by insurers to get all patients that might benefit from a statin onto one, and even measuring the number of refills per unit of time to show patient compliance, and

Whereas, the number of allowed exclusions to the statin measure in specific have decreased, which can reduce a provider's ability to hit quality targets and impact the providers quality payments, and

Whereas, despite our recommendations and education about the benefits of statins, some patients still refuse to accept a statin, and

Whereas, patient choice in the partnership between physician and patient should be honored whenever possible, and

Whereas, physicians simply cannot force patients to take a medication they do not want to take, and

Whereas, there is an ICD-10-CM code for coumadin refusal and one for medication refusal, but not a code for statin refusal, and

Whereas, a specific code for statin refusal could be useful for those patients who do not have other exclusion criteria for a statin; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA for the creation of a new specific 'statin refusal' code and advocate it be a valid exclusion criterion for patients.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 29-20

Title: Enforce AMA Principles on Continuing Board Certification

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Megan Edison, MD, and David Whalen, MD

Referred To:

House Action:

Whereas, the American Medical Association (AMA) Principles on Continuing Board Certification have been developed through the democratic process of various states' Houses of Delegates and the AMA House of Delegates, reflecting the collective will of state and national medical societies and their physician members, and

Whereas, these longstanding principles clearly demand a continuing board certification process that is low cost, evidence-based, untied to insurance and hospital credentialing, and free of harm to the physician workforce, and

Whereas, the proprietary American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) continuing board certification product continues to be high cost, high stress, without evidence over other forms of continuing medical education, required for insurance and hospital credentialing, and harmful to the physician workforce, and

Whereas, ABMS and AOA boards continue to ignore the AMA on nearly every aspect of the AMA policy handbook on continuing board certification, and

Whereas, this failure to protect physicians from recertification harm is having significant effects upon cost of care, physician burnout, and access to qualified physicians, and

Whereas, this failure to advocate successfully for these principles reflects poorly upon the ability of organized medicine to defend physicians and our right to care for patients; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to continue to actively work to enforce current AMA Principles on Continuing Board Certification; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to publicly report their work on enforcing AMA Principles on Continuing Board Certification at the Annual and Interim meetings of the AMA House of Delegates.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process
MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:
1. MOC must be voluntary.
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC.
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care.

Relevant AMA Policy:

Continuing Board Certification H-275.924
Continuing Board Certification AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

RESOLUTION 31-20

Title: Bring Insurance Credentialing into Legal Compliance on Maintenance of Certification

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Megan Edison, MD

Referred To:

House Action:

Whereas, Public Act 487 of 2018 became law on December 27, 2018, and

Whereas, this law was a direct result of resolutions adopted by the MSMS House of Delegates to end insurance company mandates to participate in or purchase maintenance of certification products in order to be accepted as an in-network provider eligible to care for patients, and

Whereas, the law states, "an insurer that delivers, issues for delivery, or renews in this state a health insurance policy issued under chapter 34 or a health maintenance organization that issues a health maintenance contract under chapter 35 shall not require as the sole condition precedent to the payment or reimbursement of a claim under the policy or contract that an allopathic or osteopathic physician in the medical specialties of family practice, internal medicine, or pediatrics maintain a national or regional certification not otherwise specifically required for licensure under article of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838," and

Whereas, despite passage of this law over two years ago, there are insurance companies in Michigan ignoring the law by not changing credentialing policy and continuing to reject physicians solely for not maintaining American Board of Medical Specialties or the American Osteopathic Association board certification; therefore be it

RESOLVED: That MSMS work with Michigan health insurance companies to change credentialing requirements to be in compliance with Public Act 487 of 2018, by requiring only initial board certification for the credentialing of in-network physicians specializing in family medicine, internal medicine, and pediatrics; and be it further

RESOLVED: That MSMS pursue legal action against Michigan health insurance companies that refuse to work with MSMS to bring the health insurance company's credentialing requirements into legal compliance with Public Act 487 of 2018 and continue to discriminate against family medicine, internal medicine, and pediatric physicians for not participating in or purchasing a maintenance of certification product.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions calling for legal intervention - $100,000+

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process
MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:
1. MOC must be voluntary.
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function
unrelated to the specialty board requiring MOC.
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care.

Relevant AMA Policy:

Continuing Board Certification D-275.954
Our AMA will:
1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a yearly report to the House of Delegates regarding the CBC process.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all

boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA will, through its Council on Medical Education, continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.

RESOLUTION 33-20

Title: Access to Direct Primary Care Physicians

Introduced by: David Whalen, MD, for the Barry County Delegation

Original Author: Belen Amat, MD

Referred To:

House Action:

Whereas, Michigan Compiled Law 500.129 recognizes direct primary care (DPC) and requires DPC practices to charge a periodic fee, avoid billing third-party payers on a fee-for-service basis, and limit any per visit charge to less than the monthly equivalent of the periodic fee, and

Whereas, DPC practices do not participate with, or bill any insurance companies, allowing DPC practices to provide high quality individualized care at affordable rates for patients, and

Whereas, the DPC options offers a plan that provides individuals and families with unlimited access to their personal physician for a flat, monthly fee, and

Whereas, patients choose DPC practices for longer office visits with their physician, increased access via phone calls, text messages, and video chat, all while being cost conscious, and

Whereas, DPC plans are not health insurance, and DPC patients often carry high deductible insurance plans and are responsible for most of the cost of outpatient testing, medications, and consults, and

Whereas, DPC physicians are very skilled at finding and negotiating low cost medication, referrals, and studies for their patients, and

Whereas, some insurance companies consider DPC physicians "out of network," and will not allow them to order medications, tests, or referrals on patients who have health insurance, even when the medical treatment is being paid 100 percent by the patient due to high deductibles, and

Whereas, insurance companies will require a patient to visit an insurance-based doctor solely to make the referral, thereby increasing healthcare costs and delaying care, and

Whereas, unlike traditional insurance-based physicians who may be out of network with particular insurance companies, DPC physicians are, by definition and legal distinction, a unique class of physicians, and out-of-network with all insurances, and

Whereas, the state of Maine recognized this distinction, and passed legislation prohibiting denial of referrals by DPC physicians; therefore be it

RESOLVED: That MSMS educate health insurers on the role of direct primary care physicians in promoting high quality care while decreasing health care costs for patients with health insurance; and be it further

RESOLVED: That MSMS work with health insurers to allow direct primary care physicians to prescribe medications, order tests, and make referrals for patients with health insurance.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

Relevant MSMS Policy:

Resolution 23-15
Resolved: That MSMS study and educate it members regarding alternative payment models for primary care including direct primary care contracts and "concierge" medicine using methods such as email, website, and webinar programs.

Relevant AMA Policy:

Direct Primary Care H-385.912
1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.

RESOLUTION 39-20

Title: End Time Limited Board Certification

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Megan Edison, MD, and David Whalen, MD

Referred To:

House Action:

Whereas, achievement of initial board certification status after residency or fellowship is widely regarded as a marker of academic competency in a medical or surgical specialty, and

Whereas, initial board certification is all that is required of time-unlimited, or "grandfathered," physicians to be board-certified without any concerns about their competence or professionalism, and

Whereas, time-unlimited physicians have the option to participate and purchase the maintenance of certification (MOC) educational product, but they do not lose initial board certification if they choose not to participate, and

Whereas, time-limited physicians must continually participate and purchase MOC, or they will lose initial board certification and be erased from publicly available certification websites if they do not comply with the MOC process, and

Whereas, continuing medical education (CME) from a robust competitive CME marketplace is widely regarded as the physician pathway to staying current and up to date in a specialty and is therefore required by most states for medical licensure and renewal, and

Whereas, the proprietary MOC educational products from the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA) have no proven academic benefit over other forms of CME to improve quality of care and patient outcomes, and

Whereas, robust local accountability systems throughout our profession (including direct observation through our work together as fellow colleagues, employer peer review, hospital peer review, and review by state Boards of Medicine) exist and assure professionalism, discipline, and self-regulation of our profession locally, and

Whereas, private medical specialty boards (e.g., ABMS, AOA) have little to no jurisdiction to ensure discipline, accountability, and professionalism of physicians, and

Whereas, the MOC product is not academically superior to other forms of CME in terms of patient outcomes and is jurisdictionally inferior to local forms of professional accountability and discipline, rendering it a duplicative burden upon younger physicians, at best, and

Whereas, loss of initial board certification status for not participating and purchasing the MOC product results in significant financial and professional harm to time-limited physicians as they are removed from insurance panels and hospitals; thereby, forcing many physicians to comply with MOC, and

Whereas, all good faith efforts by organized medicine asking ABMS and AOA to limit the cost, burden, and stress of forced MOC have been ignored, resulting in ongoing harm to physicians, and

Whereas, all good faith efforts by organized medicine asking that MOC not be tied to insurance reimbursement and hospital privileges have been ignored, and

Whereas, it is time to stop this nonsense and the harm forced MOC is causing physicians; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to call for an end to time-limited American Board of Medical Specialties and American Osteopathic Association board certification; thereby, ending discrimination against time-limited board-certified physicians, and

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to allow the purchase and participation of any proprietary continuing board certification or maintenance of certification or osteopathic continuous certification product to be a voluntary process for all board-certified physicians; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to call on the American Board of Medical Specialties and the American Osteopathic Association to make continuing board certification or maintenance of certification or osteopathic continuous certification a voluntary process separate from initial certification; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) work with the American Board of Medical Specialties and the American Osteopathic Association to ensure that initial board certification remain as a time-unlimited, earned marker of academic competency, and should not be nullified for not participating in or purchasing the maintenance of certification product.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

Relevant MSMS Policy:

Review Board Recertification and Maintenance of Certification Process

MSMS supports Maintenance of Certification (MOC) only under all of the following circumstances:

1. MOC must be voluntary.
2. MOC must not be a condition of licensure, hospital privileges, health plan participation, or any other function unrelated to the specialty board requiring MOC.
3. MOC should not be the monopoly of any single entity. Physicians should be able to access a range of alternatives from different entities.
4. The status of MOC should be revisited by MSMS if it is identified that the continuous review of physician

competency is objectively determined to be a benefit for patients. If that benefit is determined to be present by objective data regarding value and efficacy, then MSMS should support the adoption of an evidence based process that serves only to improve patient care.

Relevant AMA Policy:

Continuing Board Certification H-275.924
Continuing Board Certification AMA Principles on Continuing Board Certification
1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. CBC should be used as a tool for continuous improvement.
15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.
16. Actively practicing physicians should be well-represented on specialty boards developing CBC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.