MSV℠ MEDICAL SOCIETY OF VIRGINIA

2019 Advocacy Summit Proposal
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Advocacy Summit Proposal 1

Title of Proposal:
Study of Potential Patient-Reported Outcomes Registry for the State Employee Health Plan

On behalf of:
Virginia Orthopaedic Society

Describe the Idea or Issue:

Data collection is an integral part of our health care system and can result in better outcomes for our patients. However, our health care system often fails to collect the right kind of information. It sometimes even collects too much unusable information. As a result, we are seeing a push toward Patient-Reported Outcome measures- which are a much more efficient and effective data collection tool because they measure quality based on direct feedback from patients. Through PROs, patients give a more accurate reporting of their symptoms. For example, a patient will complete a simple questionnaire that includes questions relevant to daily functions, such as: “Did your hip replacement enhance mobility?” and “are you in less pain following the knee surgery?” That way, the physician has a clear sense of how the patient is responding. This information is then reported to a clinical data registry that records information about the health status of a population of patients and the health care they receive over varying periods of time.

The collection of structured PROs, through registries enables physicians to establish national or regional benchmarks, detect trends and identify best practices from the comparative experiences of others. The American Joint Replacement Registry is an example of a registry that helps patients achieve the best outcomes from surgeries by helping surgeons understand which treatments are most effective.

Another example, the Michigan Arthroplasty Registry Collaborative Quality Initiative (MARQI) has shown the impact of PROs. The initiative led to the reduction of blood transfusions after arthroplasty procedures from an all-joint average of 15 percent to 1.6 percent in about four years. MARQI has shown that collaborative registry work can be used effectively to improve the quality of patient care and set a new benchmark for high-quality care.

VOS believes that Virginia patients could greatly benefit from using a PRO registry. We believe it would be useful to initiate a pilot study on a specific group. We are proposing that the Virginia Department of Human Resource Management study this issue and determine whether PROs can bring value to the Commonwealth’s employee health plan.

In 2017, Texas did something similar and passed a bill requiring two of their state employee health plans to study PROs and determine whether they could improve outcomes for musculoskeletal care. We would like to see Virginia do the same in 2020.

Desired Outcome:

That the Medical Society of Virginia will support VOS legislation in 2020 that would direct the Department of Human Resources Management to conduct a study and determine whether a Patient-Reported Outcomes Registry for the state employee health plan would be of value to the Commonwealth.

Background/Supporting Information:

Word document of proposal
Texas Orthopaedic Association article
Patient-Reported Outcomes Infographic
(Found on pages 2-4 of the Appendix)

Advocacy Summit Proposal 2

Title of Proposal:
Annual Inflation Increase for Physician Medicaid Reimbursement

On behalf of:
Virginia Chapter, American Academy of Pediatrics. VA AAP is submitting this proposal with the support of their specialty colleagues: VA College of Emergency Physicians, VA Academy of Family Physicians, Virginia Psychiatric Society, Virginia Society of Eye Physicians and Surgeons, VA Society of Anesthesiology, VA Orthopaedic Society, Virginia Chapter of the American College of Radiology, Virginia Society of Plastic Surgeons and Virginia College of Obstetrics and Gynecology

Describe the Idea or Issue:

The 2018 legislative session was marked by the historic passage of Medicaid expansion, allowing up to 400,000 Virginians who were uninsured the opportunity to apply for, and receive, Medicaid coverage. MSV and the specialty societies advocated for the expansion, but also urged the legislature to ensure that those new recipients would have access to physicians, most easily achieved by increasing the rates to offset the administrative costs and burdens of participating in the program. That was not included in the final expansion. The last raise for all physicians in the Medicaid program was 2% in July 2008. This past legislative session, MSV advocated for bringing up all physician payments to 75% of Medicare but instead, the legislature passed an increase up to 70% of Medicare, affecting only adult primary care and emergency physicians who were below the 70% mark.

Any gains in payments are almost immediately erased as Medicaid payments continue to slide backward due to inflation. In addition, Medicaid managed care companies can pass on their reductions to providers, resulting in deeper cuts to physicians. Many physician practices are small businesses. There is significant overhead to the cost of a medical business, and medical costs have risen at a faster rate than general inflation.
The only recourse a private practice physician has to avoid taking an unsustainable business loss is to either limit or refuse all new Medicaid patients. For example, when pediatricians' offices cannot maintain financial viability by accepting Medicaid enrollees that pay $36 for an acute visit compared to average business overhead costs of $48 per visit, pediatricians will have to close their doors to Medicaid enrollees. Emergency physicians and any other specialists who provide EMTALA-related care are at a distinct disadvantage because they are bound by law to treat ALL patients, including Medicaid patients, under the federal EMTALA law.
Every year, the Virginia Hospital and Healthcare Association and the nursing homes request (and usually receive) an inflation rate adjustment that the General Assembly allocates out of the general fund and is part of the Medicaid forecast that happens by November 1 of each year. We would be asking to be treated in the same manner on a yearly basis.

Desired Outcome:

That the Medical Society of Virginia will lead a push for an annual Medicaid inflation increase for all physicians, supported by all the interested physician specialty groups: the Virginia Chapter of the American Academy of Pediatrics, the VA College of Emergency Physicians, the VA Academy of Family Physicians, the Virginia Psychiatric Society, the Virginia Society of Eye Physicians and Surgeons, the VA Society of Anesthesiology, the VA Orthopaedic Society, Virginia Chapter of the American College of Radiology, Virginia Society of Plastic Surgeons, and the Virginia College of

Obstetrics and Gynecology to develop a strategic legislative plan to be included in the Governor's 2020 biennial budget.

Background/Supporting Information:

VA AAP is submitting this proposal with the support of their specialty colleagues:

VA College of Emergency Physicians, VA Academy of Family Physicians, Virginia Psychiatric Society, Virginia Society of Eye Physicians and Surgeons, VA Society of Anesthesiology, VA Orthopaedic Society, Virginia Chapter of the American College of Radiology, Virginia Society of Plastic Surgeons and Virginia College of Obstetrics and Gynecology

Additional information can be found on page 5-6 of the Appendix

Advocacy Summit Proposal 3

Title of Proposal:
Reform COPN

On behalf of:
Bhushan H Pandya, MD, Virginia GI Society, Danville Pittsylvania Academy of Medicine

Describe the Idea or Issue:

GI endoscopy services can be safely and cost effectively provided in the setting of an Ambulatory Care Center. These services are most efficiently provided in an ASC setting. It is preferred by the patients and adds to their satisfaction of care.
There are significant costs associated with providing these services. Providing these services particularly to patients on Medicare/Medicaid becomes prohibitive without reimbursement for additional facility fees.

Desired Outcome:

Current laws and regulations make it extremely expensive, time consuming and almost impossible to get a COPN to establish an Ambulatory Care Center. If laws and regulations are changed consistent with MSV policy, it will be possible for physicians particularly in independent practice of Gastroenterology to provide safe, efficient and cost effective services to all their patients including those covered under Medicare and Medicaid.

Advocacy Summit Proposal 4

Title of Proposal:
State Primary Care Residency Incentive

On behalf of:
Kenneth Qiu

Describe the Idea or Issue:

Like the rest of the nation, Virginia faces a looming physician shortage, especially in primary care. Virginia has 4 MD schools which each produce excellent physicians, including VCU which has a nationally renowned FM stat program to attract future family physicians. However, upon graduation, rarely do more than 50%, on average 30%, of those who match into family medicine stay in the state despite locally having around 10 residency programs.

Desired Outcome:

MSV should support state funding to incentive medical students stay in Virginia for residency, specifically in primary care, mostly in family medicine. Scholarships, loan repayment, or other forms of financing could be set up to draw those students interested in family medicine to stay in the state for residency and statistically to practice.

Background/Supporting Information:

UVA, VCU, EVMS match lists
VAFP residency program listings

Advocacy Summit Proposal 5

Title of Proposal:
Promoting Disclosure in Recording Patient-Physician Encounters

On behalf of:
American College of Physicians - Virginia Chapter

Describe the Idea or Issue:

Given the ubiquitous possession and use of smartphones, most patients can easily record encounters with their physicians. While this practice can be a useful communication tool for both parties and is currently gaining popularity and being encouraged in certain settings, patients are not required by law to ask permission or even disclose to the physician that they are recording the encounter. The unannounced recording or potential for and/or discovery of covert recording by the patient can certainly alter the patient-physician relationship negatively in many ways. We advocate for legislation that would require patients that chose to record their physician to, at minimum, disclose this to them which will allow time for any further preparation or conversation between both parties on rules of engagement before proceeding.

Desired Outcome:

Legislation that requires patient to disclose to their physician that they will be recording their encounter.

Background/Supporting Information:

ACP Internist Article
Washington Post Article
(Found on pages 7-14 of the Appendix)

Advocacy Summit Proposal 6

Title of Proposal:
Advancing Worker Heat Protection in the State of Virginia

On behalf of:
Virginia Clinicians for Climate Action and Virginia American College of Physicians

Describe the Idea or Issue:

Excessive heat exposure poses a direct threat to workers and the economy.
The Fourth National Climate Assessment identifies outdoor workers, who often labor in extreme heat without protections, as a population that “experience(s) increased climate risks due to a combination of exposure and sensitivity."
There is currently no national or Virginia occupational heat exposure standard.

Desired Outcome:

That the Medical Society of Virginia successfully advocates for the Virginia Legislature to pass legislation and will support related efforts that advance worker heat protections.

Background/Supporting Information:

Additional information can be found on pages 15-16 of the Appendix

Advocacy Summit Proposal 7

Title of Proposal:
Extending Medicare's Primary Care Exception to resident physicians who care for Virginia Medicaid Patients

On behalf of:
American College of Physicians - Virginia Chapter

Describe the Idea or Issue:

Under current Medicare guidelines, resident physicians who staff Graduate Medical Education approved primary care clinics can independently examine and treat patients with low to medium levels of complexity as long as the resident physician has practiced for 6 months and a supervising physician is readily available and reviews the plan of care with an attestation. This “Primary Care Exception” arguably allows for greater access to care as teaching programs may be the only option for those with Medicare. Virginia Medicaid currently does not offer such an exception. Given the recent expansion of Medicaid in Virginia and concerns for access to physicians who accept Medicaid, we support legislation that would require Virginia Medicaid and any Virginia Medicaid Commercial Provider to allow for a similar arrangement for teaching programs.

Desired Outcome:
Expanded primary care access to Medicaid patients.

Background/Supporting Information:

Virginia Medicaid Provider Manual
Medicare Learning Network Guidelines for Teaching Physicians, Interns, and Residents
(Found on pages 17-104 of the Appendix)

Advocacy Summit Proposal 8

Title of Proposal:
Non-Medical Exemptions for Vaccinations

On behalf of:
MSV Medical Student Section

Describe the Idea or Issue:
The anti-vaccination movement has grown significantly over the last 20 years. The growing threat of vaccine-preventable diseases is illustrated by recent outbreaks around the United States and in Virginia. As members of the medical community, we support the vaccination guidelines of the American Academy of Pediatrics, American Academy of Family Physicians, the Center for Disease Control, and the American Medical Association. The Commonwealth of Virginia currently allows non-medical exemptions for vaccinations. Other states have responded to the threat of vaccine-preventable diseases by discontinuing non-medical exemptions for immunizations. We propose changing the current Virginia law to allow only medical exemptions for vaccination. We believe the state should be proactive about this issue before we are forced to be reactive.

Desired Outcome:
Current law allows students with non-medical exemptions to attend school in Virginia. The Medical Student Section of the Medical Society of Virginia proposes the elimination of non-medical vaccine exemptions in Virginia. The proposed change would remove the non-medical exemption from current law. The goal is to allow only medical exemptions from vaccination for children to attend public and private school in the state of Virginia. The following laws are examples of the changes we hope to implement: 12VAC5-11-20, 22.1-271.2., and 32.1-46 (see attached documents). We recognize there are multiple additional laws that would need to be modified as well.

Background/Supporting Information:

<u>Herd immunity</u>
Herd immunity is the resistance to spread of disease within a population that results from a sufficiently high proportion of the population being immunized. It provides an indirect benefit to patients who cannot be vaccinated through prevention of disease transmission. For example, patients with specific medical conditions, such as severe allergic reactions to previous vaccines, known immunodeficiency, and other contraindications recommended by the CDC, cannot receive immunizations. In order to achieve herd immunity, communities must immunize a large enough fraction of the population to protect those who are unable to receive vaccinations. While it is often cited that a threshold of 95% vaccination is needed to achieve herd immunity, limiting factors, such as vaccine efficacy, heterogeneous populations, and nonrandom vaccination, cause difficulty in determining an exact fraction of the population needed to prevent transmission of diseases. Thus, it is imperative that all those who are able to safely receive the recommended immunizations are vaccinated to prevent harm to those who need medical exemptions.

<u>Current Vaccination & Exemption Rates</u>
While the nationwide level of children without vaccines is relatively low, it has increased from 0.3% of children in 2001 to 1.3% in 2015. The Commonwealth of Virginia has vaccine coverage rates of 95.5% for MMR, 98.2% for TDaP, 93.3% for 2-doses of VZV, and 93.5% for Polio for children enrolled in Kindergarten in the past school year. From the 2009-10 school year to the 2017-18 school year, the percentage of total vaccine exemptions in Virginia has increased from 0.9% to 1.5%, and non

medical exemptions, specifically, have increased from 0.7% to 1.1% of children enrolling in kindergarten.

Outbreaks

Measles was declared eradicated in the United States in 2000 after an initiative for routine second-dose measles vaccines was implemented in 1989. Since January 1, 2000, there have been over 1400 reported cases of measles in the United States, and a 2016 study reported on 970 cases with detailed vaccination data. Of these 970 cases, 59% were unvaccinated despite being medically eligible with 41% having non-medical exemptions. Therefore, nearly a third of the measles cases since the year 2000 were among those who were unvaccinated due to a non-medical exemption. This provides a significant opportunity to increase the vaccination rate and achieve the target goals necessary for herd immunity.

Within Virginia alone, multiple outbreaks of preventable infectious diseases have occurred over the past five years. In 2018, a mumps outbreak occurred in which 178 cases were reported across the state. Compared to the 4 years prior, which had an average number of 29 cases per year, 2018 demonstrated a 513% increase in cases. The number of reported Whooping Cough cases has also increased, with an average of 325 cases per year over the past five years, and a peak number of cases in 2014 with 501 cases reported. Even measles, a disease previously acknowledged to have been eradicated in the US, has been reported within Virginia, with 2 cases in 2014 and 1 case in 2015 and 2018.

Vaccine Law

Current Virginia law sets a list of mandatory vaccinations for disease control measures. The current law requires that these immunizations be administered before entering school, but the law allows both medical and non-medical exemptions. Medical exemptions may be granted for severe allergic reactions to previous vaccines, known immunodeficiency, and other contraindications recommended by the CDC. Non-medical exemptions may be granted for religious beliefs if the student or parent/guardian signs an affidavit stating that the administration of immunizations conflicts with the student's religious tenets or practices,.

Across the country, individual states dictate which non-medical exemptions are allowed, and there are currently three states that do not allow any non-medical exemptions: Mississippi, California, and West Virginia. A 1979 Mississippi state Supreme Court case ruled religious exemptions were unconstitutional, because it violates the 14th amendment. California legislation that went into effect on July 1, 2016 eliminated the ability to apply for new exemptions to immunization requirements based on personal or religious beliefs. West Virginia health code does not allow non-medical exemptions for immunizations. Washington,, Oregon, and New York are currently considering legislation that would restrict non-medical vaccine exemptions.

Organizational Support:

Among physician professional organizations, there is widespread support for restricting vaccine exemptions. The Medical Society of Virginia has already voted on and passed a resolution that supports the elimination of all non-medical vaccine exemptions in Virginia. Furthermore, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians, and the American Medical Association all support the elimination of non-medical exemptions for immunizations to protect those who cannot receive vaccines.

Background/Supporting Information:

Virginia Code Section 32.1-46

Virginia Code Section 22.1-271.2

12VAC5-110-80

(Found on pages 105-111 of the Appendix

Advocacy Summit Proposal 9

Title of Proposal:
Prevent bundling of PME and E/M codes

On behalf of:
Kurt Elward, MD

Describe the Idea or Issue:

Our colleagues were recently notified by their billing company that CIGNA has recently begun bundling a preventive service when done on the same day as an E & M service.
So, for example, if we submitted 99213-25 with 99396, the 99396 code is denying.

When questioned at the basic level, their response is that they are bundling the codes based on McKesson editing rules. They stated that we can submit notes for review.

This is in direct violation of CPT policies, and we have not noted this with any other payers.

Several years ago, most of the insurers were bundling when a modifier 25 was used. The RICO settlements of 2005 fixed most of this, but now we are seeing some recurrent activity.

For anyone who does a preventive service and also manages complaints and/or meds/ chronic conditions in the same visit, this is an absolute killer. The only way to fight it is to have the patient return for a separate visit, which is of course massively inconvenient.

Desired Outcome:

1. The MSV engage insurers to resolve this practice for any carrier.
2. MSV brings this to the attention of the legislators, the Northam Administration, VAHP, the Bureau of Insurance.
3. MSV engages the AMA in approaches to address this issue with us.
4. MSV alerts its members about the practice and to notify MSV about specific situations where this is occurring and how it is affecting patients.
5. MSV works with patient advocacy groups such as the Boards on Aging and AARP to put additional pressure on insurers.

Background/Supporting Information:
Medical Economics Blog Post
AAFP Blog Post
AAP News Article
(Found on pages 112-118 of the Appendix)

Advocacy Summit Proposal 10

Title of Proposal:
Banning Conversion Therapy

On behalf of:
Richmond Academy of Medicine

Describe the Idea or Issue:

The medical literature shows conversion therapy is a dangerous and ineffective modality. At the 2018 MSV Annual meeting, the House of Delegates passed a resolution dealing with Conversion Therapy which said MSV opposes the use of conversion therapy or any similar practice, including but not limited to reparative therapy, ex-gay therapy, or sexual orientation change efforts in those under age 18.

In the 2019 General Assembly session, the legislature defeated a bill to ban conversion therapy and it is now working its way through the Health Department Boards.

Desired Outcome:
The Richmond Academy of Medicine requests that MSV add banning Conversion Therapy for those under the age of 18 to its public policy and legislative priority agendas. This includes supporting efforts by any state medical Boards to ban the practice.

Advocacy Summit Proposal 11

Title of Proposal:
Commonwealth Care Health Benefits Program

On behalf of:
Richmond Academy of Medicine

Describe the Idea or Issue:

Premiums for individuals on the ACA have been escalating for the last several years. This is particularly impacting those individuals who do not receive subsidies due to their income being above 400% of the federal poverty level. In addition, these policies have particularly high deductibles and out-of-pocket maximums before the insurance coverage kicks in. These policies also have particularly narrow networks of providers and no out-of-network benefits. The Trump administration has contributed to undermining the ACA in several ways. They have eliminated reimbursement for the cost-sharing reductions payments. They have drastically reduced funding for efforts to assist people to sign up for the ACA. They have eliminated the penalty for the individual mandate to buy health insurance. They have not continued the reinsurance program initiated in the early years of the ACA. All of these factors have contributed to increased premiums and last year a 4% decrease in the number of individuals to sign up for the ACA. This will continue to result in lack of access to affordable healthcare for many of our patients and poor reimbursement for services to our physicians.

In the General Assembly this year, Senator Dunnavant proposed SB 1717 the Commonwealth Care Health Benefits Program. This bill sought to pool all the individuals in the state into one insurance pool to help bring down the risk that the current individual local markets have failed to do. This would be a state run entity much like a large employer based healthcare insurance plan. Or very similar to the state run plan currently provided for the state employees. It would include a reinsurance provision and disease management as well. Apparently while this bill passed the Senate unanimously it was left in the rules committee. Somehow is was placed as a budget amendment into the budget with funding beginning studying this in 2020. However we need action on this sooner as we are facing increased premiums again for 2020 unless the state takes some action to stabilize this important insurance marketplace. This has been also studied by the Governor in the Virginia Market Stability Work Group with the same conclusions but no action.

Desired Outcome:
The Richmond Academy of Medicine requests that MSV urge the state to begin work to stabilize the Commonwealth Care Health Benefits Program now, prior to the budgeted 2020 study. Because we are facing increased premiums for 2020, action is needed now, not later.

Background/Supporting Information:
SB1717 from the 2019 General Assembly Session

(Found on pages 119-120 of the Appendix)

Advocacy Summit Proposal 12

Title of Proposal:
Increasing Access to Palliative Care

On behalf of:
Richmond Academy of Medicine

Describe the Idea or Issue:
Palliative Care (PC) has been shown to improve quality of life and decrease physical, psychological and spiritual distress in patients with serious illness. Providing PC for patients with serious illness throughout the Commonwealth will decrease the fear and suffering associated with death. An assessment of specialist PC availability is needed to identify deficiencies and improve patient access. This includes determining the number of board certified and fellowship trained PC physicians, Nurse practitioners and other Interdisciplinary team members with PC training. In addition, for a more comprehensive assessment, a statewide assessment of advance care planning efforts, POST implementation, and hospice availability would be useful. Evaluation of Advance Care Planning efforts could also include an assessment of each hospital's Electronic Medical Record for code status orders, POST documentation, storing and accessing advance directives, etc.

Desired Outcome:
The Richmond Academy of Medicine requests that the Medical Society of Virginia work to identify Virginia's Palliative Care needs. We'd like MSV to work with stakeholders to determine the number of physicians, nurses, social workers, etc. that would be required in each county and/or community/region of the state to achieve a meaningful level of saturation of palliative care specialists. By identifying these palliative care needs, MSV can ultimately improve physical, psychological and spiritual well-being of patients living with serious illness, help to decrease the fear and suffering associated with a life-limiting diagnosis and decrease the desire for medically assisted death.

Advocacy Summit Proposal 13

Title of Proposal:
Firearm Risk/Harm Reduction

On behalf of:
Richmond Academy of Medicine

Describe the Idea or Issue:
MSV has a number of policies supporting laws and regulations relating to firearms including: Policy 145.003 which promotes trauma control and increased public safety, Policy 17-204 which supports gun violence restraining orders as mechanisms to decrease gun related suicides and homicides and Policy 515.001 which opposes any type of domestic violence and supports the inclusion of educational material regarding resources, criminal laws, and prevention in government publications related to marriage and families.

Research indicates that states which restrict access to firearms by abusers under restraining orders saw an 8% decrease in intimate partner homicides (Vigdor, et al). Research also indicates that individuals with prior misdemeanor convictions are at greater risk of future violence and firearm-related crimes (Wintemute, et al). District of Columbia vs. Heller upheld the right of individual states to impose restrictions on gun ownership.

In the 2018 Virginia General Assembly session, SB 732 as introduced would prohibit “a person who has been convicted of stalking, sexual battery, assault and battery of a family or household member, brandishing a firearm, or two or more convictions of assault and battery from possessing or transporting a firearm” but this bill was passed by indefinitely.

Desired Outcome:
The Richmond Academy of Medicine requests that the Medical Society of Virginia staff seek to introduce (and actively support) legislation creating gun violence restraining orders (also known as extreme risk restraining orders) and legislation prohibiting gun ownership by individuals convicted of prior violent misdemeanors, such as 2018 SB 732.

Background/Supporting Information:
SB732 from 2018 GA Session

(Found on pages 121-127 of the Appendix)

Advocacy Summit Proposal 14

Title of Proposal:
Limit Sales of Assault Weapons

On behalf of:
Richmond Academy of Medicine

Describe the Idea or Issue:
On February 16, 2018 the American Academy of Family Physicians, American College of Physicians, the American Academy of Pediatrics, the American College of Obstetrics and Gynecology and the American Psychiatric Association all renewed their call on government to act on the public health epidemic of gun violence including placing constitutionally appropriate restrictions on the manufacture and sale of assault weapons and large capacity magazines. On February 28, 2018 the American College of Surgeons reiterated their continued support of restrictions on assault weapons and large-capacity ammunition clips. Multiple studies have demonstrated an inverse relationship between limits on firearm ownership and gun-related death rates.

Current MSV policy expresses support for future laws and regulations relating to firearms which would promote trauma control and increased public safety (Policy 145.003) and current MSV Policy also opposes any type of Domestic violence and supports the inclusion of educational material regarding resources, criminal laws, and prevention in government publications related to marriage and families (Policy 515.001). District of Columbia vs. Heller upholds the right of individual states to impose restrictions on gun ownership.

Desired Outcome:
The Richmond Academy of Medicine asks that the Medical Society of Virginia actively pursue and endorse any legislation that limits sale and ownership of large capacity magazines, bump stocks, and firearms with features designed to increase their rapid firing ability as defined in H.R. 3355 of the 103rd Congress. Additionally, we ask that the Medical Society of Virginia actively pursue and endorse any legislation which promotes uniform/universal background checks for gun sales.

Background/Supporting Information:
District of Columbia vs. Heller

(Found on pages 128-130 of the Appendix)

Advocacy Summit Proposal 15

Title of Proposal:
Monitoring the Enforcement of Legislation

On behalf of:
Richmond Academy of Medicine

Describe the Idea or Issue:
The history of citizens, physicians and, therefore, the MSV has been to focus on educating and, ultimately influencing elected officials to pass laws as a means of correcting identified problems or improving existing situations. The was evident in the 2019 General Assembly session as demonstrated by a number of notable successes (i.e., signed legislation on step therapy exception processes, copay accumulator ban, etc.). However, as we learned from the past with the "Omnibus Utilization Review Fix", passed legislation without appropriate regulations, regulatory oversight and consequences for violations makes these legislative efforts essentially worthless. If the regulations and consequences for violating the laws are not identified, reported or enforced and/or there are loopholes or exceptions that allow the words and intent of the legislation to be ignored, the identified issues can neither be corrected or improved.

Desired Outcome:
MSV develop an ongoing and robust program of regulatory oversight in concert with at least its members and other professional and patient organizations to ensure that legislation supporting our health care priorities have appropriate regulations and that these laws and regulations are vigorously enforced. This program should include, at least, mechanisms to allow for input on regulatory construction and dissemination as well as an ongoing monitoring with reporting and regular data analyses to ensure legal compliance as well as a mechanism to engage appropriate Commonwealth agencies in the enforcement of any violations.