Medical Society of Virginia Proposed 2018 Budget

Submitted by the MSV Board of Directors

To ensure that the proposed budget is consistent with evolving financial conditions, the MSV Board of Directors will review and approve an updated budget at its October meeting immediately preceding the House of Delegates; the approved budget will then be distributed to the House of Delegates at its first session.
MSV 2017 POLICY COMPRENDIUM TEN YEAR REVIEW

Dr. Arthur Vayer Jr., Speaker
Dr. Alan Wynn, Vice-Speaker

WHEREAS, the policy making procedure for implementation and utilization of the *Policy Compendium of the Medical Society of Virginia* was adopted by the Board in September 1992, and updated in 2001, and

WHEREAS, the procedure requires that 10 years after the adoption of each policy action, the Speakers and MSV Staff will present to the House of Delegates a “Ten Year Policy Review Report,” encouraging appropriate consideration of each item, and that unless each such policy is acted upon by the subsequent House of Delegates, it will cease to be policy to the MSV and will be placed in the archives section of the Compendium, and

WHEREAS, consideration by the House of Delegates to add, amend or archive additional policies prior to ten years after their adoption may be included in the review as deemed appropriate by the Speakers and MSV Staff, and

WHEREAS, upon review, it is evident that some items in the Policy Compendium should be removed or revised based on their relevance or timeliness, therefore be it

RESOLVED, that the Medical Society of Virginia adopt the recommendations in the enclosed report.
15.006 - High Speed Police Pursuits
Date: 11/8/1997
The Medical Society of Virginia recognizes high speed pursuits as a public health issue. MSV recommends that the appropriate governmental agencies in Virginia implement policies concerning high speed chases and provide training in vehicular pursuit to appropriate personnel. MSV recommends that the State Medical Examiner’s office compile statistics on, and report to appropriate agencies, fatalities associated with high speed police pursuit.
Reaffirmed 10/28/2007
Recommendation: Reaffirm

35.001 - American Association of Medical Assistants
Date: 11/8/1997
The Medical Society of Virginia considers that the American Association of Medical Assistants (AAMA) is an important and worthwhile organization and urges physicians to support their medical assistants and encourage their membership in AAMA.
Reaffirmed 10/28/2007
Recommendation: Reaffirm

55.001 - Breast Cancer/Insurance Coverage of Screening Mammography
Date: 11/8/1997
The Medical Society of Virginia encourages third party payers and government to develop financial mechanisms for screening mammography through endorsements, selective procedure contracting, and other means.
Reaffirmed 10/28/2007
Recommendation: Reaffirm

85.004 - Physician Assisted Suicide and Euthanasia
Date: 11/8/1997
In dealing with the terminally ill, suffering patient, physicians may ethically:

1. Withdraw life-prolonging procedures or decline to initiate such treatment in situations in which a patient is terminally ill and has given informed consent for this to be done either personally or through an advance directive, or in instances in which the patient is unable to give such consent it is obtained from an authorized family member or a surrogate.

2. Prescribe medication to a patient even though the potential exists for inappropriate use by the patient that may result in death, provided the physician’s intent in prescribing such medication is not to cause death or to assist the patient in committing suicide.

3. In situations where the distinction between relieving suffering and causing a terminally ill patient’s death may be blurred, the physician should exercise his/her best medical judgment in caring for the patient.

4. Withhold or withdraw treatment from a terminally ill patient that the physician reasonably believes to be futile either in terms of promoting or improving the health of the patient or alleviating the patient’s suffering, provided the physician’s purpose in so doing is not actively to cause the patient’s death, but rather to allow death to occur with minimal suffering.
In accordance with the above statements (which are consistent with and supplemented by the views of the Council on Ethical and Judicial Affairs of the American Medical Association 2.17, 2.20 and 2.21), the Medical Society of Virginia strongly opposes the practice of physician assisted suicide or euthanasia.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

120.005 - Mailing of Controlled Drug Samples
Date: 11/8/1997

The Medical Society of Virginia condemns solicitations offering narcotic/analgesic chemical substances through the U.S. Postal Service without adequate safeguards and considers that such solicitation is unethical and should be illegal.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

120.006 - Physician Dispensing
Date: 11/8/1997

The Medical Society of Virginia supports physician dispensing of prepackaged drugs for a fee or charge when it is in the best interest of the patient.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

125.002 - Off Label Use of Drugs or Devices
Date: 11/8/1997

The Medical Society of Virginia opposes the practice by accident and sickness insurers and health care plans of denying coverage for any drug or device solely on the basis that the drug or device is used for a condition other than a use approved by the Food and Drug Administration.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

130.008 - Patient Choice of Hospital
Date: 11/8/1997

MSV supports that when medically practical, Emergency Medical Services agencies licensed by the Commonwealth of Virginia and their personnel engaging in the treatment and transport of patients to area hospitals, should honor patient, family or physician requests for specific hospital destinations.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

160.003 - Free Clinics
Date: 11/8/1997

The Medical Society of Virginia emphatically supports voluntarily staffed Free Clinics.

The Medical Society applauds physician involvement in the development of and participation in Free Clinics and encourages local component societies to publicize free clinic activities so that such services are recognized and utilized to their fullest capacity.
The Medical Society supports the existing civil immunity protections for volunteer health professionals and for the free clinics themselves.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

165.019 - Third Party Payer Retroactive Denials
Date: 11/8/1997
MSV opposes retroactive denials of previously authorized and paid physician claims by third-party payers.
Reaffirmed 10/28/2007
Recommendation: Reaffirm

180.007 - Low Cost Insurance Product
Date: 11/8/1997
The Medical Society of Virginia supports the concept of a low cost health insurance product and that efforts are continued in pursuing a low cost insurance product to be available for uninsured Virginians, low income workers, and small businesses.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

185.005 - Prostate Cancer Screening
Date: 11/8/1997
MSV supports insurance coverage for scientifically sound methods of screening for prostate cancer.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

270.011 - Virginia Birth-Related Neurological Injury Compensation Program
Date: 11/8/1997
The Medical Society of Virginia fully supports the Virginia Birth-Related Neurological Injury Compensation Fund and supports that notice describing the program and its benefits be given to all obstetric patients. The Medical Society of Virginia supports the statutory definition of “birth-related neurological injury” but is willing to consider any change of the program’s current definition based on its merit.

The Medical Society continues to monitor the actuarial soundness of the fund and supports the statutory reduction of assessments so long as the fund remains sound.

The Medical Society supports the establishment of a trust fund or other appropriate mechanism designed to ensure prudent investment of the fund’s resources for the benefit of the injured patient. The Medical Society opposes any attempt to redirect the funds from its intended purpose.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

275.009 - Plan Expulsion and Licensure Board Discipline
Date: 11/8/1997
MSV opposes the practice of physician expulsion from health benefit plans on the basis of licensure board disciplinary action without suspension or revocation of license, specifically censure or reprimand. MSV supports well-defined disciplinary categories that would accurately describe the nature of the
disciplinary action.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

**275.014 - Board of Medicine Sanctions**
Date: 11/8/1997

The Medical Society of Virginia opposes publication of a sanction recommendation until the entire appeal process has run its course.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

**330.006 - Medicare Private Contracting**
Date: 11/8/1997

MSV opposes the requirement that doctors who privately contract with Medicare patients must opt not to bill Medicare for treating Medicare patients for a two-year period.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

**345.004 - Mental Health Parity**
Date: 10/31/1998

The MSV supports the concept of insurance coverage parity for mental disorders and physical illness.

The Medical Society of Virginia, recognizing the importance of mental health treatment and adequate insurance coverage for the treatment of mental illnesses, supports legislation to require parity insurance and HMO coverage for the treatment of mental illnesses.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

**345.005 - Nondiscriminatory Reimbursement**
Date: 11/8/1997

The Medical Society of Virginia endorses a nondiscriminatory reimbursement policy in order to preserve adequate psychiatric care in the Commonwealth of Virginia.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

**390.003 - Payment for Physician Surgical Assistants**
Date: 11/8/1997

MSV opposes Medicare reduction of surgeons’ reimbursement when physician surgical assistants are used for complex surgical procedures.

Reaffirmed 10/28/2007
Recommendation: Reaffirm
435.003 - Expand Immunity Laws Covering Voluntary Physician Services
Date: 10/30/1993

The Medical Society of Virginia believes that appropriate state immunity statutes covering physician
services should be expanded to include physicians working in emergency medical service settings, hospitals, or other settings during disaster conditions.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

435.006 - Malpractice Review Panels
Date: 10/30/1993

The Medical Society of Virginia supports enactment of meaningful tort reform by amending the statute relating to medical malpractice review panels to require the full participation by all parties after the panel has been requested.

The Medical Society of Virginia supports the idea that the panel decision alone, and not evidence of testimony and deliberations of the panel, should be admissible at the trial of the negligence action.

The Medical Society of Virginia supports the establishment of a formal, post-panel settlement conference, with adverse financial consequences for the party not following the settlement conference recommendations and later receiving an adverse verdict at trial.

The Medical Society of Virginia supports legislation to restore the notice of claim language to the Code of Virginia relating to proceedings and panels.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

435.010 - Premium Discounts as Incentive for Panel Service
Date: 11/8/1997

The Medical Society of Virginia encourages malpractice companies to provide appropriate premium discounts to physicians who participate in medical malpractice review panels.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

435.012 - Statute of Limitations
Date: 11/8/1997

The Medical Society of Virginia supports a two-year statute of limitations without a discovery rule for medical malpractice.

Reaffirmed 10/28/2007
Recommendation: Reaffirm

435.013 - Strengthen Good Samaritan Laws
Date: 10/30/1993

The Medical Society of Virginia supports legislation requiring payment of court and attorney fees to a defendant who is named in a lawsuit and subsequently eliminated from the suit by application of the Virginia Good Samaritan Act.
Reaffirmed 10/28/2007  
Recommendation: Reaffirm

460.001 - Animal Research  
Date: 11/8/1997  
The Medical Society of Virginia supports the need for the use of animals in research.  
Reaffirmed 10/28/2007 
Recommendation: Reaffirm

470.001 - Ban on Boxing  
Date: 11/8/1997  
The Medical Society of Virginia supports legislation to ban boxing in the Commonwealth of Virginia.  
Reaffirmed 10/28/2007 
Recommendation: Reaffirm

505.009 - Smoking on School Property  
Date: 11/8/1997  
The Medical Society of Virginia urges state and local school boards to prohibit smoking and other forms of tobacco use on school property.  
Reaffirmed 10/28/2007 
Recommendation: Reaffirm

530.004 - Medical Student Society Reorganization  
Date: 11/8/1997  
The MSV is committed to the inclusion of medical students at all levels of the decision or policy making process affecting all physicians in the State. The MSV Medical Student Section will provide a forum within the MSV for the exchange of information among students and their more senior colleagues.  
Reaffirmed 10/28/2007 
Recommendation: Reaffirm

545.001 - Fall Meeting  
Date: 11/8/1997  
The annual meeting of the Medical Society shall continue to be held in the fall.  
Reaffirmed 10/28/2007 
Recommendation: Reaffirm

545.002 - First Year Delegates Instructional Meeting  
Date: 11/8/1997  
An annual instructional meeting with the first year delegates shall be conducted prior to the first session of the House of Delegates.  
Reaffirmed 10/28/2007 
Recommendation: Reaffirm
RECOMMENDATION: REAFFIRM AS AMENDED

10.004 - Small Personal Watercraft Regulation
Date: 11/8/1997

MSV encourages the enforcement of regulations regarding safe and responsible operation of personal watercraft. Operators and passengers should be educated about the dangers of intoxication with drugs or alcohol while engaged in motor vehicle or watercraft operation. MSV supports the enforcement of relevant regulations.

Reaffirmed 10/28/2007
Reaffirm as amended

15.010 - Physician Reporting to DMV; Immunity
Date: 11/8/1997

The Medical Society of Virginia supports legislation "to provide immunity for physicians who report to the Department of Motor Vehicles patients whose physical condition is not compatible with safe driving".

Reaffirmed 10/28/2007
Recommendation: Reaffirm as amended

35.004 - Legislation Mandating Medically Necessary Services by Allied Health Professions
Date: 11/8/1997

MSV will advocate that any legislative act in the Commonwealth which seeks mandated health insurance coverage for services provided by allied health professions must include provisions that will require that physicians determine "medical necessity" and that qualified physicians supervise allied health services to assure assessment and management are cost-effective and consistent with accepted medical standards.

Reaffirmed 10/28/2007
Reaffirm as amended

35.010 - Scope of Practice Position Statement
Date: 1/9/2001

Introduction

Allied health professionals have the luxury of being one issue organizations who can year in and year out diligently lobby the legislators until they get legislation through which will increase their scope of practice. Essentially they want to practice as a medical doctor, but it is a lot easier to get a M.D. by legislation rather than through a decade of education. Physicians must take the time to educate their legislators on the risk to patient safety and quality of care when non-medically trained individuals seek to treat and diagnose patients with medical conditions, particularly when they seek direct access. As a first step in the efforts to educate the legislators on these issues, it is important that we define and describe the roles and responsibilities of the physician as the leader of the collaborative health care team.

Quality of Care
The Medical Society of Virginia believes a patient care team offers the While we recognize that each member of the healing professions brings unique talents to bear on the care of patients, and while cost containment is an important aspect of the delivery of health care, we reaffirm that the delivery of the highest quality of care to patients in the Commonwealth is our first and major concern. To ensure quality of care, maximize continuity and coordination of care and to guarantee patients are diagnosed by or directed to the most appropriate provider of care, independent practice by allied health or mid-level health practitioners would fragment care and must be opposed. Using these providers in lieu of a physician is second-tier care. 

**Definition of Collaborative Practice**

Experience and the literature are clear that the best quality health care is delivered by health care teams that collaborate closely and share responsibilities according to their unique abilities and training. These teams are best led by physicians whose intensive and extensive education and ongoing rigorous regulation qualify them to oversee the many variables inherent in patient care. A collaborative practice is one where the health care providers work together in complimentary interdependent roles to provide the highest quality care for patients, families, and communities. (Definition from former head of the nurse practitioner program at the University of Virginia School of Nursing) Key elements in collaboration include conjoint problem solving, shared decision-making, task interdependency and shared documentation. 

**Appropriate Supervision and Oversight by the Physician**

Physicians should work closely with many mid-level providers and it is necessary that they should develop guidelines for these types of relationships. This is especially important to ensure each patient is seeing the most appropriate health care provider for their needs and that care can be coordinated effectively and delivered safely. Since mid-level providers and most allied health practitioners are responsible to different boards and unique sections of the Code of Virginia, there is a need to have guiding principles for physician supervision and interaction vis-à-vis each type of provider. Therefore, the Medical Society of Virginia accepts the following position statements on Guidelines for Physicians supervising mid-level and allied health providers:

1. The physician is ultimately responsible for coordinating and managing the care of patients, and with the appropriate input of mid-level and allied other health providers, ensuring the quality of health care provided to patients in all settings.
2. Health care services delivered by physicians and mid-level or allied health providers must be within the boundaries of each practitioner’s authorized scope of practice, as defined by state law.
3. The role of the mid-level and allied health providers in the delivery of care should be defined through mutually agreed upon collaborative guidelines, protocols and agreements that reflect the best available information for delivery of care.
4. The extent of involvement by mid-level and allied health providers in the assessment and implementation of treatment will depend on the complexity and acuity of the patient’s condition and the training, experience and preparation of the provider as adjudged by the physician and as outlined in the collaborative agreement.
5. The physician will strive to set the highest standards for the supervision of mid-level and allied health providers in all settings. The physician, when appropriate and in collaboration with allied health providers, should also delineate when collaboration is appropriate. Optimal supervision occurs while the patient is still available for observation. The continuum of supervision decreases as time passes. Physicians should not supervise providers with whose abilities they are not familiar.
6. The physician must be available for consultation with mid-level or allied health providers at all times, either in person or through telecommunication systems or reasonably available means.
7. Patients should be made clearly aware at all times whether they are being cared for by a physician or a mid-level or allied health provider.
8. The physician and mid-level or allied health provider together should review all delegated patient services on a regular basis, as well as the mutually agreed upon protocols or guidelines for practice.
9. The physician is responsible for clarifying and familiarizing the mid-level or allied health provider with his/her supervising methods and means of delegating patient care.
10. The physician has a responsibility to provide the best health care in the most cost effective and convenient way possible as long as quality of care is not compromised.

11. Both the physician and the mid-level and allied health providers will be responsible for continuing education and utilization of advanced information and technology resources.

12. Direct reimbursement should not be permitted if it will interfere with collaboration/integration or the direct supervision of the healing arts practitioner's activities by a physician. The patient care team should determine how to accept reimbursement for patient care; such methods should support the collaborative work by the patient care team.

13. The Department of Health Professions and the Board of Medicine are the appropriate governmental bodies to be charged with carefully studying and making recommendations regarding issues of licensure.

**Interactions with Specialty Societies**

The development of supervisory guidelines, protocols, and collaborative agreements must be accomplished with input and guidance from the appropriate specialty societies. The Medical Society of Virginia will work collaboratively with physician specialty societies on scope of practice matters to achieve the best outcomes for patients in the Commonwealth.

Reaffirmed 10/28/2007

*Reaffirm as amended*

**155.001 - Truth in Virginia Health Care Database**

Date: 11/8/1997

MSV opposes the collection of charge data as a substitute for cost data and endorses legislation to support the collection of meaningful cost data.

Reaffirmed 10/28/2007

*Reaffirm as amended*

**165.011 - Physician Re-Credentialing by Managed Care Plans**

Date: 11/8/1997

MSV supports physicians maintaining their status with all health plans, including managed care plans, and believes that when physicians change in a practice location or practice arrangement, their status with all managed care plans should remain unchanged; and that there be no need should not prompt for re-selection or renewal of the credentialing process for those physicians when such changes occur.

Reaffirmed 10/28/2007

*Recommendation: Reaffirm as amended*

**180.003 - Billing for Medically Unnecessary Uncovered Care**

Date: 11/8/1997

MSV supports legislation or regulation to require that all third-party payers allowing physicians to bill patients for care deemed by the plan to be "non-covered" or "medically unnecessary" if the patient agrees in advance to bear financial responsibility for the services.

Reaffirmed 10/28/2007

*Recommendation: Reaffirm as amended*
The Medical Society of Virginia supports good faith negotiations on these third party payer fair business practices with the appropriate health plans or state organizations. Should negotiations not achieve satisfactory results, the Medical Society of Virginia shall seek appropriate regulatory or legislative action. The President of the Medical Society of Virginia shall establish an ad hoc committee to guide and monitor the accomplishment of this policy and to study the following additional issues:

A. The need for insurers to file a medical impact statement prior to amending policies that govern access and treatment to medical care, and

B. The substance and structure of such a statement, if sufficient need exists, to warrant a medical impact statement, and

C. The need for a statute of limitations for retroactive refunds by insurers, and

D. The need for assurance that there will be no retaliation against physicians or groups who do not accept certain contracts offered by insurers, and

E. Determine if precertification processes used by many insurers is detrimental to medical care and treatment.

The Medical Society of Virginia believes supports the that these managed care following fair business practices should include but not be limited to:

I. Payment issues:
   A. Establish a statutory definition of a clean claim,
   B. Place a time limit for full payment of clean claims,
   C. Disclose to the contracted practice the processing procedure for claims approval,
   D. Prohibit the arbitrary bundling of unbundled claims,
   E. Prohibit automatic or arbitrary downcoding of claims and request the review of such acts by the Virginia Commissioner of Insurance,
   F. Prohibit the garnishment of payment on Explanation of Benefits (EOB),
   G. Limit the time for retroactive denial of payments when requesting a refund from a physician after the time the service was provided,
   H. Publish the contracted prices to be paid for claims 3 months prior to their effective date, and,
   I. Publish the contracted adjudication guidelines three months in advance of their effective date.
   J. Prohibit health plans from fining physicians or denying/withholding payment in instances of patient non-compliance with health plan referral requirements.

II. Contract Issues:
   A. Require a reasonable time limit for physicians to receive certification in order to be paid by the plan, or require the plan to pay for the services while waiting for certification,
   B. Prohibit the "Most Favored Nation" clause from contracts, and,
   C. Prohibit retaliation against physicians or groups who do not accept certain contracts offered by insurers.
III. Physician Due Process:
A. Require a reasonable time limit to receive a precertification authorization for treatment,
B. Provide physicians access to their profiling data, and,
C. Provide procedural due process to physicians expelled from a health plan to include adequate notification of removal, explanation of the reasons for the removal, and the ability to contest the proposed removal through an external appeals process.

IV. Patient Issues:
A. Require that precertification by telephone be toll free for physicians and patients,
B. Require a managed care organization (MCO), insurer, health plan, dental plan, or pharmacy benefits manager using a formulary to disclose to its subscribers members and participating physicians their initial formulary and annually thereafter initially, the frequency of formulary changes and at least annually its formulary and a description of the process for developing the formulary and evaluating new therapies,
C. Require any carrier using a restrictive formulary for prescription medications to allow patients to obtain, without penalty to the physician and the patient and in a timely manner, specific drugs and medications not included in the formulary when the formulary’s equivalent has been clinically ineffective or when the physician treating the patient believes the formulary’s medication causes, or is reasonably expected to cause adverse or harmful reactions in the patient,
D. Eliminate the necessity for approval or referral from the primary care physician in order for patients to be covered for after-hours urgent care or emergency service in accordance with the prudent layperson statute,
E. Require MCOs to educate their members on after-hours medical care that their physicians are available after hours for medical advice, but that the decision for payment for after-hours urgent care or emergency service is made by the MCO, based on criteria of medical necessity in accordance with state and federal law,
F. Require insurance companies to log in appeals at the time of their receipt,
G. That MCOs health plans not encourage short-term mail order prescriptions and not financially penalize those who have prescriptions filled locally,
H. Create an objective and timely process for considering the authorization of investigational treatments and for evaluating coverage of innovative technologies, drugs, devices, and procedures.

The Medical Society of Virginia believes that any third-party payer should not interfere in the physician patient-relationship and will strongly oppose any business practices that may compromise the care of patients.

Reaffirmed 10/28/2007
Recommendation: Reaffirm as amended

285.003 – Capitation

Date: 11/8/1997

A. The Medical Society should not seek to legislatively eliminate capitation as mechanism of payer reimbursement to physicians since it represents only one type of reimbursement among a variety of mechanisms, of which Fee for Service is another. Such action might invite an attempt to legislatively outlaw fee for service reimbursement for similar reasons. Also, to do away with capitation as health insurance option could be considered to be in opposition to the long standing AMA policy of pluralism in a patient’s right to choice. The Medical Society of Virginia supports strong physician involvement and
regulatory oversight of health plans using capitation as the basis for reimbursement. Capitated plans must:

B. To empower and protect the physician to advocate for the patient within the capitation system of reimbursement, the following qualities should be sought through legislation and regulation:

- Allow physicians to have participation in and final say in determining and participating in capitation plans, quality management improvement programs, and guidelines.
- Adequately reimburse physicians appropriately to ensure providers are able to absorb risk and provide appropriate patient care.

MSV supports strong and continued evaluation of capitated health plans by the State Health Commissioner and Insurance Commissioner and suggests:

- Requiring the plan to disclose to the employee/plan member of the capitation plan the exposure to the incentive risks and insurance risks imposed upon the physician.
- The State Health Commissioner and Insurance Commissioner must robustly evaluate the capitation plan to declare the covered benefits in the plan, the quality management system improvement program, and the actuarially determined funding of the plan are appropriate and adequate to provide a level of care to the plan members as meeting State standards.
- Requiring all licensed capitation plans licensed to operate in the State to provide adequate ‘stop loss’ insurance to empower and protect the physician to give the member medical care that meets Health Commissioner standards, provide appropriate and necessary medical care to their patients.

Reaffirmed 10/28/2007
Recommendation: Reaffirm as amended

480.001 - State Funding for Electronic Health Information Systems
Date: 11/8/1997
MSV actively supports and endorses continued a state funding of electronic health information systems that improve access and communication of health information for physicians with protection of patient confidentiality. Physicians should not be required to pay for the ability to use such electronic health information exchange or system.

Reaffirmed 10/28/2007
Recommendation: Reaffirm as amended

RECOMMENDATION: AMENDED BY SUBSTITUTION

- Secondhand Smoke (Substitution)

The Medical Society of Virginia supports access to clean smoke-free air for all citizens in the Commonwealth, especially children.

The Society supports efforts to eliminate tobacco smoke in public places and places of employment in order to protect Virginians from the hazards of passive smoke inhalation. Further, MSV supports efforts to make it illegal to smoke in a car with a minor present.

MSV opposes efforts to repeal protections for the public from secondhand smoke.
Recommendation: Amend 505.004 by substitution and archive policies 505.001, 505.005 and 60.016 as the principles are now included in the substitution.

505.004 - Public Indoor Spaces; Passive Smoke Inhalation
Date: 11/11/1989
The Medical Society of Virginia specifically supports legislative efforts to eliminate tobacco smoke in public places and places of employment in order to protect Virginians from the hazards of passive smoke inhalation.
Reaffirmed 10/28/2007

505.001 - Legislation Restricting Tobacco Use/Indoors
Date: 11/9/1991
The Medical Society of Virginia supports the Virginia Indoor Clean Air Act.
Reaffirmed 10/24/2010

505.005 - Repeal of Local Ordinances
Date: 11/11/1989
The Medical Society of Virginia opposes any legislation designed to force repeal of any ordinances already in place to protect the public from secondhand smoke.
Reaffirmed 10/24/2010

60.016 - Tobacco and Child Health in the Commonwealth
Date: 10/30/1993
The Medical Society of Virginia, acting in defense of all citizens and children, and in an effort to prevent ill health, supports legislation to maintain and strengthen the Virginia Clean Indoor Air Law enabling citizens and children of the Commonwealth to have clean indoor air in all public places and in private business where nonsmokers work or may frequent.
Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

➢ **Reimbursement for Emergent Medical Care (Substitution)**

The Medical Society of Virginia opposes any health plan requirements, including managed care plans that may cause a delay in care, such as pre-authorization, for emergent medical services.

Further, MSV opposes the denial of provider reimbursement for these services under any circumstances.

Recommendation: Amend 185.004 by substitution and archive policy 130.005, as well as 230.001 as the principles are now included in the substitution.

185.004 - Insurance Denial of Reimbursement for Failure to Notify Primary Care Physician for Emergency Room Admissions
Date: 11/8/1997
MSV supports legislation prohibiting the practice of denial of provider reimbursement secondary to nonnotification of the managed care organization’s primary care physician or gatekeeper prior to the "on call" physician assuming care of the seriously ill patient.
MSV endorses the following principles:
a) Patients should not be required to receive preauthorization from a health plan prior to receiving emergency services;
b) Health plans should be required to educate their enrollees about coverage for emergency services, including the location of participating emergency departments, the appropriate use of 911, costsharing provisions for emergency services, and the processes and procedures for obtaining emergency care;
c) Health plans should be required to cover emergency services provided to patients who meet the “prudent layperson” standard under Virginia law.

Reaffirmed 10/28/2007

130.005 - Emergency Physician/Managed Care Interface
Date: 11/8/1997
MSV endorses the following principles:
  o patients should not be required to receive preauthorization from a health plan prior to receiving emergency services;
  o health plans should be required to educate their enrollees about coverage for emergency services, including the location of participating emergency departments, the appropriate use of 911, costsharing provisions for emergency services, and the processes and procedures for obtaining emergency care;
  o Health plans should be required to cover emergency services provided to patients who meet the “prudent layperson” standard under Virginia law.

Reaffirmed 10/28/2007

230.001 - Acute Emergent Medical/Surgical Service Pre-Authorization
Date: 10/30/1999
The Medical Society of Virginia supports legislation making preauthorization of acute emergent medical and/or surgical services by insurance plans unnecessary in determining reimbursement for hospitals and physicians.
Reaffirmed 10/25/2009

➢ Medical Necessity Criteria (Substitution)

The Medical Society of Virginia supports requiring any person who defines medical necessity criteria, evaluates the medical necessity of physicians’ care of patients, or who have authority to issue denials of treatment or services for a health plan operating in Virginia, be licensed to practice medicine in the Commonwealth of Virginia and Board certified in the appropriate specialty when applicable.

Recommendation: Amend 275.006 and archive policy 320.001, as well as 275.004 as the principles are now included in the substitution.

275.006 - Medical Decision Making
Date: 11/8/1997
MSV supports legislation that would require a Virginia medical license to be held by individuals who determine “medical necessity” for reimbursement on behalf of health plans.
Reaffirmed 10/28/2007
320.001 - Medical Necessity/Practice of Medicine
Date: 11/9/1991
The Medical Society of Virginia shall use its best efforts by all means possible, including legislation if necessary, to require persons who render opinions about the medical necessity of physicians' care of patients or who have authority to issue preauthorization denials of treatment be licensed to practice medicine in the Commonwealth of Virginia and Board certified in the appropriate specialty when applicable.
Reaffirmed 11/4/2001
Reaffirmed 10/26/2014

275.004 - Licensure of Managed Care Decision Makers
Date: 10/31/1998
The Medical Society of Virginia supports legislative efforts to require that managed care treatment decision makers, whether in or out of state, be required to hold a valid Virginia license for their particular discipline.
Reaffirmed 10/12/2008

- Health Plan Liability (Substitution)

The Medical Society of Virginia supports holding Virginia health insurance plan, including managed care plan, liable for damages for harm to a patient caused by the health care treatment decisions made by its employees.

Further, the MSV supports holding physicians harmless who, following pursuit of available appeals procedures, are unable to provide care they deem medically appropriate because of a health plan’s determination of coverage.

Recommendation: Amend 165.007 by substitution and archive policy 320.002 as the principles are now included in the substitution.

165.007 - Insurance Company Liability
Date: 11/8/1997
MSV will support legislation or regulation which would mandate that Virginia health insurance companies, HMOs or other managed care entities be held liable for damages for harm to an insured or enrollee caused by the health care treatment decisions made by its employees, agents, ostensible agents or representatives acting on its behalf.
Reaffirmed 10/28/2007

320.002 - Review Agents/Hold Harmless
Date: 11/9/1991
The Medical Society of Virginia shall pursue legislation which would require entities that conduct utilization review to hold harmless physicians who, following pursuit of available appeals procedures, adhere to an entity's final determination denying coverage of a recommended treatment on the basis that it is medically unnecessary or inappropriate.
Reaffirmed 11/4/2001
Reaffirmed 10/26/2014

- Medical Education Funding (Substitution)
The Medical Society of Virginia recognizes the importance of academic medical centers and high-quality medical education in the Commonwealth and across the nation.

Academic medical centers are essential to train high-quality health care professionals and to conduct medical research necessary for quality health care.

Virginia’s academic medical centers are integral to meeting the current and future needs of all the citizens of the Commonwealth. As such, the Society supports appropriate state and federal funding for undergraduate and graduate medical education, and research that enables Virginia’s academic medical centers to meet these needs.

Recommendation: Amend 305.006 by substitution and archive policies 215.001 and 305.003 as the principles are now included in the substitution.

305.006 - State Support of Medical Education
Date: 11/8/1997
MSV will pursue its advocacy goals for medical education in the context of the overall future needs of all the citizens of the Commonwealth.
Reaffirmed 10/28/2007

215.001 - Academic Medical Centers
Date: 11/5/1994
The MSV recognizes the importance of academic medical centers and supports measures to protect the integrity of quality medical education.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

305.003 - Medical Education Funding and Support of Academic Centers
Date: 11/4/1995
The Medical Society of Virginia believes quality academic medical centers are essential for well-trained health care professionals and medical research necessary for quality health care. Continuation of Virginia’s teaching centers must be a collaborative effort and it is the Commonwealth of Virginia’s responsibility to generate more appropriate state funding to support graduate and undergraduate medical education.
Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

➢ Do Not Resuscitate Orders (Substitution)

The Medical Society of Virginia recommends that every hospital and medical staff have a written policy consistent with the Virginia Healthcare Decisions Act regarding “No Code/Do Not Resuscitate (DNR)” orders, also referred to as “Allow Natural Death” orders, which uses the following guidelines:

a. That the attending physician take measures to ensure that both the decision and the reasons for No Code/DNR are clearly communicated to those who have vital need to know.

b. That the attending physician and hospital staffs familiarize themselves with the requirements of the Virginia Healthcare Decisions Act and the significance of the Living Will so as to be able to take advantage of the immunity from liability it provides in connection with the writing of "No Code/DNR" orders.
MSV supports the applicability of Emergency Medical Services Do Not Resuscitate orders to minors with documented "terminally ill" or "incompatible with extended life" conditions when properly executed by the parents and/or legal guardians and the attending physician.

Recommendation: Amend 130.003 by substitution and archive policy 130.002 as the principles are now included in the substitution.

130.003 - Do Not Resuscitate Orders - Minors
Date: 11/8/1997
MSV supports the applicability of Emergency Medical Services Do Not Resuscitate orders to minors with documented "terminally ill" or "incompatible with extended life" conditions when properly executed by the parents and/or legal guardians and the attending physician.
Reaffirmed 10/28/2007

130.002 - Do Not Resuscitate Orders - Hospital Policies
Date: 10/31/1998
The Medical Society of Virginia recommends that every hospital and medical staff have a written policy consistent with the Virginia Healthcare Decisions Act regarding "No Code/Do Not Resuscitate (DNR)" orders, also referred to as "Allow Natural Death" orders, which uses the following guidelines:

a. That the attending physician take measures to ensure that any No Code/DNR decision is in the best overall interest of the patient and that both the decision and the reasons for it are clearly communicated to those who have vital need to know.
b. That the attending physician and hospital staffs familiarize themselves with the requirements of the Virginia Healthcare Decisions Act and the significance of the Living Will so as to be able to take advantage of the immunity from liability it provides in connection with the writing of "No Code/DNR" orders.
Reaffirmed 10/24/2010

➤ Child Firearm Injury Prevention (Substitution)

The Medical Society of Virginia supports public education programs to reduce injuries to children from firearms as well as the dangers and legal liabilities of recklessly leaving loaded, unsecured firearms accessible to children.

Further, the Society will MSV will cooperate and collaborate with interested advocacy groups regarding child firearm injury prevention.

The Medical Society of Virginia supports requiring safety devices to be sold with each gun sold in Virginia, either at a regulated gun store or through other means such as gun shows.

Recommendation: Amend 60.010 by substitution and archive policy 60.007 and policy 145.001 as the principles are now included in the substitution.

60.010 - Preventive Measures for Firearm Injuries to Children
Date: 11/8/1997
MSV will cooperate and collaborate with interested advocacy groups regarding the dangers and legal liabilities of recklessly leaving loaded, unsecured firearms accessible to children.
Reaffirmed 10/28/2007

60.007 - Firearms
Date: 11/3/1990
The Medical Society of Virginia supports education programs to reduce injuries to children from firearms.
Reaffirmed 11/2/2012

145.001 - Children and Gun Safety
Date: 10/30/1999
The Medical Society of Virginia supports legislation to require safety devices to be sold with each gun sold in Virginia, either at a regulated gun store or through other means such as gun shows. Further, the MSV continues to support Medical Society of Virginia Alliance and other public education gun safety programs.
Reaffirmed 10/24/2010
Reaffirmed 10/26/2014

 Infant and Child Death Investigation (Substitution)
The Medical Society of Virginia endorses the position of the American Academy of Pediatrics and urges all attending physicians to obtain autopsies on all suspected cases of Sudden Infant Death Syndrome.
Further, the MSV supports making an inquiry to the Central Registry of the Department of Social Services for child deaths under age seven. MSV supports referral to the police and the district medical examiner when an inquiry reveals confirmed or suspected child abuse.

Recommendation: Amend 245.001 by substitution and archive 60.004 and 245.002 as the principles are now included in the substitution.

245.001 - Autopsies
Date: 11/8/1997
The Medical Society of Virginia endorses the position of the American Academy of Pediatrics and urges all attending physicians to obtain autopsies on all suspected cases of Sudden Infant Death Syndrome.
Reaffirmed 10/28/2007

60.004 - Child Death Investigation
Date: 10/31/1992
The Medical Society of Virginia supports legislation to provide a mechanism by which an inquiry into the Central Registry of the Department of Social Services is made of all child deaths under age seven; and be it further
The Medical Society of Virginia supports referral to the police and the district medical examiner to determine if further investigation is needed if an inquiry to the Central Registry of the Department of Social Services reveals that the child or caretaker was involved in a prior founded or reason to suspect case of child abuse.
Reaffirmed 11/2/2012

245.002 - Diagnosis and Autopsies of Sudden and Unexpected Deaths
Date: 10/31/1992
The Medical Society of Virginia actively supports legislation requiring that the diagnosis of Sudden Infant Death Syndrome shall not be made until other causes are excluded by a thorough postmortem exam.
The Medical Society of Virginia actively supports legislation which requires that autopsies be performed in all sudden and unexpected deaths in infants less than one year of age.
Reaffirmed 11/2/2012
**In-School Health Services**

The Medical Society of Virginia supports requiring that every school division in the Commonwealth of Virginia employ or contract through the Health Department for registered nurses, at an appropriate staffing level, meeting or exceeding the U.S. Department of Health and Human Services' recommendations for nurse-to-student ratios, and that every school division in the Commonwealth of Virginia be required to have a formal relationship with a specific physician for supervision of school nursing services and for arranging specialty consultation as necessary.

Recommendation: Amend 60.012 by substitution and archive policy 60.009 as the principles are now included in the substitution.

60.012 - School Nurse Shortage  
Date: 11/8/1997  
MSV supports the U.S. Department of Health and Human Services' recommendations for nurse-to-student ratios and encourages every system in the Commonwealth to meet or exceed these recommendations.  
Reaffirmed 10/28/2007

60.009 - In-School Health Services  
Date: 10/31/1992  
The Medical Society of Virginia supports legislation requiring that every school division in the Commonwealth of Virginia employ or contract through the Health Department for registered nurses, at an appropriate staffing level and that every school division in the Commonwealth of Virginia be required to have a formal relationship with a specific physician for supervision of school nursing services and for arranging specialty consultation as necessary.  
Reaffirmed 11/2/2012

**Health Education in Schools (Substitution)**

The Medical Society of Virginia supports comprehensive clinical evidence-based health education in Virginia.

Recommendation: Amend 170.001 by substitution and archive 170.002, 170.003 and 440.012 as the principles are now included in the substitution.

170.001 - Addition of Testicular Cancer Education to the High School Health Class Curriculum  
Date: 11/8/1997  
MSV recommends that information be included in high school health class curriculum about the importance of the male self-testicular exam, including its presentation, epidemiology, and the technique.  
MSV will promote development of a curriculum on testicular cancer with physician and appropriate special society input to support and encourage the Department of Education to include it in the Standards of Learning for Health Classes  
Reaffirmed 10/28/2007
170.002 - Comprehensive Health Education  
Date: 11/3/1990  
The Medical Society of Virginia supports the concept of comprehensive health education programs.  
Reaffirmed 11/2/2012

170.003 - Family Life Education  
Date: 11/8/1997  
MSV supports the inclusion of Family Life Education in the state mandated curriculum for public schools in Virginia.  
Reaffirmed 10/28/2007

440.012 - Information and Education  
Date: 11/4/1995  
The Medical Society of Virginia supports teaching prevention and control of sexually transmitted diseases in public, private and parochial schools.  
Reaffirmed 11/06/2005  
Reaffirmed 10/25/2015

RECOMMENDATION: ARCHIVE

120.002 - Expiration Dates on Prescription Drugs  
Date: 11/8/1997  
The Medical Society of Virginia supports legislation to require all prescription labels to include the expiration date of the medication dispensed.  
Reaffirmed 10/28/2007  
Recommendation: Archive

Reason to archive: FDA regulation 211.137 requires expiration dates

120.004 - Guidelines for the Practicing Physician for the Treatment of Chronic, Non Cancer Pain  
Date: 11/8/1997  
MSV will maintain Guidelines for the Practicing Physician for the Treatment of Chronic, Non-Cancer Pain. Guidelines will be made available upon request from MSV headquarters.  
Reaffirmed 10/28/2007  
Recommendation: Archive

Reason to archive: Guidelines are maintained on the WEB, required printed guidelines is obsolete

290.002 – Communications  
Date: 11/8/1997  
The Medical Society of Virginia shall assist in mechanisms of communication and instruction between the Virginia Department of Medical Assistance Services and participating physicians, to promote efficient provision of and uniform standards for the delivery of quality and cost effective medical care.
Reaffirmed 10/28/2007
Recommendation: Archive

Reason to archive: This is already a routine business practice of MSV.

435.011 - Standard of Care
Date: 11/8/1997

The Medical Society of Virginia opposes the admission into evidence of practice parameters. It also opposes a national standard of care as Virginia’s standard of care. Furthermore, the Medical Society should seek improvements to Virginia’s definition of an expert witness.

Reaffirmed 10/28/2007
Recommendation: Archive

Reason to archive: Recommended by MSV legal counsel to align with current law

440.015 - Mandatory Reporting of E. Coli Foodborne Illnesses to State Health Department
Date: 11/8/1997

MSV supports the requirement that all cases of food borne Shiga-like toxin positive E. Coli-associated illness be reported to the State Health Department on a mandatory basis.

Reaffirmed 10/28/2007
Recommendation: Archive

Reason to archive: Current Virginia law requires E. Coli Shiga toxin to be reported to the Virginia Department of Health.
MSV POLICY COMPENDIUM UPDATES

Dr. Arthur Vayer Jr., Speaker
Dr. Alan Wynn, Vice-Speaker

WHEREAS, the Medical Society of Virginia Policy Compendium is an important resource for MSV leadership, MSV members, and MSV staff as it guides action and position on issues of importance, and

WHEREAS, consideration by the House of Delegates to add, amend or archive additional policies prior to ten years after their adoption may be included in the review as deemed appropriate by the Speakers and MSV Staff, and

WHEREAS, upon additional review, it is evident that some items in the Policy Compendium should be removed or revised based on their relevance or timeliness and the organizational structure be updated, therefore be it

RESOLVED, that the Medical Society of Virginia adopt the recommendations in the enclosed report.
RECOMMENDATION: REAFFIRM AS AMENDED

60.001 - Addiction of Children Addiction in Children
Date: 11/11/1989
The Medical Society of Virginia supports measures to prevent the addiction of in children in the Commonwealth and in the Nation through the resources at its command.
Reaffirmed 10/25/2009

Recommendation: Reaffirm as amended

185.002 - Coverage of Medical Formulas and Foods for Medicaid Patients Suffering from PKU
Date: 11/4/2002
The Medical Society of Virginia supports legislation to mandate Medicaid coverage of PHE-restricted diets for PKU patients over 18 years of age.
Reaffirmed 11/2/2012

Recommendation: Reaffirm as amended

180.006 - Insurance Market Reform
Date: 10/30/1993
The Medical Society of Virginia supports administrative or legislative action to requiring that the actual discount on each hospital claim and the amount actually paid to the hospital for an insurance claim be made available to both the plan member and, in the case of employer-sponsored insurance, the plan member’s employer and employee.
Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

Recommendation: Reaffirm as amended

180.013 - Requests for Patient Information
Date: 5/31/2014
The Medical Society of Virginia supports the American Medical Association’s efforts to address the issue opposes of insurance companies’ unrestricted gathering of patient information and will continue to monitor this practice.

Recommendation: Reaffirm as amended

190.001 - Timely Insurance Claims Payment
Date: 11/4/1995
The Medical Society of Virginia supports legislation requiring managed care organizations the timely payment of claims and supports efforts to require all health plans to pay interest on claims unpaid thirty days after submission.
Reaffirmed 11/06/2005
Reaffirmed 10/25/2015

Recommendation: Reaffirm as amended
230.006 - Physician Hospital Admitting Privileges and Managed Care Organizations Plan Participation
Date: 10/30/1999
The Medical Society of Virginia supports legislation that prevents insurance companies from terminating or accepting physicians based on the hospital at which they have admitting privileges.
Reaffirmed 10/25/2009

Recommendation: Reaffirm as amended

285.010 - Removal of Physicians from Insurance Plans "Without Cause"
Date: 10/30/1993
The Medical Society of Virginia supports legislation to forbid the practice of insurance companies to remove physicians from their plans "without cause."
Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

Recommendation: Reaffirm as amended

245.006 - One Web Portal for Newborn Reports State Databases
Date: 1/16/2012
The Medical Society of Virginia supports legislation to link integrating all state-based reporting systems for newborn hearing and blood spot screenings with the Virginia Immunization Information System (VIIS), Electronic Death Registry System, and Prescription Monitoring Program, in a physician’s EMR system or a single-sign on based web-based portal.

Recommendation: Reaffirm as amended
RECOMMENDATION: AMEND BY SUBSTITUTION

- Care of Patients with HIV/AIDS (Substitution)

The Medical Society of Virginia supports the Centers for Disease Control Guidelines for HIV Counseling, Screening, Testing, Prevention, Care, Reporting, and Surveillance.

Recommendation: Amend 20.001 by substitution and archive 20.002 through 20.016 as the principles are now included in the substitution.

20.001 - Care of HIV/AIDS Patients; Autopsies
Date: 11/9/1991
The Medical Society of Virginia supports the position that while any physician has the right to refuse to accept responsibility for the medical care of any given patient, refusal to do so solely because the patient may have AIDS, or is HIV positive, does not constitute ethical behavior. The MSV also believes that hospitals have a moral obligation to accept such patients for care including the performance of autopsies, if requested.
Reaffirmed 10/30/2011

20.002 - CDC Guidelines for Health Care Workers
Date: 11/8/1997
The MSV supports the safety measures and guidelines endorsed by the Center for Disease Control, the AMA, the American Hospital Association, and the Surgeon General for all health care workers coming into contact with potentially HIV infected patients.
Reaffirmed 10/28/2007

20.016

20.003 - Comprehensive Plan/Pediatric AIDS
Date: 11/3/1990
The Society shall support the Virginia Department of Health’s Division of Disease Prevention in their provision of an HIV management plan which places appropriate emphasis upon pediatric AIDS and HIV infected patients and which includes prevention, care, treatment, and reimbursement with respect to HIV and AIDS patients.
Reaffirmed 11/2/2012

20.004 - Control of the Spread of AIDS
Date: 10/31/1992
The Medical Society of Virginia continues to support the use of public health measures in dealing with AIDS that have served us well in the past with regard to other communicable diseases, such as surveillance, detection, tracing of sources, education and research, and that it continue to support providing increased resources to the Virginia Department of Health to allow expanded use of these measures, until HIV/AIDS inevitably takes its place on the list of controlled or eradicated diseases.
Reaffirmed 11/2/2012

20.005 - Education Regarding High Risk Behavior
Date: 11/8/1997
The Medical Society of Virginia encourages all health care professionals to teach their patients, whether in high risk groups or not, and the public at large to avoid the high risk activities associated with acquisition of HIV infection, especially indiscriminate or anonymous sexual contact or sharing the use of needles contaminated with another’s blood.
Reaffirmed 10/28/2007
20.006 - Ethical Obligation; Counseling
Date: 11/8/1997
The Medical Society of Virginia encourages all health care professionals to recognize their ethical obligation to care for patients with HIV infection and to provide or arrange for the counseling of such patients as means to avoid transmission of their infection to other individuals.
Reaffirmed 10/28/2007

20.007 - Family Treatment of HIV/AIDS
Date: 11/9/1991
The Medical Society of Virginia supports the concept of coordinated care within the family with respect to the management and treatment of individuals with HIV infection and AIDS.
Reaffirmed 10/30/2011

20.008 - Funding for Testing and Counseling
Date: 11/8/1997
The Medical Society of Virginia supports the efforts of the Department of Health to obtain appropriate funding for testing and counseling and tracking in connection with HIV infection.
Reaffirmed 10/28/2007

20.009 - HIV Prevention through Clean Syringe Availability
Date: 11/8/1997
MSV, as part of its efforts to prevent the spread of HIV, hepatitis and other blood borne diseases in Virginia, supports legislation in the General Assembly: (a) to modify drug paraphernalia laws so that adult injection drug users may legally possess syringes and needles and (b) to establish syringe-exchange programs for adult injection drug users.
Reaffirmed 10/28/2007

20.010 - Involvement of Component Societies
Date: 11/3/1990
The Medical Society of Virginia urges continued participation of local component societies and physicians in the care and management of HIV and AIDS patients in their local communities.
Reaffirmed 11/2/2012

20.011 - Marriage Licenses
Date: 11/3/1990
The Society opposes routine HIV antibody testing in conjunction with the issuance of marriage licenses.
Reaffirmed 11/2/2012

20.012 - Prisons
Date: 11/3/1990
The Society endorses HIV antibody testing in prisons only when ordered by a physician on a case by case basis.
Reaffirmed 11/2/2012

20.013 - Testing of Health Care Workers
Date: 11/9/1991
The Medical Society of Virginia endorses the continuing efforts of the CDC and the AMA in developing guidelines with respect to testing of health care workers for HIV infection.
Reaffirmed 10/30/2011

20.015 - Voluntary Testing for Pregnant Women
Date: 11/8/1997
The Medical Society of Virginia recommends that physicians offer routine HIV testing to all pregnant women and women of childbearing age in the State of Virginia, and that physicians performing such testing do so only with the informed consent of their patients.
The Medical Society of Virginia recommends that physicians provide to pregnant women and women of childbearing age who undergo an HIV test appropriate retesting, education, counseling and follow-up, as needed. 
Reaffirmed 10/28/2007

20.016 - CDC Guidelines for HIV Counseling, Testing, and Referral 
Date: 11/2/2012 
The Medical Society of Virginia supports the Centers for Disease Control Revised Guidelines for HIV Counseling, Testing, and Referral, section on Targeted versus Routinely Recommended HIV Counseling, Testing and Referral (CTR). MSV specifically supports the following statements:

Determining Individual HIV Risk Through Risk Screening: A client's individual HIV risk can be determined through risk screening based on self-reported behavioral risk and clinical signs or symptoms. Behavioral risks include injection-drug use or unprotected intercourse with a person at increased risk for HIV. Clinical signs and symptoms include STDs, which indicate increased risk for HIV infection, or other signs or symptoms (e.g., of acute retroviral or opportunistic infections), which might suggest the presence of HIV infection. Insufficient data exist to support the efficacy of any one risk-screening approach over others (e.g., face-to-face discussion or interviews, self-administered questionnaires, computer-assisted interviews, or simple open-ended questions asked by providers)

Recommendations for Routinely Recommended and Targeted CTR by Setting and Circumstance: Decisions regarding whether to recommend routine or targeted services are based on the behavioral and clinical HIV risk of the client population in the setting, the level of HIV prevalence of the setting, and the behavioral and clinical HIV risk of individual clients. These factors should not be used to determine recommendations for CTR in circumstances in which treatment potential exists (i.e., perinatal transmission and acute occupational or nonoccupational exposure). These guidelines may be found here.

➢ Allied Mental Health Provider Prescription Authority (Substitution)

The Medical Society of Virginia opposes any efforts by psychologists, social workers, licensed professional counselors, and pastoral counselors to obtain prescription privileges.

Recommendation: Amend 35.006 by substitution and archive 345.006 and 120.007 as the principles are now included in the substitution.

35.006 - Psychologists’ Prescriptive Authority 
Date: 11/4/2001 
The Medical Society of Virginia opposes legislation allowing psychologists to prescribe medications. 
Reaffirmed 10/30/201

345.006 - Non-Psychiatrist Prescribing Medicines 
Date: 11/5/1994 
The MSV opposes the independent prescribing of medications by non-physician psychologists. 
Reaffirmed 11/7/2004 
Reaffirmed 10/26/2014

120.007 - Prescriptive Authority 
Date: 10/31/1998
The Medical Society of Virginia opposes any efforts by psychologists, social workers, licensed professional counselors and pastoral counselors to obtain prescription privileges.
Reaffirmed 10/12/2008

➢ **Child Car Safety (Substitution)**

The Medical Society of Virginia supports the American Academy of Pediatrics’ recommendations on child restraint devices and seat positioning. Further, the Society supports a uniform system of attachment of car safety seats in vehicles.

MSV supports public education programs regarding the proper use of car safety seats for children.

Recommendation: Amend 15.002 by substitution and archive 60.015 as the principles are now included in the substitution.

15.002 - Child Restraint Devices
Date: 11/4/1995
The Medical Society of Virginia supports the American Academy of Pediatrics’ recommendations on child restraint devices and seat positioning.
Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

60.015 - Support for use of Car Safety Seats for Children
Date: 11/4/2000
The Medical Society of Virginia encourages public education programs regarding the proper use of car safety seats for children and supports the federal government’s mandate to create a uniform system of attachment of car safety seats in vehicles.
The Medical Society of Virginia supports the American Academy of Pediatrics’ policies on car safety seats, encourages the use of car safety seats or other approved devices for children over four years old who are too small for the adult restraint system and supports training to secure them properly in vehicles.
Reaffirmed 10/24/2010

➢ **School Bus Drivers Screening (Substitution)**

The Medical Society of Virginia recommends that physical examinations of school bus drivers include questions about history of mental illness, diabetes, hypertension, epilepsy, previous alcoholism or drug abuse, and the use of medication, all of which might affect the ability to drive a bus. Further, the MSV supports random testing for the presence of alcohol or drugs for school bus drivers.

Recommendation: Amend 15.001 by substitution and archive 15.009 as the principles are now included in the substitution.

15.001 - Alcoholism and Drug Abuse Screening
Date: 11/2/1996
The Medical Society of Virginia supports the establishment of a program in school districts to
screen randomly those applying to be school bus drivers to detect such characteristics as the presence of alcohol or drugs, which are difficult to detect through physical examination.
Reaffirmed 11/5/2006
Reaffirmed 10/16/2016

15.009 - Physical Examination Form
Date: 11/2/1996
The Medical Society of Virginia recommends that physical examinations of school bus drivers include questions about history of mental illness, diabetes, hypertension, epilepsy, previous alcoholism or drug abuse, and the use of medication, all of which might affect the ability to drive a bus.
Reaffirmed 11/5/2006
Reaffirmed 10/16/2016

➤ Medical Student Loans and Debt (Substitution)
The Medical Society of Virginia supports efforts to reduce medical student debt, including scholarships, lowering interest rates, and other effective loan repayment programs. The Society strongly supports the availability of medical student loans in Virginia and supports efforts, including overdue debt collection, to maintain the availability of these programs.

Recommendation: Amend 305.001 by substitution and archive 305.004, 305.005, and 305.007 as the principles are now included in the substitution.

305.001 - Collection of Overdue Debts
Date: 11/5/1994
The Medical Society of Virginia supports efforts to collect overdue debts from the present medical student loan programs in order to help preserve provision for future loan funds to medical students.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

305.004 - New Programs of Assistance
Date: 11/5/1994
The Medical Society of Virginia supports new programs which would provide scholarship assistance for Virginia medical students.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

305.005 - State Loan Program
Date: 11/5/1994
The Medical Society of Virginia opposes legislative efforts to reduce or eliminate medical student loans currently available in Virginia.
The Medical Society of Virginia supports legislative efforts to reduce medical student debt and loan interest rates.

- **Increased Funding for Residency Training (Substitution)**

The Medical Society of Virginia encourages medical schools, residency programs, as well as state and federal government to work cooperatively to graduate and train physicians in high-need medical specialties. The Society supports state, public, and/or private sector funding allocated to medical residency in areas of physician shortages and high-need specialties such as primary care, emergency medicine, psychiatry, and pediatric psychiatry, as well as underserved areas.

Recommendation: Amend 305.009 by substitution and archive 305.002, 200.005, 345.009 as the principles are now included in the substitution.

- **305.009 Increasing Funding for Residency Training**
  Date: 10/25/2015
  The Medical Society of Virginia (MSV) will seek means to increase state public and/or private sector funding allocated to medical residency in areas of physician shortage.

- **305.002 - EMS/GME Funding**
  Date: 11/5/1994
  The MSV urges Congress to retain funding for emergency medicine residency programs at current levels thereby ensuring “a safety net” capable of delivering emergency care and providing the necessary back-up to managed care plans and physicians’ offices.
  Reaffirmed 11/7/2004
  Reaffirmed 10/26/2014

- **200.005 - Medical School Primary Care Practice Programs**
  Date: 10/31/1992
  The Medical Society of Virginia should encourage the state to strengthen primary practice programs within the medical schools to the extent that at least 50% of graduates practice as primary care physicians and, if necessary, urge budgetary incentives by the state legislature to achieve such a goal.
  Reaffirmed 11/2/2012

- **345.009 - Training/Child Psychiatry**
  Date: 11/5/1994
  The Medical Society of Virginia encourages and supports the expansion and training of child psychiatry at all medical schools in Virginia and recognizes this area of medical specialty as a critically unmet need.
Helmet Safety (Substitution)

The Medical Society of Virginia encourages the use of safety helmets whenever appropriate, such as riding horses, bicycles, mopeds and "off road" vehicles.

Further, the MSV supports mandatory requirements for helmet use by minors when operating bicycles and by motorcycle operators and passengers. MSV is opposed to the repeal of mandatory helmet laws.

Recommendation: Amend 10.001 by substitution and archive 15.005 and 15.001 as the principles are now included in the substitution.

10.001 - Helmets
Date: 11/4/1995
The Medical Society of Virginia continues to support legislative efforts to require the use of bicycle helmets for minors.
Reaffirmed 11/2/2012

15.005 - Helmet Law; Repeal
Date: 11/5/1994
The Medical Society of Virginia endorses the use of helmets by motorcycle operators and passengers and is opposed to the repeal of mandatory helmet laws.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

15.011 - Safety Helmets
Date: 10/31/1998
The MSV encourages the use of safety helmets by riders of horses, bicycles, mopeds and "off road motorcycles."
Reaffirmed 10/12/2008

Housing Safety (Substitution)

The Medical Society of Virginia supports installation of smoke detectors in all residential structures built in Virginia.

Recommendation: Amend 10.002 by substitution and archive 10.003 as the principles are now included in the substitution.

10.002 - New Construction
Date: 11/4/1995
The Medical Society of Virginia believes that smoke alarms should be installed in all homes, apartments, and other residential structures built in Virginia.
Reaffirmed 11/06/2005
Reaffirmed 10/25/2015
10.003 - Public Housing
Date: 11/5/1994
The Medical Society of Virginia supports a requirement that all public housing units be sufficiently equipped with smoke detectors.
Reaffirmed 11/7/2004
Reaffirmed 10/26/2014

Childhood Immunizations (Substitution)

The Medical Society of Virginia supports the immunization recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians and the Centers for Disease Control as the required schedule for the immunization of infants and for school entry, including higher education, in the Commonwealth of Virginia. MSV supports the elimination of all non-medical vaccine exemptions in Virginia.

Finally, MSV supports efforts by the Commonwealth of Virginia to fund the purchase of necessary vaccines and their provision to all healthcare practitioners.

Recommendation: Amend 440.001 by substitution and archive 440.006, 440.033, and 440.009 as the principles are now included in the substitution.

440.001 - Childhood Immunization Schedule
Date: 11/6/2005
The Medical Society of Virginia supports that the Code of Virginia Section regarding childhood immunizations schedules be consistent with the most current, commonly agreed upon immunization recommendation by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, the Centers for Disease Control and Prevention and the American Academy of Family Physicians as the required schedule for the immunization of infants and for school entry in the Commonwealth of Virginia.
Reaffirmed as amended 10/25/2015

440.006 - Funding for Vaccines
Date: 10/30/1993
The Medical Society of Virginia supports efforts by the Commonwealth of Virginia and the State Health Commissioner to fund the purchase of necessary vaccines and the provision of such vaccines to private practitioners.
Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

440.033 - Non-Medical Exemption Requirements for Vaccines
Date: 10/25/2015
The Medical Society of Virginia (MSV) supports legislation that would eliminate all non-medical vaccine exemptions in Virginia.

440.009 - Immunizations for all Students Entering College
Date: 10/30/1993
The Medical Society of Virginia supports the immunization recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians and the Centers for Disease Control for students entering institutions of higher education.
Reaffirmed 11/5/2006
Reaffirmed as amended 10/16/2016
State Emergency Medical Services (Substitution)

The Medical Society of Virginia reaffirms that the Office of Emergency Medical Services (OEMS) and the authority for the development and promulgation of rules and regulations governing EMS should remain within the purview of the Department of Health.

The Medical Society of Virginia believes there should be adequate physician representation on the Emergency Medical Services Board to include designees of MSV, Virginia College of Emergency Physicians, Virginia Chapter of American Academy of Pediatrics and the Virginia Chapter, American College of Surgeons.

Recommendation: Amend 130.010 by substitution and archive 130.011 and 130.012 as the principles are now included in the substitution.

130.010 - Reorganization of State Office Emergency Medical Services
Date: 11/4/1995
The Medical Society of Virginia reaffirms that the Office of Emergency Medical Services (OEMS) and the authority for the development and promulgation of rules and regulations governing EMS should remain within the purview of the Department of Health and Board of Health, and that any change in the current administrative structure, location and function of the OEMS be considered only after careful study and clear demonstrated benefit to the patients served by the EMS system.
Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

130.011 - State Emergency Medical Services Advisory Board
Date: 11/5/1994
The Medical Society of Virginia supports the specific designation of a member of the Virginia Chapter, American Academy of Pediatrics as a pediatric emergency specialist representative on the State Emergency Medical Services Advisory Board.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

130.012 - State EMS Advisory Board Reorganization
Date: 11/4/1995
The Medical Society of Virginia supports the work of the Emergency Medical Services Board and believes there should be adequate physician representation on the Board to include designees of MSV, Virginia College of Emergency Physicians, Virginia Chapter of American Academy of Pediatrics and the Virginia Chapter, American College of Surgeons.
Reaffirmed 11/06/2005
Reaffirmed as amended 10/25/2015

Tobacco Sales Tax (Substitution)

The Medical Society of Virginia condemns the introduction of new tobacco products and promotions particularly those designed to attract young people, and supports the ban such of products and promotions.

The Medical Society of Virginia strongly supports a significant tobacco tax increase as a measure to reduce tobacco use in our population. Revenue from such a tax should be used to support health related programs for the citizens in the Commonwealth, tobacco education in elementary and middle schools, funding for childhood respiratory and cardiovascular disease prevention and treatment, as well as
subsidizing tobacco farmers who choose to harvest non-tobacco crops.

Recommendation: Amend 60.017 by substitution and archive 505.003 as the principles are now included in the substitution.

60.017 - Tobacco Tax and Child-Directed Promotions
Date: 10/30/1993
The Medical Society of Virginia condemns the introduction of new tobacco products and promotions, particularly those designed to attract young people, and urges the General Assembly and the Governor of the Commonwealth to ban such products and promotions. The Medical Society of Virginia urges the General Assembly and the Governor of the Commonwealth to increase taxes substantially on tobacco products to reduce tobacco use, while increasing government revenues for positive social and health services and support, to include, but not limited to, tobacco education in elementary and middle schools, funding for childhood respiratory and cardiovascular disease prevention and treatment, as well as subsidizing tobacco farmers who choose to harvest non-tobacco crops.
Reaffirmed 10/30/2003
Reaffirmed 05/31/2014

505.003 - Legislation to Increase Cigarette Tax
Date: 11/4/2002
The Medical Society of Virginia strongly supports a significant tobacco tax increase as a measure to reduce tobacco use in our population. The Medical Society of Virginia supports legislation which would require that funds generated by an increase in the state tobacco tax be used to support health related programs for the citizens in the Commonwealth.
Reaffirmed 11/2/2012

➢ Reimbursement for Mandated Medical Services (Substitution)

The Medical Society of Virginia is believes all providers must be adequately reimbursed for all state and federally mandated medical services.

Further, reimbursement for medical services provided subject to Emergency Medical Treatment and Active Labor Act (EMTALA) be made to all providing institutions on an equivalent basis for equivalent services.

Recommendation: Amend 160.004 by substitution and archive 130.006 as the principles are now included in the substitution.

160.004 - Funding for Mandated Medical Procedures
Date: 10/30/1999
The Medical Society of Virginia is opposed to the provision of unfunded medical mandates by the Commonwealth of Virginia. Additionally, the Medical Society of Virginia supports legislation to provide adequate funding mechanisms for all state medical mandates, now and in the future.
Reaffirmed 10/25/2009

130.006 - EMTALA Funding
Date: 10/31/1998
The Medical Society of Virginia recommends that reimbursement for medical services provided subject to Emergency Medical Treatment and Active Labor Act (EMTALA) be made to all providing institutions on an equivalent basis for equivalent services. MSV supports appropriate federal funding to accompany the increased demands placed by EMTALA upon such institutions. Reaffirmed 10/25/2009

- **Physician Reimbursement for Electronic Services (Substitution)**

  The Medical Society of Virginia believes physicians should be reimbursed at a fair fee of their choosing for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail, or other form of communication.

  Further, MSV believes these services should be reimbursed by health insurance plans.

  Recommendation: Amend 385.001 by substitution and archive 385.002 as the principles are now included in the substitution.

  385.001 - Payment for Electronic Services
  Date: 11/4/2000
  The Medical Society of Virginia adopts the following as adapted from AMA Policy H-390-859 – Reimbursement for Telephonic and Electronic Communications:
  Physicians should uniformly be compensated for their professional services, at a fair fee of their choosing, for established patients with whom the physician has had previous face-to-face professional contact, whether the current consultation service is rendered by telephone, fax, electronic mail, or other form of communication.
  MSV shall press CMS and other payers for separate recognition of supplemental communication work, as a service not covered by Medicare and therefore chargeable as a patient convenience service outside the benefit package of Medicare.
  Reaffirmed 10/24/2010

  385.002 - Physician Reimbursement for Telephone Consultations
  Date: 10/31/1998
  The Medical Society of Virginia supports the use of CPT codes for telephone consultations and encourages physicians to use such CPT codes.
  The Medical Society of Virginia encourages third party payers to reimburse for these codes as described in the current editions of Current Procedural Coding.
  Reaffirmed 10/12/2008

- **Payment for Surgical Procedures (Substitution)**

  The Medical Society of Virginia supports reasonable fees for medical and surgical services rendered by physicians of the Commonwealth.

  Further, MSV believes physicians and their patients should jointly decide where surgical procedures should be performed. Health plans should reimburse physicians appropriately should the necessary office infrastructure in place to safely perform surgery in an office setting. Reimbursements for procedures occurring in office should also include a facility fee.

  Recommendation: Amend 285.001 by substitution and archive 285.007 as the principles are now included in the substitution.
Physicians’ Guidelines for Prescriptions (Substitution)

The Medical Society of Virginia adopts the following guidelines:

- All prescriptions must be initiated by the prescribing physician, or appropriately licensed prescribers.
- Authority to dispense may be provided by his signature on the prescription or by direct personal communication by the prescribing physician or an assistant under the physician's direct and immediate supervision to the pharmacist.
- When a prescription has been filled or refilled the maximum number of times as initially designated, it is an expired prescription. Authorization to refill an expired prescription must be obtained by the pharmacist by direct personal communication with the prescribing physician or an assistant under the physician's direct and immediate supervision, or by a new prescription.
- When a pharmacist has concern in his own mind about the timeliness of a prescription refill, patient's need, and all other factors that demonstrate the appropriateness of the physician contact, he should contact the physician for the purpose of obtaining authorization to fill or refill the prescription.
- Patient Profiles maintained by the pharmacist which document the patient's drug history are considered important documents that would be available to assist the pharmacist in familiarizing the physician with the patient and concurrent drugs prescribed by other physicians.
- Using the patient as an intermediary in communications between the physician and pharmacist is unacceptable; e.g., the physician should not tell the patient to inform the pharmacist that the physician approves additional refills of a prescription.
- The Committee discourages use of the term “PRN” as a prescription refill authorization is discouraged.
- and recommends that Physicians should be specific in designating 1) the frequency, 2) a maximum time limit, and 3) a maximum number of refills.
- The use of patient medication instruction forms and other patient education material by physicians is encouraged.

Recommendation: Amend 120.003 by substitution and archive 115.001 as the principles are now included in the substitution.
120.003 - Guidelines for Prescriptions
Date: 11/5/1994
The Medical Society of Virginia adopts the following guidelines:
All prescriptions must be initiated by the prescribing physician, or appropriately licensed prescribers.
Authority to dispense may be provided by his signature on the prescription or by direct personal communication by the prescribing physician or an assistant under the physician's direct and immediate supervision to the pharmacist. 2. When a prescription has been filled or refilled the maximum number of times as initially designated, it is an expired prescription. Authorization to refill an expired prescription must be obtained by the pharmacist by direct personal communication with the prescribing physician or an assistant under the physician’s direct and immediate supervision, or by a new prescription.
When a pharmacist has concern in his own mind about the timeliness of a prescription refill, patient's need, and all other factors that demonstrate the appropriateness of the physician contact, he should contact the physician for the purpose of obtaining authorization to fill or refill the prescription.
Patient Profiles maintained by the pharmacist which document the patient's drug history are considered important documents that would be available to assist the pharmacist in familiarizing the physician with the patient and concurrent drugs prescribed by other physicians.
Using the patient as an intermediary in communications between the physician and pharmacist is unacceptable; e.g., the physician should not tell the patient to inform the pharmacist that the physician approves additional refills of a prescription.
The Committee discourages use of the term "PRN" as a prescription refill authorization and recommends that physicians be specific in designating 1) the frequency, 2) a maximum time limit, and 3) a maximum number of refills.
Reaffirmed 11/7/2004
Reaffirmed as amended 10/26/2014

115.001 - Patient Medication Instruction Forms
Date: 11/5/1994
The Medical Society of Virginia supports the use of patient medication instruction forms and other patient educational material by the physicians in the state of Virginia.
Reaffirmed 11/7/2004
Reaffirmed 05/31/2014
Reaffirmed as amended 10/26/2014

- Patient-Physician Communication (Substitution)
The Medical Society of Virginia strongly condemns any interference by the government or other third parties that may compromise a physician’s ability to use their medical judgment as to what information or treatment is in the best interest of the patient. MSV supports communication between a patient and his/her physician on how compensation arrangements and other policies relevant to patient care may impact the quality of his/her care.

Further, the Medical Society of Virginia opposes any efforts to limit, interfere, or restrict communications between a patient and their physician.

Recommendation: Amend 140.001 by substitution and archive 390.004 as the principles are now included in the substitution.
140.001 - Freedom of Communication Between Physicians and Patients
Date: 10/31/1992
The Medical Society of Virginia strongly condemns any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient.

The Medical Society of Virginia, working with other organizations as appropriate, vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or interfere with the physician-patient relationship.

The Medical Society of Virginia shall communicate to appropriate governmental bodies its continued opposition to any regulation that proposes restrictions on physician-patient communications.
Reaffirmed 11/2/2012
Reaffirmed 10/26/2014

390.004 - Physician/Patient Communications
Date: 10/30/1999
The Medical Society of Virginia supports communication between a patient and his/her physician on how compensation arrangements and other policies relevant to patient care may impact the quality of his/her care.
Reaffirmed 10/25/2009

RECOMMENDATION: ARCHIVE

60.013 - Speed Limits
Date: 11/5/1994
The Medical Society of Virginia encourages and supports statewide legislation that would require a 25-mileper-hour maximum speed limit zone surrounding schools that is in effect only during the arrival and departure of students, such zone to be indicated by flashing yellow lights and other road signs set distant from the school to enable traffic to comply. If the school is located on a divided highway, this speed limit would apply to traffic in both directions.
Reaffirmed 11/7/2004

Recommendation: Archive

Reason to archive: Va Code 46.2-873 passed in 2006 with school zone speed limits.

90.001 - Opposition to Onerous Regulation
Date: 10/31/1992
The Medical Society of Virginia opposes the more onerous regulation of medical practice imposed by the Americans with Disabilities Act and asks that the American Medical Association work to decrease the burden
of the more onerous portions of the Americans with Disabilities Act on physicians’ practices.
Reaffirmed 11/2/2012

Recommendation: Archive

Reason to archive: Americans with Disability Act regulation is now in all local building codes, so the policy is obsolete

160.007 - Physician Verbal Orders
Date: 10/31/1998
The Medical Society of Virginia advocates that physician verbal orders may be countersigned at the time of completion of the medical record.
Reaffirmed 10/12/2008

Recommendation: Archive

Reason to archive: Conflicts with Medicare regulations

165.023 - Anti-Trust Relief for Physicians
Date: 1/16/2012
The Medical Society of Virginia supports allowing physicians to negotiate collectively with insurance companies by asking our state’s congressmen and senators to co-sponsor or support House Resolution 1409, the “Quality Health Care Coalition Act of 2011,” in its current and un-amended form.

Recommendation: Archive

Reason to archive: Bill did not pass

300.002 - Maintenance of Certification
Date: 10/26/2014
The Medical Society of Virginia supports the following American Medical Association policies:

H-275.950 Board Certification
Our AMA (1) reaffirms its opposition to the use of board certification as a requirement for licensure or reimbursement; (2) seeks an amendment to the new Medicaid rules that would delete the use of board certification as a requirement for reimbursement and would address the exclusion of internal medicine, emergency medicine, or other specialties; and (3) opposes mandatory MOC as a condition of medical licensure, and encourage physicians to strive constantly to improve their care of patients by the means they find most effective. (Res. 143, A-92; Reaffirmed by Res. 103, A-98; Reaffirmation A-00; Reaffirmed: CME Rep. 16, A-09; Appendix: CME Rep. 6, A-14)

H-275.924 Maintenance of Certification
AMA Principles on Maintenance of Certification (MOC):
1. Changes in specialty-board certification requirements for MOC programs should be
longitudinally stable in structure, although flexible in content.

2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by each board for MOC.

4. Any changes in the MOC 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. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permit 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 would not be 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 MOC 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 MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

9. The AMA affirms the current language regarding continuing medical education (CME): "By 2011, each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part 2. The content of CME and self-assessment programs receiving credit for MOC 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 Physician’s Recognition Award (PRA) Category 1, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and or American Osteopathic Association Category 1A)."

10. MOC is an essential but not sufficient component to promote patient-care safety and quality. Health care is a team effort and changes to MOC should not create an unrealistic expectation that failures in patient safety are primarily failures of individual physicians.

(H-275.954 Maintenance of Certification and Osteopathic Continuous Certification

Our AMA will:

30. 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.

31. 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.

32. 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.)
33. 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. (CME Rep. 2, I-15; Appended: Res. 911, I-15; Appended: Res. 309, A-16; Appended: CME Rep. 02, A-16)

Further, MSV opposes maintenance of certification as a mandated requirement for licensure, credentialing, or reimbursement.

Recommendation: Archive

Reason to archive: Included in new policy 300.005

300.004 - Maintenance of Certification Completely Voluntary

Date: 10/25/2015

The Medical Society of Virginia (MSV) supports the updated 2014 AMA MOC Principles, including:

- MOC 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.
- The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, and intent to maintain or change practice.
- MOC should be used as a tool for continuous improvement.
- The MOC program should not be a mandated requirement for licensure, credentialing, payment, network participation or employment.
- Actively practicing physicians should be well-represented on specialty boards developing MOC.
- MOC activities and measurement should be relevant to clinical practice.
- The MOC process should not be cost-prohibitive or present barriers to patient care.

Recommendation: Archive

Reason to archive:Included in new policy 300.005
Resolution To Ask The Medical Society Of Virginia (MSV) To Study The Constitution Of The State Of Virginia And Present A Plan For The Creation Of An Entity Within The State Of Virginia To Be Responsible For and to Carry Out The Delivery Of Medical Care

Submitted by Monroe G. Baldwin, Jr., M. D.

WHEREAS, only physician/doctors are ultimately responsible for the delivery of medical care, and

WHEREAS, Virginia physicians/doctors are licensed by the state, and

WHEREAS, the MSV operating in a free market is simply another organization competing for its rights when in truth medicine/MSV is a pillar of society in search of a structure to carry out its responsibilities along with government in its many forms in counties and cities and the judicial system with its courts, and

WHEREAS, delivery of healthcare in a free market economy stimulates a drive for profit by doctors and hospitals. The price of being cured of or symptoms being ameliorated is very difficult to determine, and

WHEREAS, the medical delivery system in a free market moves towards communities able to pay whereas the preponderance of illness is in the lower socioeconomic class who are unable to pay, and

WHEREAS, the supply demand curve being automatically operational in a free market guarantees that within time prices (healthcare plans) will rise above the affordability of some working people (today's working poor) which is ethically wrong violating the profession of medicine's time honored solution which is to request what the patient can afford and no more, and

WHEREAS, there are gross inequities in the pay for specialties and primary care rendering it difficult to attract medical students into the family practice field especially with students carrying large debt, and

WHEREAS, family practice is the bedrock of medical delivery and needs to be near the communities it serves and on which specialties depend not only for referrals but to cover sick call in order for the specialties to carry out their more complicated office and hospital procedures in a timely way, and

WHEREAS, there needs to be a physician/doctor run medical monitoring system within the entity that educates doctors about their practice so they can improve and correct any deficiencies, and

WHEREAS, an entity representing all physician/doctors in the state of Virginia could collect physician charges from federal and state governments as well as commercial carriers in order to pay doctors properly and place them where needed, therefore be it

RESOLVED, that the MSV study the composition of the Virginia state Constitution and present a plan for an entity within the state to be responsible for and carry out the delivery of healthcare.
Truth in Advertising

Submitted by Virginia Society of Plastic Surgery

WHEREAS, survival in the modern marketplace requires promotion of a physician’s practice and credentials in various advertising media, and

WHEREAS, most practitioners do so ethically, but there currently is a loophole in Virginia’s health regulations that can be exploited, and

WHEREAS, Virginia’s regulations require disclosure of the name of the specialty board, but does not specify that such a board must be a legitimate educational body, and

WHEREAS, healthcare consumers may not be able to distinguish between legitimate boards and less reputable organizations thereby devaluing the term board-certified to Virginia patients seeking an adequately trained and qualified physician, and

WHEREAS, boards with lower standards may pose a risk to patient safety in the Commonwealth, and

WHEREAS, there is a national coalition concerned about this issue comprised of the American Medical Association, American Academy of Dermatology Association, American Academy of Facial Plastic and Reconstructive Surgery, American Academy of Otolaryngology – Head and Neck Surgery, American College of Emergency Physicians, American Osteopathic Association, American Society for Dermatologic Surgery Association, and American Society of Plastic Surgeons, therefore be it

RESOLVED, the Medical Society of Virginia supports specifying that “board-certified” must refer to an American Board of Medical Specialties (ABMS), American Osteopathic Association Board Certification (AOA), or other boards that maintain similarly high standards of certification.
Resolution to Improve Obesity Medicare & Insurance Coverage

Richmond Academy of Medicine

WHEREAS, in 2010, the Congressional Budget Office released a report that showed obesity rates among Americans had more than doubled from 13 to 28 percent from 1987 to 2007, and

WHEREAS, since then, obesity rates have grown measurably worse with nearly 70 percent of Americans affected by excess weight or obesity, and 42 percent of Americans projected to become affected by obesity by 2030, and

WHEREAS, estimated direct obesity costs are 5.7% of total U.S. Health expenditures and Healthcare costs related to obesity exceed $400 billion each year, and

WHEREAS, a majority of Americans affected by excess weight or obesity are also at risk for over 230 associated diseases including heart disease, stroke, fatty liver, type 2 diabetes, dementia, depression, respiratory impairment, certain cancers and marked diminished life expectancy and deprives individuals on average from 19 years of healthy living making obesity a healthcare and financial epidemic/burden requiring access to a full range of safe and effective treatment options, and

WHEREAS, treatments that reduce the weight as little as 5-10% have been shown to improve quality of life, reduce mortality, significantly improve cardiovascular and other obesity related diseases, and save $2137/year per individual, and

WHEREAS, in June 2012 the U.S. Preventative Services Task Force (USPSTF) recommended that clinicians screen all adult patients for obesity and offer or refer patients with body mass index of 30 kg/m2 or higher to intensive multicomponent behavioral interventions to promote sustained weight loss for obese adults (grade B recommendation.), and

WHEREAS, in June 2013 the American Medical Association officially declared Obesity as a disease (Resolution 420) stating the “American Medical Association recognizes Obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention,” and

WHEREAS, in June 2017 the U.S. Preventative Services Task Force (USPSTF) recommended that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status (recommendation B), and

WHEREAS, several medical associations such as the Obesity Medicine Association and the National Institutes of Health define Obesity as a chronic, relapsing, multi-factorial, neurobehavioral disease, wherein an increase in body fat promotes adipose tissue dysfunction and abnormal fat mass physical forces, resulting in adverse metabolic, biomechanical, and psychosocial health consequences, and

WHEREAS, since 2011, the Center of Medicare and Medicaid Services (CMS) has determined that Interventional Behavioral Therapy (IBT) for Obesity, defined as all people who have a body mass index (BMI) of 30 kg/m2 or greater, is necessary for the prevention or early detection of illness or disability and is appropriate for individuals entitled to benefits under Part A or enrolled under part B and is recommended with a grade A or B by the USPSTF, and
WHEREAS, CMS offers coverage of screening and Interventional Behavioral Therapy (IBT) to help eligible patients lose weight but restricts such coverage to the Primary Care Provider in the primary care setting and excludes other appropriate evidence based treatment modalities, and

WHEREAS, primary care physicians by CMS includes physicians with designation in Family Medicine, general Internal Medicine, Obstetrician/Gynecology and Pediatric Medicine, or Nurse Practitioners, Clinical nurse specialists or physician assistants. PCPs are not trained in the delivery of IBT, offices are not properly equipped, and restricting care services to primary care doctors is unusual and represents a biased and stigmatizing practice, and

WHEREAS, CMS states that ER departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities and hospice are not considered primary care settings, and

WHEREAS, for Medicare beneficiaries who are diagnosed with Obesity whose counseling is furnished by a qualified PCP or other PCP in a primary care setting, CMS covers:

• One face-to-face visit every week for the first month
• One face-to-face visit every other week for months 2-6
• One face to face visit every month for months 7-12, if the beneficiary achieves a reduction in weight of at least 3 kg (6.6 lbs) over the course of the first 6 months of intensive therapy if this goal is not reached, therapy typically ends. The PCP can assess the patient for another Obesity screening benefit after an additional 6-month period, and

WHEREAS, The Treat and Reduce Obesity Act (TROA) in the 115th Congress (s. 1509) will provide Medicare beneficiaries and their healthcare providers with meaningful tools to reduce obesity by improving access to weight-loss counseling and new prescription medications for chronic weight management, and

WHEREAS, The Treat and Reduce Obesity Act (TROA) will provide Centers for Medicare and Medicaid Services (CMS) with the authority to expand the Medicare benefit for intensive behavioral counseling by allowing additional types of health care providers, such as dieticians, psychologists and specialty physicians (obesity medicine specialists, endocrinologists, bariatric surgeons, psychiatrists, etc.) as well as community-based programs to offer counseling, and

WHEREAS, TROA will expand Medicare Part D to provide coverage of FDA-approved prescription drugs for chronic weight management, and

WHEREAS, while the legislation is focused on improving access to obesity treatments for Medicare beneficiaries, it is important to remember that often times private and employer based insurance plans base their coverage on matching Medicare coverage; therefore, this legislation is important to all Americans, therefore be it

RESOLVED, that the Richmond Academy of Medicine and the Medical Society of Virginia through its delegation to the AMA support coverage for healthcare costs associated with medical, surgical, nutritional and behavioral treatment interventions for patients diagnosed with Obesity.
AMA Potential Resolution: I-17 Fees for Taking Maintenance of Certification Examination

Submitted by Dr. Ed Koch

WHEREAS, the process of board certification has a central role in self-regulation of physician quality standards;

WHEREAS, each specialty has established non-profit organizations to administer this required evaluation to obtain and maintain board certification;

WHEREAS, these organizations charge fees for the examination process that averages $110.00/year for Family Medicine to $610.00 per year for colo-rectal surgery;

WHEREAS, the physicians taking the examination incur other costs such as review courses, travel expenses, and lost wages from their current practice;

WHEREAS, physician reimbursement has declined for many and further complicates the process involved in the cost of taking the exam;

WHEREAS, the cumulative net assets of the various certifying organizations as stated in the reference below, is excessive and totals more than 584 million dollars (JAMA, August 1, 2017, Volume 318, #5: pages 477-479);

RESOLVED, that AMA BOD request a reduction in MOC fees for these examinations so as to work towards a balanced/neutral budget of these medical boards given their status as non-profit organizations.
Resolution on Membership in MSV Committees

Submitted by Richmond Academy of Medicine

WHEREAS, the Medical Society of Virginia relies upon physician involvement from across the Commonwealth to move forward its legislative and policy agendas, and

WHEREAS, a new process has been implemented to receive, review and evaluate legislative and policy proposals, and

WHEREAS, stated goals of the MSV strategic plan include to strengthen the connection of physicians, raise up the voices of physicians, expand engagement of physicians in the house of medicine and to unify the community of physicians in Virginia, and

WHEREAS, the MSV strategic plan sets as an additional goal to “execute a strategic communication plan that builds mutually beneficial relationships between MSV, physicians and the public”, and

WHEREAS, this includes working in collaboration with component societies and specialty societies, therefore be it

RESOLVED, that membership on the MSV Advocacy Committee have, in addition to membership in MSV, a requirement of active membership in a recognized component society or a specialist society, and be it further

RESOLVED, that active membership in a component society or a specialist society be strongly encouraged for members being considered for appointment to all MSV committees, taskforces, etc., and be it further

RESOLVED, that preference will be given to candidates who are active members of both a component society and a specialist society.
Resolution Recognizing Healthcare as a Basic Human Right

Submitted by Richmond Academy of Medicine

WHEREAS, a recent editorial in the Journal of the American Medical Association exhorts professional societies to speak with a single voice and say that health care should be a basic right for every person, and not a privilege, therefore be it

RESOLVED, that the Medical Society of Virginia join with the many professional societies that recognize health care is a basic human right for every person and not a privilege.
Virginia Medical Student Clerkship Support

Submitted by Norfolk Academy of Medicine and MSV 2nd District

WHEREAS, Virginia ranks below the national rate of active physicians 265.6 per 100,000 population, and

WHEREAS, Virginia medical school admissions increased 56.4 percent between 2004 and 2014, and

WHEREAS, every third-year medical student must complete core clerkship rotations, and

WHEREAS, many of these rotations at Virginia State supported Medical School training occurs in community-based training sites where financially uncompensated community-based primary care physicians provide teaching and mentorship of these students, and

WHEREAS, recent trends in off-shore medical schools and out of state private, students are targeting Virginia sites for third-year clerkships and community-based primary care physicians are financially compensated for providing clerkships for these off-shore and out-of-state medical students, and

WHEREAS, Virginia medical schools struggle to compete for community-based primary care faculty with few exceptions, therefore be it

RESOLVED, that the Medical Society of Virginia (MSV) support the tax credits for uncompensated community-based primary care physicians providing third-year core clerkships for Virginia medical students and clerkships for Virginia physician assistant students, and be it further

RESOLVED, that MSV will work collaboratively with the Virginia medical schools and other key partners to develop guidelines and limits for these tax credits.
Revision of "Good Samaritan" Statutes for Team Physicians

Submitted by Dr. Sterling Ransone

WHEREAS, the Commonwealth of Virginia currently has a Good Samaritan statute (§ 8.01-225) that provides for liability protection for "any person who, in good faith, renders emergency care or assistance, without compensation, to any ill or injured person," and

WHEREAS, many physicians serve in a volunteer capacity for public and private school-sponsored teams or other sports clubs, and

WHEREAS, the nature of sports related injuries varies dramatically and could be retroactively ruled non-emergent, therefore be it

RESOLVED, the Medical Society of Virginia will support including liability protection for non-emergent care by volunteer team physicians in the Commonwealth of Virginia.
WHEREAS, human trafficking, defined as the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bonding or slavery, is a rising problem in the commonwealth of Virginia, and

WHEREAS, in Virginia in 2016, there were 152 cases of human trafficking discovered, an increase over 2015, and there is evidence that many more exist, and

WHEREAS, 80% of the individuals are women, so that these individuals may require emergency room services or appointments with an obstetrician and gynecologist, and

WHEREAS, the American Congress of Obstetrics and Gynecology has developed policies and opinions about this public health problem, therefore be it

RESOLVED, that MSV develop a policy to assist physicians in the Commonwealth to identify these individuals and provide guidelines that allow physicians to report their concerns to the appropriate governmental agencies with anonymity.
WHEREAS, the people of the Commonwealth of Virginia should have some form of health care, and
WHEREAS, expansion of Medicaid in the Commonwealth would allow for 400,000 more citizens to be covered under the Affordable Care Act, and
WHEREAS, the ACA is the law of the land and was not repealed, and
WHEREAS, our state legislature has refused to expand Medicaid, therefore be it
RESOLVED, that the Medical Society of Virginia urges the House of Delegate and the Virginia Senate to pass legislation that would expand Medicaid in the Commonwealth of Virginia.
Medicare at 55 Act

Submitted by Dr. Edilberto O. Pelausa and MSV 2nd District

WHEREAS, people in the 55-64 age group face unique health challenges and especially high health care costs, and

WHEREAS, the average person in this age group pays more than $1,200.00 in annual out-of-pocket costs and is at a greater risk of suffering from chronic conditions such as diabetes or arthritis and medical emergencies such as heart attack and stroke, and

WHEREAS, under the Medicare at 55 Act, an individual between the ages of 55 and 64 who buys into Medicare would receive the same benefits and protections as an individual enrolled under Medicare parts A, B, and D, be it therefore

RESOLVED, that the MSV instruct our AMA Delegation to recommend that the AMA support the "Medicare at 55 Act" introduced by Senator Debbie Stabenow (D-Mich), allowing Americans aged 55-64 who are vulnerable to significant illness to buy into Medicare early and obtain better and less expensive health coverage compared to private insurers who could charge them three times or higher.
Single Payer System
Submitted by Dr. Jay D. Brock

WHEREAS, the United States spends $3.5 Trillion annually on health care, of which approximately
$500 Billion is spent to accommodate the health insurance industry, and

WHEREAS, that $500 Billion is more than enough to provide for the healthcare for all currently
uninsured U.S. residents, and

WHEREAS, administrative costs for the current system accounts for 31% of our healthcare dollar,
compared to 14% for the Single Payer Systems of other industrialized countries, which
provide comparable care for an average of about half the cost while still allowing for
levels of compensation to providers similar to that in this country, and

WHEREAS, the current system of health insurance is unnecessarily complex for patient and
healthcare provider alike, resulting in severe financial difficulties for patients and
expensive billing systems and uncompensated care for providers, and

WHEREAS, when for-profit insurance companies deny needed care to our patients and
simultaneously enhance their 'bottom line' we believe it to be an irreconcilable conflict of
interest, and

WHEREAS, the Affordable Care Act has failed to solve the underlying problems of the current system
of health insurance, leaving tens of millions of Americans uninsured and many tens of
millions more underinsured, and

WHEREAS, an appropriately structured Single Payer System would replace the current overly
complicated payment system, and does NOT represent socialized medicine--where the
government otherwise would own all the healthcare facilities and all healthcare workers
would be employees of the government, and

WHEREAS, the United States already has a foundation for a nationally based system of health
insurance in this country in the form of Medicare, and

WHEREAS, an "Improved Medicare for All/ Single Payer System" would solve many of the current
health insurance problems in this country, such as Universal Coverage, access to all
medically necessary care for patients and lower administrative costs and burdens to
providers, and

WHEREAS, H.R. 676, the "Expanded and Improved Medicare for All Act" introduced in the current
Congress of the United States would replace the current unworkable health insurance
system with such a Single Payer System, that can cover every US resident for all
medically necessary care with first dollar coverage, with funding via payroll, income, and
other progressive taxes that would mean 95% of American households will pay less for
their healthcare than they do now, and

WHEREAS, we already spend enough money in the healthcare system to cover all US residents, we
just do not spend it wisely, and

WHEREAS, the Hippocratic Oath puts the needs of our patients above all other needs, therefore be it

RESOLVED, the MSV amend by substitution policy 165.016 with the following language:
“MSV will support a national system of providing and financing a Single Payer System of health insurance that will:

- Cover everyone, without copays or deductibles, for all medically necessary care, using a single large and efficient risk pool that does not penalize people based on age, illness, or disability; and where everyone contributes, based on payroll, income, and other progressive taxes;
- Promote competition and preserve a patient's choice of physician or other health care provider, including hospital and other health care facilities;
- Relieve businesses of all sizes from providing health insurance to their employees, thus removing the tie between an individual’s health insurance and their employment; and
- Advance an efficient and provider-friendly administrative and reimbursement system”, and therefore be it further

RESOLVED, the MSV supports H.R. 676, the “Expanded and Improved Medicare for All Act”, which proposes changing our health insurance payment system into an 'Improved Medicare for All/Single Payer System', and

RESOLVED, the MSV AMA delegation shall bring a resolution stating the same principles, and supporting H.R. 676, to the next annual conference of the American Medical Association for their approval.
Gun Violence Restraining Orders

Submitted byDr. Stuart Henochowicz and American College of Physicians, Virginia Chapter

WHEREAS, more than 33,000 people were killed in 2014 by firearms by either suicide or homicide, and

WHEREAS, Gun Violence Restraining Orders (GVRO) allow law enforcement to remove guns from persons who are a threat of violence to themselves or others, and

WHEREAS, HB 1758, a bill that sought to enact GVROs in Virginia, was proposed in the 2017 legislative session by Representative Sullivan, therefore be it

RESOLVED, that the Medical Society of Virginia support gun violence restraining orders as a mechanism to decrease gun related suicides and homicides.
Medicaid Reform for Adults Receiving Social Security Disability Income

Submitted by Dr. John Paul Verderese on behalf of the American College of Physicians Virginia Chapter

WHEREAS, Medicaid is currently available in the state of Virginia only to disabled persons who do not exceed a combined household income threshold or possess other assets that would make them ineligible, and

WHEREAS, patients in Virginia who receive social security disability income (SSDI) can, in some cases, cause them to exceed the income eligibility threshold and render them ineligible for Medicaid, and

WHEREAS, the majority of states offer automatic Medicaid eligibility to disabled patients regardless of income source or threshold, therefore be it

RESOLVED, that the MSV support automatically enrolling patients in Virginia on SSDI onto Medicaid.
Resolution on Tobacco Control and Health Care in Virginia

Submitted by Richmond Academy of Medicine

WHEREAS, both cancer incidence and our overall health care costs in Virginia are clearly related to the use of tobacco products by our citizens, and

WHEREAS, Virginia’s tax on cigarettes is only 30 cents per pack compared to the national average of $1.65 per pack, and

WHEREAS, the tobacco habit resulting from the nicotine frequently begins in youth where price is especially important, and

WHEREAS, both increasing the tobacco tax and increased funding for tobacco use prevention programs will dissuade young adults from initiating the use of tobacco products, therefore

be it

RESOLVED, that the Medical Society of Virginia revise current policy 505.003 as follows: (changes underlined)

The Medical Society of Virginia strongly supports a significant tobacco tax increase of at least $1.35 to reach the national average of $1.65 for this tax as a measure to reduce tobacco use in our population. The Medical Society of Virginia supports legislation which would require that at least 10% of the funds generated by an increase in the state tobacco tax be used to support health related programs for the citizens in the Commonwealth.
Resolution to Improve Step Therapy in Virginia

Submitted by Richmond Academy of Medicine

WHEREAS, step therapy or “fail first” protocols are policies, practices and programs established by utilization review agents that establish a specific sequence of interventions for specified medical conditions for enrollees. These protocols appear to be economically based in that they require patients to use a lower cost drug or service before permitting use of more expensive drugs or services, and

WHEREAS, step therapy is an established benefit management tool used by commercial carriers, self-insured employers, Medicare Advantage/Part D programs, and Medicaid as well as other utilization review agents such as pharmacy, radiology and therapy benefit managers and specialty pharmacies, and

WHEREAS, an increasing number of insurers are utilizing step therapy or fail first policies that require patients to try and fail one or more formulary covered medications before providing coverage for the originally prescribed non-preferred or non-formulary medication, and

WHEREAS, the decision-making process and/or clinical evidence for the step therapy or fail first protocols and appeal/override decisions are frequently not revealed, and

WHEREAS, if a patient changes insurers, or if a drug they are currently taking, is moved to a non-preferred or non-formulary status, patients may be put through the step therapy process again even if the patient is stable, potentially causing great harm to the patient, and

WHEREAS, inappropriately applied step therapy can negatively impact patient health due to the delay in receiving clinically prescribed appropriate care, and

WHEREAS, there is frequently no transparent, efficient or expedited step therapy or fail first protocol appeal process in exceptional clinical situations, and

WHEREAS, the act of appealing these protocols creates an undue burden on health care providers, their staff and patients, thereby wasting valuable health care resources and increasing costs; therefore be it

RESOLVED, that MSV work with stakeholders to reform step therapy in Virginia to require health plans to cite clinical review data as justification for denials, create a uniform and expedited appeals process, and establish a process for patients who transition from insurance plans.
Resolution Revising Health Care Legislation

Submitted by Richmond Academy of Medicine

WHEREAS, the Affordable Care Act was developed to address problems both in access to health care for our citizens and to halt the increasing cost of health care in our nation, and

WHEREAS, there will continue to be legislative efforts to improve our current health care plan but whatever our political views, physicians have a major social responsibility for the patient population they serve to be sure the current health plans keeps in mind the best interests of their patients, therefore be it

RESOLVED, that it be policy of the MSV to communicate to the public and to our legislators our strong support for the 2017 American Medical Association list of guiding principles for health insurance and health care access for any future federal or Commonwealth government health care plans.
Resolution to Improve Upon the Current Prior-Authorization Law in the State of Virginia

Submitted by Richmond Academy of Medicine

WHEREAS, prescription prior-authorization requires health care providers to go through many extra steps to obtain an insurer’s approval prior to prescribing medications, and

WHEREAS, prior-Authorization requires hours of uncompensated physician and staff work, and

WHEREAS, prior-Authorizations continues to be unnecessary and constitutes an undue burden; and

WHEREAS, private offices and hospitals employ numerous people to cope with the added burdens of required prescription prior-authorizations adding to overall health care costs, and

WHEREAS, a 2014 article in the “Journal of the American Board of Family Medicine” estimated that insurers’ prior-authorization practices currently cost the nation’s entire health-care system between $23 billion to $31 billion a year, and

WHEREAS, in 2015 the Governor signed a bill which was meant to improve transparency, uniformity and efficiency in the current prescription prior authorization process, and

WHEREAS, despite the current law existing, insurers still drag their collective feet when physicians try to settle prior authorization matters in a timely way for their patients, and

WHEREAS, the current prior-authorization appeals process is arduous and oft impossible with the following common practices occurring:

• Many appeals (unless “urgent”) take months to get a decision because most health plans don’t acknowledge receipt of appeal and often claim to not have received the appeal even though a fax confirmation exists;
• Initial authorization requests are directed through an off-shore call center slowing down the authorization because of language barriers.
• Some health plans require a written authorization from the patient in order to do an appeal, which is often required for medical services as well which slows down the process
• When trying to get a drug authorized that is non-formulary, the health plan isn’t required to do a tier exception and the costs of the drug can be outrageous.
• Generic drugs can be as expensive or more expensive than some brand name drugs
• Health plans are requiring physicians to go through the prior authorization process to screen for contraindications, not trusting that the physician (and the pharmacy) is properly screening the patient; and

WHEREAS, the Medical Society of Virginia has been committed to this issue, successfully helping to pass the 2015 prior authorization bill in the 2015 General Assembly Session, therefore be it

RESOLVED, that the Medical Society of Virginia continue to work with Insurers and request they be more open and transparent about their approval (and rejection) processes and demand that they release information identifying the common evidence-based parameters for insurers’ approval of the 10 most frequently prescribed chronic disease management prescription drugs, as required by the 2015 law, and be it further
RESOLVED, that the Medical Society of Virginia, work with the General Assembly to push insurance companies to upgrade the electronic approval of prescription requests, which has been shown to bring cost savings in other states within a few years of its implementation, and be it further

RESOLVED, that the Medical Society of Virginia join the American Medical Association to aid in prior-authorization reform with a goal of building a dialogue between providers, health plans and their third parties to cut out needless administrative waste from the system.
WHEREAS, health plans have instituted a number of mechanisms to restrict medically necessary care to patients including step therapy and prior authorization, and

WHEREAS, these cost-control mechanisms are used to limit prescription medications, therapies, medical equipment, procedures, services and imaging, and

WHEREAS, step therapy is a cost-control process that many health plans use for prescriptions, and

WHEREAS, prior authorization is a health plan cost-control process many health plans use for prescriptions, procedures, and services, and

WHEREAS, these processes require providers to obtain approval, which most often requires hours of uncompensated physician and staff work, and

WHEREAS, despite the 2015 law passed in Virginia, physician practices are still experiencing numerous problems with prior authorizations, and

WHEREAS, frequently health plans change their criteria for “medical necessity” with little to no notice or explanation, and

WHEREAS, these mechanism cause interruption in the care of the patient and interferes in the doctor-patient relationship, therefore be it

RESOLVED, the Medical Society of Virginia opposes any health plan mechanism that interferes in the timely delivery of medically necessary care, therefore be it further

RESOLVED, the Medical Society of Virginia supports requiring health plans to provide physicians with real time access to covered benefits, the criteria for “medical necessity” and cost information so that physicians and their patients may work together to choose the most cost-effective medically appropriate treatment for patient care.
Resolution Regarding the Withdrawal of Insurance Providers from the ACA and Individual Marketplace

Submitted by Richmond Academy of Medicine

WHEREAS, Anthem recently pulled out of the ACA marketplace as well as the individual market outside of the ACA in Virginia, and

WHEREAS, patients covered by Anthem ACA and individual policies will no longer have those benefits, and

WHEREAS, these patients will now have no option to purchase their health insurance with or without government assistance if they wish to stay with Anthem, and

WHEREAS, Anthem and other health plans provide insurance for the Commonwealth of Virginia State Health Benefits Program which is the insurance program made available to state employees, and

WHEREAS, with many large insurers like Anthem leaving the ACA and individual marketplace in Virginia, it is impossible for individuals who are self-employed, work for a small business, or retired prior to age 65, to find affordable health insurance, and

WHEREAS, health plans who provide coverage for the state could provide similar coverage for individuals in the state who may be self-employed, work for a small business, or retired prior to age 65, etc., therefore be it

RESOLVED, that the Medical Society of Virginia propose policy changes which will require health plans participating in the Commonwealth of Virginia State Benefits Program to also provide individual coverage for the public at large in the regions in which they participate, and be it further

RESOLVED, these individual policies must be commensurate with what the plan offers state employees including both benefits and premiums.
WHEREAS, our nation is experiencing serious societal, medical, and psychological problems associated with abuse of prescription opioid and other DEA schedule II drugs, and

WHEREAS, the ongoing efforts have not been effective at reducing fatalities, reducing addiction, controlling diversion, doctor shopping, or fraudulent prescriptions, and

WHEREAS, the Virginia Prescription Monitoring Program (PMP) has created an opportunity for better control of opioid prescribing, but has not impacted diversion or abuse, and

WHEREAS, it is possible to e-prescribe schedule II medications through highly regulated and monitored software, and

WHEREAS, requiring that all schedule II prescriptions be submitted though this software may allow for an interface with the Virginia PMP as well as adjacent state PMP’s, and more careful scrutiny of prescribing patterns and at risk patients, and

WHEREAS, four other states currently have required e-prescribing of schedule II medications and have seen benefits, and

WHEREAS, it is imperative that the MSV lead any initiative that will impose some outside control of the patient physician relationship and the practice of medicine, therefore be it

RESOLVED, that the MSV convene a taskforce comprised of physicians from a variety of practice settings, including hospital-based, large and small group practice, solo practitioners, specialties, and geographic settings to conceptualize how to devise and implement electronic prescribing of schedule II medications, and be it further

RESOLVED, that this initiative be undertaken within the next 3 months with a goal to make recommendations that can be shared and receive feedback from MSV members within 6 months, and be it further

RESOLVED, that the task force explore and consider the following topics:

- Mandatory e-prescribing for schedule 2 medications
- Requiring a patient-physician relationship based upon a face to face clinical encounter as defined by the health regulatory board of Virginia (or, in the case of a covering situation, clinic)
- All electronic prescribing software approved for use in Virginia be connected to the PMP (all electronic prescribing platforms must be interoperable).
- Interoperability with the PMP’s of Virginia’s bordering states.
- Waivers and/or subsidization for doctors documenting financial hardship, technology challenges and/or no local broadband service, and for those who write few schedule II prescriptions.
- Identifying the costs associated with implementing the process for physicians and physician groups and how to make it affordable.
- Guidelines on the use paper of prescriptions for specified situations and settings.
- Appropriateness of variable prescribing limits for specific meds and/or dosing based upon patient’s condition, type (hospice), and physician specialty and, possibly, with opioid/pain med CME requirements
• Design methods for data collection to monitor impact and other research considerations
• Design methods to detect problem patients and physicians and consider methods for prevention and intervention when necessary, and be it further

RESOLVED, that this taskforce shall make a report to the MSV Board of Directors with a recommended position on mandatory e-prescribing to inform the ongoing work as established by HB 2165.