RESOLUTION TO CURTAIL DIRECT CONSUMER ADVERTISING OF PRESCRIPTION DRUGS

Submitted by the Richmond Academy of Medicine

WHEREAS, The US has had a steady and potentially harmful increase in direct public advertising of prescription drugs, particularly since the FDA oversite was reduced in 1997, and

WHEREAS, This increase has had an adverse effect on our public by misinformation, the overuse of some agents, as well as inappropriate prescribing, an increase in health care costs and potential interference in patient-health provider relationships, and

WHEREAS, The AMA already in 2017 supported the need for a ban on direct to consumer advertising for prescription drugs, and

WHEREAS, The AMA 2017 position regarding a ban on such advertising has been ineffective in correcting this continuing problem, and

WHEREAS, Such direct public advertising of prescription drugs has been effectively prohibited by law in all countries except the US and New Zealand, therefore be it

WHEREAS, The FDA has failed to do so, therefore be it

RESOLVED, That RAM and MSV encourage MSV's AMA Delegation to urge the AMA Advocacy Program to maintain the stand they have taken on direct advertising of prescription drugs but now recommend passage of a federal law to accomplish such a ban.

RESOLUTION TO INCREASE TRANSPARENCY AND REGULATION OF PHARMACY BENEFIT MANAGERS IN VIRGINIA

Submitted by the Richmond Academy of Medicine

WHEREAS, The Medical Society of Virginia has policy concerning the regulation and licensing of Pharmacy Benefit Managers (PBMs), and

10.3.20 Regulate And License Pharmacy Benefit Managers Who Serve Virginians --- Date: 10/21/2018
The Medical Society of Virginia, in concert and collaboration with local and specialty physician organizations, pharmacist organizations, patient organizations and any other interested and affected parties work to ensure that the Virginia Insurance Commissioner has authority to appropriately oversee the actions of PBMs providing services to Virginians and are held accountable for their actions in the pricing, management and dispensing of medications to Virginians.

WHEREAS, PBMs continue to operate without official oversight by the Commonwealth of Virginia, and

WHEREAS The recent vertical integration of health insurance companies and PBMs makes their relationships more opaque, and

WHEREAS, The lack of transparency in formulary construction, pricing and out of pocket costs to consumers are contributing to the increasing costs of healthcare in the Commonwealth, and

WHEREAS, These formulary and pricing practices are resulting in higher drug costs to our patients, thereby leading to increasing difficulties for our patients to adhere to treatment plans, and

WHEREAS, PBMs' formulary and pricing practices are interfering with the patient-physician relationship and the practice of medicine within the Commonwealth, and

WHEREAS, Organizations such as the Alliance for Transparent and Affordable Prescriptions (ATAP) have model pharmaceutical pricing transparency policies (attached) that could be used to inform action on this issue, therefore be it

RESOLVED, That the Medical Society of Virginia will prioritize implementing MSV Policy 10.3.20 by actively working with all interested parties to collect data, monitor and report on PBM/health insurers' formulary policies, and be it further

RESOLVED, That the Medical Society of Virginia will support and promote legislation and/or regulation to achieve the goals stipulated in MSV Policy 10.3.20 at least through

RESOLUTION REGARDING THE MAINTENANCE OF CERTIFICATION PROCESS

Submitted by the Richmond Academy of Medicine

WHEREAS, Physician practice viability is an MSV strategic priority; and

WHEREAS, Physicians are among the nation's most rigorously trained professionals; and

WHEREAS, Requirements for maintaining the skills needed to serve their patients vary greatly depending upon patient population and treatments available; and

WHEREAS, The individual physician, Rather than nonmedical testing and psychometrics officials within Maintenance of Certification (MOC) Corporations, is in a better position to determine how best to maintain the needed practice skills[1,2]; and

WHEREAS, Annual externally imposed study requirements enforce conformity rather than encourage the independence of thought, research, and investigational pursuits essential for innovative professional careers and creative medical scientists[3,4]; and

WHEREAS, Physicians prefer independent lifelong learning and collaboration with universities and specialty societies to define medical excellence within their profession rather than MOC test scores[5,6]; and

WHEREAS, Specialty Boards statisticians and test designers have applied an industrial-based modified Angoff Standard for determining the minimum level of subspecialty competence while this standard is known to fail in medicine, science, and clinical issues of high complexity[7,8]; and

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[1]Centor RM, Fleming DA, Moyer DV. "Maintenance of Certification: Beauty Is in the Eyes of the Beholder." *Annals of Internal Medicine* 2014; 161: 226–27.

[2]Slovic P, Finucane ML, Peters E, et al. "The Affect Heuristic." *European Journal of Operational Research* 2007; 177: 1333–52.

[3]Iglehart JK, Baron RB (bee). "Ensuring Physicians' Competence — Is MOC the Answer?" *New England Journal of Medicine* 2012; 367: 2543–49.

[4]McCollum AM, Austin C, Nawrocki J, et al. "Investigation of the First Laboratory-Acquired Human Cowpox Virus Infection in the United States." *Journal of Infectious Diseases* 2012; 206: 63–68. *(NOTE: The gifted "second physician" infectious disease specialist who suspected and confirmed the cowpox scenario was not Board certified in infectious disease.)*

[5]Marshall JL. "Taking the Boards: A Frisking, then a Mugging." *Medscape Oncology* March 20, 2014. www.medscape.com..

[6]Mandrola J. "Call Time-Out for the ABIM MOC Mandate." Medscape Multispecialty April 1, 2014. www.medscape.com. *(NOTE: Over 15,000 petition signatures begun at the American College of Cardiology meeting.)*

[7]United States Customs and Border Protection, Angoff Procedure. 2008.

[8]Verheggen MM, Muijitjens AM, et al. "Is an Angoff Standard an Indication of Minimal Competence of Examinees or of Judges?" *Advances in Health Sciences Education: Theory and Practice* May 2008; 13: 203–11.

WHEREAS, Many believe the direct and indirect costs of mandatory recertification are unprecedented in other businesses or health care professions; and

WHEREAS, High cost MOC programs divert physician funds and require significant physician time commitments away from their practices and patient care services[9], empowering nonmedical regulators and insurers while disenfranchising patients and physicians[10,11]; and

WHEREAS, In the opinion of some, mandatory recertification reduces patient access to care by encouraging early retirement of physicians who are providing excellent, much needed care; and

WHEREAS, In the opinion of some, MOC revenues finance generous executive salaries and private, tax-exempt, high revenue professional testing industry and a corporate testing monopoly [12]; and

WHEREAS, Linkage of a physician's hospital staff privileges solely to MOC recertification violates The Joint Commission (formerly JCAHO) medical staff credentialing recommendations (Section 482.22 a2)[13] ; and

WHEREAS, There is no current MSV policy calling for opposition to mandatory MOC requirements for physicians and physicians already board-certified, therefore be it

RESOLVED, That the MSV acknowledge that the requirements within the Maintenance of Certification process are costly and time intensive, and they result in significant disruptions to the availability of physicians for patient care, and be it further

RESOLVED, That the MSV acknowledge that after initial specialty board certification, the MSV affirms the professionalism of the physician to pursue the best means and methods for maintenance and development of their knowledge and skills, and be it further

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[9]AMA Council on Medical Education, Report 10. "An Update of MOC, Osteopathic Continuous Certification, and Maintenance of Licensure." June 2012.
[10]Fisher W. "When We Reward Regulators More Than Doctors." May 6, 2014. http://drwes.blogspot.com.
[11]Kempen P, Christman K. "MOC update: Maintenance of Certification and the Regulatory Capture of Medicine." Association of American Physicians and Surgeons (AAPS) Webinar March 23, 2014.
[12]Havighurst CC, King NM. Private credentialing of health care personnel: an antitrust perspective. Part Two. *American Journal of Law and Medicine* 1983; 9: 263-334

[13]**Code of Federal Regulations Title 42 - Public Health** Volume: 5Date: 2011-10-01Original Date: 2011-10-01Title: Section 482.12 - Condition of participation:Governing body.http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol5/xml/CFR-2011-title42-vol5-sec482-12.xml.

RESOLVED, That MSV reaffirms the value of continuing medical education, while opposing mandatory Maintenance of Certification as a requirement for licensure, hospital privileges, and reimbursement from third party payers.

RESOLUTION TO ENSURE VIRGINIA INSURERS KEEP POLICIES UP TO DATE IN REAL TIME ONLINE

Submitted by the Richmond Academy of Medicine

WHEREAS, Insurers have policies dictating circumstances where prior authorization is required, and

WHEREAS, Practices access the insurer policy database to determine if prior authorization is required and obtain it prior to ordering certain tests, procedures or medications, and

WHEREAS, Insurers' policies sometimes do not state prior authorization is required for certain tests, procedures, or medications, and

WHEREAS, Insurers deny the claim stating that prior authorization was indeed required or that the patient's policy has specific exceptions, and

WHEREAS, This creates an unnecessary burden and stress on the patient and practice since the service has already been delivered, therefore be it

RESOLVED That the Medical Society of Virginia work with insurers and the Virginia Bureau of Insurance to require them to keep prior authorization policies up to date in real time in an easily accessible online format and that if the policy does not state that prior authorization is required for certain tests, procedures, or medications, the insurer must pay for the contracted service and not retroactively request further documentation prior to payment for said services.

RESOLUTION TO REGULATE THIRD PARTY PRIOR AUTHORIZATION

Submitted by the Richmond Academy of Medicine

WHEREAS, Some insurers in Virginia use third party companies to manage prior authorization, and

WHEREAS, Practices routinely obtain prior authorization through the companies, and

WHEREAS, Insurers often deny claims stating that prior authorization was not obtained when in fact it was through the third party company, and

WHEREAS, Insurers continue to deny claims even after electronic appeals made demonstrates prior authorization was obtained, and

WHEREAS, Insurers are requesting PAPER documentation of the prior authorization which creates unnecessary work and delay which causes stress for the patient and practice, therefore be it

RESOLVED, The Medical Society of Virginia work with insurers and the Virginia Bureau of Insurance to enforce that once prior authorization is obtained for services through a third party company, the insurer must reimburse for services at the contracted rate without requiring any additional documentation.

RESOLUTION TO STOP ROBOCALLS IN VIRGINIA

Submitted by the Richmond Academy of Medicine

WHEREAS, Robocalls annoy almost everyone and increased exponentially in 2018 to over 47 billion and 20 per day per person in Virginia, and

WHEREAS, Over 40% of robocalls aim to steal your money, personal identity, or both, and

WHEREAS, Answering the call increases the likelihood the problem will get worse by 40%, if the unwanted caller determines there is another person at the other end of the line, and

WHEREAS, Phone call volume is high in healthcare and difficult to manage already, and

WHEREAS, Our patients also receive robocalls from "medical specialists" to inform them of test results and upcoming appointments and they are afraid to not answer the phone, and

WHEREAS, A stream of robocalls also disrupted the network of a medical paging company sending emergency dispatches that could have delayed vital medical care, making the difference between a patient's life and death according to the FCC, and

WHEREAS, This past April Tufts Medical Center received almost 5,000 scam phone calls in two hours—bringing communications at the hospital to a standstill, and

WHEREAS, Healthcare workers must answer calls as the call may be critical to patient care, therefore be it

RESOLVED That the Medical Society of Virginia work to support a ban on unsolicited robocalls in Virginia due to the adverse effect they have on patient care.