

## DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

### AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee B

Peter Rheinstein, MD, JD, Chair

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1 Your Reference Committee recommends the following consent calendar for acceptance:

2  
3 **RECOMMENDED FOR ADOPTION**

- 4  
5 1. Board of Trustees Report 11 — Safe and Effective Overdose Reversal  
6 Medications in Educational Settings  
7 2. Board of Trustees Report 19 — Attorneys’ Retention of Confidential Medical  
8 Records and Controlled Medical Expert’s Tax Returns After Case Adjudication  
9 3. Resolution 205 — Medical-Legal Partnerships & Legal Aid Services  
10 4. Resolution 209 — Native American Voting Rights  
11 5. Resolution 212 — Advocacy Education Towards a Sustainable Medical Care  
12 System  
13 6. Resolution 221 — Reforming Medicare Part B Drug Reimbursement to Promote  
14 Patient Affordability and Physician Practice Sustainability  
15 7. Resolution 223 — Increase in Children’s Hospital Graduate Medical Education  
16 Funding  
17 8. Resolution 227 — Medicare Reimbursement for Telemedicine  
18 9. Resolution 228 — Waiver of Due Process Clauses  
19 10. Resolution 230 — Protecting Patients from Inappropriate Dentist and Dental  
20 Hygienist Scope of Practice Expansion  
21 11. Resolution 231 — Supporting the Establishment of Rare Disease Advisory  
22 Councils  
23 12. Resolution 232 — Medicare Advantage Part B Drug Coverage  
24 13. Resolution 235 — Establish a Cyber-Security Relief Fund  
25 14. Resolution 238 — AMA Supports Efforts to Fund Overdose Prevention Sites  
26 15. Resolution 248 — Sustain Funding for HRSA (Health Resources Services and  
27 Administration) 340B Grant-Funded Programs  
28 16. Resolution 250 — Endorsement of the Uniform Health-Care Decisions Act  
29

30 **RECOMMENDED FOR ADOPTION AS AMENDED**

- 31  
32 17. Board of Trustees Report 09 — Council on Legislation Sunset Review of 2014  
33 House Policies  
34 18. Board of Trustees Report 12 – AMA Efforts on Medicare Payment Reform  
35 19. Board of Trustees Report 14 — Physician Assistant and Nurse Practitioner  
36 Movement Between Specialties

- 1 20. Board of Trustees Report 16 — Support for Mental Health Courts
- 2 21. Board of Trustees Report 17 — Drug Policy Reform
- 3 22. Board of Trustees Report 18 — Supporting Harm Reduction
- 4 23. Resolution 201 — Research Correcting Political Misinformation and
- 5 Disinformation on Scope of Practice
- 6 24. Resolution 204 — Staffing Ratios in the Emergency Department
- 7 25. Resolution 206 — Indian Health Service Youth Regional Treatment Centers
- 8 26. Resolution 207 — Biosimilar Use Rates and Prevention of Pharmacy Benefit
- 9 Manager Abuse
- 10 27. Resolution 208 — Improving Supplemental Nutrition Programs
- 11 28. Resolution 214 – Support for Paid Sick Leave
- 12 29. Resolution 215 — American Indian and Alaska Native Language Revitalization
- 13 and Elder Care
- 14 30. Resolution 216 — The AMA Supports H.R. 7225, the Bipartisan “Administrative
- 15 Law Judges Competitive Service Restoration Act”
- 16 31. Resolution 219 — Bundling for Maternity Care Services
- 17 32. Resolution 220 — Restorative Justice for the Treatment of Substance Use
- 18 Disorders
- 19 33. Resolution 222 — Studying Avenues for Parity in Mental Health & Substance
- 20 Use Coverage
- 21 34. Resolution 224 — Antidiscrimination Protections for LGBTQ+ Youth in Foster
- 22 Care
- 23 35. Resolution 229 — Opposition to Legalization of Psilocybin
- 24 36. Resolution 233 — Prohibiting Mandatory White Bagging
- 25 37. Resolution 234 — State Prescription Drug Affordability Boards – Study
- 26 38. Resolution 239 — Requiring stores that sell tobacco products to display NYS
- 27 Quitline information
- 28 39. Resolution 242 — Cancer Care in Indian Health Services Facilities
- 29 40. Resolution 247 — Prohibit Health Benefit Plans From Charging Cost Sharing for
- 30 Covered Prostate Cancer Screening
- 31 41. Resolution 249 — Pediatric Specialty Medicaid Reimbursement
- 32 42. Resolution 252 – Model Legislation to Protect the Future of Medicine
- 33 43. Resolution 253 – Addressing the Failed Implementation of the No Surprises Act
- 34 IDR Process

#### 36 **RECOMMENDED FOR ADOPTION IN LIEU OF**

- 37
- 38 44. Board of Trustees Report 13 — Prohibiting Covenants Not-to-Compete
- 39 45. Resolution 210 — Support for Physicians Pursuing Collective Bargaining and
- 40 Unionization
- 41 Resolution 236 — Support of Physicians Pursuing Collective Bargaining and
- 42 Unionization
- 43 46. Resolution 213 — Access to Covered Benefits with an Out of Network Ordering
- 44 Physician
- 45 Resolution 245 — Patient Access to Covered Benefits Ordered by Out-of-
- 46 Network Physicians
- 47 47. Resolution 217 — Protecting Access to IVF Treatment
- 48 Resolution 226 — Protecting Access to IVF Treatment
- 49 48. Resolution 251 — Streamline Payer Quality Metrics
- 50

1 **RECOMMENDED FOR REFERRAL**

- 2
- 3 49. Board of Trustees Report 15 — Augmented Intelligence Development,  
4 Deployment, and Use in Health Care  
5 Resolution 202 — Use of Artificial Intelligence and Advanced Technology by  
6 Third Party Payors to Deny Health Insurance Claims  
7 Resolution 246 — Augmented Intelligence in Health Care  
8 50. Resolution 218 — Designation of Descendants of Enslaved Africans in America  
9 51. Resolution 243 — Disaggregation of Demographic Data for Individuals of  
10 Federally Recognized Tribes

11

12 **RECOMMENDED FOR NOT ADOPTION**

- 13
- 14 52. Resolution 225 — Humanitarian Efforts to Resettle Refugees

15

16 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

- 17
- 18 53. Resolution 237 — Encouraging the Passage of the Preventive Health Savings  
19 Act (S.114)  
20 54. Resolution 244 — Graduate Medical Education Opportunities for American  
21 Indian and Alaska Native Communities

22

23

24

25 **Amendments**

26 **If you wish to propose an amendment to an item of business, click here: [Submit](#)**  
27 **[New Amendment](#)**

1 **RECOMMENDED FOR ADOPTION**

2  
3 (1) BOARD OF TRUSTEES REPORT 11 — SAFE AND  
4 EFFECTIVE OVERDOSE REVERSAL MEDICATIONS IN  
5 EDUCATIONAL SETTINGS

6  
7 RECOMMENDATION:

8  
9 Madam Speaker, your Reference Committee recommends  
10 that Board of Trustees Report 11 be adopted and that the  
11 remainder of the Report be filed.

12  
13 **HOD ACTION: Recommendations in Board of Trustees**  
14 **Report 11 adopted and the remainder of the Report filed.**

15  
16 The Board of Trustees recommends that the following be adopted, and that the remainder  
17 of the report be filed:

- 18  
19 1. Existing American Medical Association (AMA) policy entitled, “Increasing  
20 Availability of Naloxone and Other Safe and Effective Overdose Reversal  
21 Medications” (Policy H42 95.932), be reaffirmed, and (Reaffirm HOD Policy)
- 22 2. The third resolve of Policy H-95.908, “Increase Access to Safe and Effective  
23 Overdose Reversal Medications in Educational Settings” be rescinded and that the  
24 policy be updated as noted. (Modify Current HOD Policy)
- 25  
26 1. Our AMA will encourage states, communities, and educational settings to  
27 adopt legislative and regulatory policies that allow schools to make safe and  
28 effective overdose reversal medications readily accessible to staff and  
29 teachers to prevent opioid overdose deaths in educational settings.
- 30 2. Our AMA will encourage states, communities, and educational settings to  
31 remove barriers to students carrying safe and effective overdose reversal  
32 medications.
- 33 ~~3. Our AMA will study and report back on issues regarding student access to safe~~  
34 ~~and effective overdose reversal medications.~~

35  
36 Your Reference Committee heard supportive testimony for the recommendations of Board  
37 of Trustees Report 11. Your Reference Committee agrees that our AMA must continue  
38 efforts to support increased access to naloxone and other overdose reversal medications  
39 and reduce the stigma directed toward individuals who use drugs. Therefore, your  
40 Reference Committee recommends that Board of Trustees Report 11 be adopted, and  
41 that the remainder of the report be filed.

1 (2) BOARD OF TRUSTEES REPORT 19 — ATTORNEYS'  
2 RETENTION OF CONFIDENTIAL MEDICAL RECORDS  
3 AND CONTROLLED MEDICAL EXPERT'S TAX  
4 RETURNS AFTER CASE ADJUDICATION  
5

6 RECOMMENDATION:  
7

8 Madam Speaker, your Reference Committee recommends  
9 that Board of Trustees Report 19 be adopted and the  
10 remainder of the Report be filed.  
11

12 **HOD ACTION: Recommendations in Board of Trustees**  
13 **Report 19 adopted and the remainder of the Report filed.**  
14

15 The Board of Trustees recommends that the following be adopted in lieu of Resolution  
16 240-A-23 and the remainder of this report be filed:  
17

- 18 1. That our American Medical Association advocate that attorneys' discovery  
19 requests for the personal tax returns of a medical expert for the opposing party  
20 should usually be limited to 1099-MISC forms (miscellaneous income) (New HOD  
21 Policy); and  
22
- 23 2. RESOLVED, That our AMA support through legislative or other relevant means  
24 the proper return or destruction of client medical records and medical expert's  
25 personal tax returns by attorneys within sixty days of the conclusion of the litigation  
26 (New HOD Policy).  
27

28 Your Reference Committee heard supportive testimony on the recommendations of Board  
29 of Trustees Report 19. Your Reference Committee heard that seeking a medical expert's  
30 entire personal income tax returns is, in most instances, overly broad and unnecessarily  
31 invades the expert's privacy. Testimony supported limiting personal tax return discovery  
32 of a medical expert to miscellaneous income (1099-MISC forms), as it strikes a reasonable  
33 balance between allowing the probing for potential bias and protecting the expert's privacy  
34 and burdens. However, there was minimal testimony provided that noted that  
35 amendments should be made to the report to reflect that most contract EM physicians  
36 only receive a 1099 for all of their professional physician payments which would not  
37 adequately protect them from having to disclose the majority of their taxable income when  
38 testifying as an expert in a case. Your Reference Committee also heard that during  
39 litigation, certain documents that contain sensitive or confidential information, such as  
40 client medical records and tax returns, of medical experts are provided for the court and  
41 that there should be a reasonable timeframe after which such documents are destroyed.  
42 Therefore, your Reference Committee recommends that Board of Trustees Report 19 be  
43 adopted, and the remainder of the report be filed.

1 (3) RESOLUTION 205 — MEDICAL-LEGAL PARTNERSHIPS  
2 & LEGAL AID SERVICES  
3

4 RECOMMENDATION:  
5

6 Madam Speaker, your Reference Committee recommends  
7 that Resolution 205 be adopted.  
8

9 **HOD ACTION: Resolution 205 adopted.**

10  
11 RESOLVED, that our American Medical Association support the establishment and  
12 funding of medical-legal partnerships and civil legal aid services to meet patients' legal  
13 needs. (New HOD Policy)  
14

15 Your Reference Committee heard mostly supportive testimony for Resolution 205.  
16 Testimony indicated that Medical-Legal Partnerships (MLPs) had a proven track record of  
17 success in addressing issues concerning social determinates of health and advancing the  
18 goals of health equity. Testimony also noted numerous organizations, including the  
19 American Bar Association, that support the growth and effectiveness of Medical-Legal  
20 Partnerships. Very minimal testimony opposed the resolution noting a lack of  
21 understanding surrounding how these asks would be funded. In response to the testimony  
22 noting funding concerns additional testimony stated that this resolution was not intended  
23 to require our AMA to fund MLPs, and instead represented an opportunity for a  
24 collaboration between our AMA, the American Bar Association, and the Association of  
25 American Medical Colleges, as well as other interested organizations in advancing MLPs.  
26 Given the predominantly positive testimony, your Reference Committee recommends that  
27 Resolution 205 be adopted.  
28

29 (4) RESOLUTION 209 — NATIVE AMERICAN VOTING  
30 RIGHTS  
31

32 RECOMMENDATION:  
33

34 Madam Speaker, your Reference Committee recommends  
35 that Resolution 209 be adopted.  
36

37 **HOD ACTION: Resolution 209 adopted.**

38  
39 RESOLVED, that our American Medical Association support Indian Health Service, Tribal,  
40 and Urban Indian Health Programs becoming designated voter registration sites to  
41 promote nonpartisan civic engagement among the American Indian and Alaska Native  
42 population. (New HOD Policy)  
43

44 Your Reference Committee heard testimony in support of Resolution 209. Your Reference  
45 Committee heard that it is important that our AMA support the designation of Indian Health  
46 Service, Tribal, and Urban Indian (ITU) Health Programs as official voter registration sites  
47 to promote nonpartisan civic engagement among American Indian and Alaska Native  
48 communities. Your Reference Committee further heard that civic engagement via voting  
49 can have a significant impact on social/structural determinants of health, and that this  
50 resolution is consistent with AMA policy that acknowledges that voting is a social

1 determinant of health. Testimony also stated that medical schools, teaching hospitals, and  
2 other federal agencies such as the Veterans Health Administration are recognized as  
3 designated voter registration sites, therefore, ITU health programs deserve the same  
4 designation to promote increased engagement in voting by Native peoples, especially  
5 given their close proximity to Native communities. Therefore, your Reference Committee  
6 recommends that Resolution 209 be adopted.

7  
8 (5) RESOLUTION 212 — ADVOCACY EDUCATION  
9 TOWARDS A SUSTAINABLE MEDICAL CARE SYSTEM

10  
11 RECOMMENDATION:

12  
13 Madam Speaker, your Reference Committee recommends  
14 that Resolution 212 be adopted.

15  
16 **HOD ACTION: Resolution 212 adopted.**

17  
18 RESOLVED, that our American Medical Association explore innovative opportunities for  
19 engaging the public in advocacy on behalf of an improved healthcare environment.  
20 (Directive to Take Action)

21  
22 Your Reference Committee heard limited but supportive testimony on Resolution 212.  
23 Your Reference Committee heard that AMA policy addresses the education of medical  
24 students and physicians on advocacy techniques and encourages their involvement in  
25 AMA advocacy efforts. Testimony also noted that our AMA believes that better-informed  
26 and more active citizens will result in better legislators, better government, and better  
27 health care. Your Reference Committee further heard that our AMA already has robust  
28 grassroots activities that include outreach to engage patient advocates through its Patient  
29 Advocate Network (PAN), and that PAN has been active on issues including Medicare,  
30 drug pricing, and prior authorization. Your Reference Committee also heard testimony that  
31 greater involvement of the public in AMA advocacy efforts potentially could make our AMA  
32 more effective in its advocacy on behalf of patients and the profession. Therefore, your  
33 Reference Committee recommends that Resolution 212 be adopted.

34  
35 (6) RESOLUTION 221 — REFORMING MEDICARE PART B  
36 DRUG REIMBURSEMENT TO PROMOTE PATIENT  
37 AFFORDABILITY AND PHYSICIAN PRACTICE  
38 SUSTAINABILITY

39  
40 RECOMMENDATION:

41  
42 Madam Speaker, your Reference Committee recommends  
43 that Resolution 221 be adopted.

44  
45 **HOD ACTION: Resolution 221 adopted.**

46  
47 RESOLVED, that our American Medical Association support the creation of a new  
48 reimbursement model for Part B drugs that 1) Disentangles reimbursement from the drug  
49 price, or any weighted market average of the drug price, by reimbursing physicians for the  
50 actual cost of the drug, and 2) Ensures adequate compensation for the cost of acquisition,

1 inventory, storage, and administration of clinically-administered drugs that is based on  
2 physician costs, not a percent of the drug price (New HOD Policy); and be it further  
3

4 RESOLVED, that our AMA maintain the principles that any revised Part B reimbursement  
5 models should promote practice viability, especially for small physician practices,  
6 practices in rural and/or underserved areas, and practices with a significant proportion of  
7 Medicare patients, to promote continued treatment access for patients. (New HOD Policy)  
8

9 Your Reference Committee heard supportive testimony on Resolution 221. Your  
10 Reference Committee heard that Resolution 221 addresses important needs for  
11 restructuring Medicare Part B drug reimbursement to better reflect the actual costs  
12 physicians incur in acquiring, storing, and administering drugs. Your Reference Committee  
13 heard that the resolution emphasizes ensuring adequate compensation for physicians,  
14 particularly focusing on the sustainability of small practices and those in rural or  
15 underserved areas. Therefore, your Reference Committee recommends that Resolution  
16 221 be adopted.  
17

18 (7) RESOLUTION 223 — INCREASE IN CHILDREN'S  
19 HOSPITAL GRADUATE MEDICAL EDUCATION  
20 FUNDING  
21

22 RECOMMENDATION:  
23

24 Madam Speaker, your Reference Committee recommends  
25 that Resolution 223 be adopted.  
26

27 **HOD ACTION: Resolution 223 adopted.**  
28

29 RESOLVED, that our American Medical Association collaborate with other relevant  
30 medical organizations to support and advocate for increased funding for the Children's  
31 Hospitals Graduate Medical Education program, recognizing the vital role it plays in  
32 shaping the future of pediatric healthcare in the United States. (Directive to Take Action)  
33

34 Your Reference Committee heard supportive testimony on Resolution 223. Your  
35 Reference Committee heard about how important consistent, and increased, funding is  
36 for Children's Hospital Graduate Medical Education (CHGME) programs as well as the  
37 important work undertaken by CHGME. Further testimony noted that CHGME is funded  
38 separately from other GME funding and receives considerably less funding than other  
39 GME programs leading to an inability to sustain growth in residency programs. Testimony  
40 also highlighted that our AMA has policy in line with this resolution and noted that our AMA  
41 has signed onto letters this year and last year asking for more CHGME funding, and  
42 consistently advocates for holistic funding increases for GME. Therefore, your Reference  
43 Committee recommends that Resolution 223 be adopted.



1 (8) RESOLUTION 227 — MEDICARE REIMBURSEMENT  
2 FOR TELEMEDICINE  
3

4 RECOMMENDATION:  
5

6 Madam Speaker, your Reference Committee recommends  
7 that Resolution 227 be adopted.  
8

9 **HOD ACTION: Resolution 227 adopted.**

10  
11 RESOLVED, that our American Medical Association support removal of the December 31,  
12 2024 “sunset” date currently set for Medicare to cease reimbursement for services  
13 provided via telemedicine, such that reimbursement of medical services provided by  
14 telemedicine be continued indefinitely into the future, consistent with what would be  
15 determined by the Relative Value Update Committee (“RUC”). (New HOD Policy)  
16

17 Your Reference Committee heard strong supportive testimony on Resolution 227.  
18 Testimony reflected that a permanent telehealth solution is undebated at this juncture as  
19 it has provided vast improvement in access to care for both rural, urban, and underserved  
20 populations such as the environmental benefits due to decreased travel for medical  
21 appointments. An amendment was proposed to adopt more flexible telehealth  
22 reimbursement models, suggesting the need for adaptability in valuing these services.  
23 However, testimony also overwhelmingly noted that our AMA has been active in its  
24 advocacy efforts as part of the AMA Recovery Plan for America’s Physicians and has  
25 consistently urged Congress to implement a permanent solution to supplant the flexibility  
26 granted by the public health emergency’s waivers. Therefore, given the strong support  
27 and compelling benefits discussed, your Reference Committee recommends that  
28 Resolution 227 be adopted.  
29

30 (9) RESOLUTION 228 — WAIVER OF DUE PROCESS  
31 CLAUSES  
32

33 RECOMMENDATION:  
34

35 Madam Speaker, your Reference Committee recommends  
36 that Resolution 228 be adopted.  
37

38 **HOD ACTION: Resolution 228 adopted as amended to read**  
39 **as follows:**

40  
41 **RESOLVED, that our AMA will engage in advocacy for**  
42 **adoption of such legislation to eliminate waiver of due**  
43 **process clauses at the federal level.**  
44

45 RESOLVED, that our American Medical Association advocate that waiver of due process  
46 clauses be eliminated from all employment agreements between employed physicians  
47 and their non-physician employers, and be declared unenforceable in physicians’  
48 previously-executed employment agreements between physicians and their non-  
49 physician employers that currently exist (Directive to Take Action); and be it further

1 RESOLVED, that our AMA will engage in advocacy for adoption of such legislation at the  
2 federal level. (Directive to Take Action)

3  
4 Your Reference Committee heard predominantly supportive testimony on Resolution 228.  
5 Testimony noted that most physicians are employed, and because they have little  
6 bargaining power with employers, cannot walk away from bad employment deals or  
7 negotiate due process clauses in employment or other contracts. Testimony also indicated  
8 that many states do not recognize medical staff bylaws as a contract so many physicians  
9 have no protections under hospital bylaws against due process waivers. Further  
10 testimony revealed that due process waivers harm patients because they discourage  
11 physicians from speaking out about patient care concerns and effectively make physicians  
12 at-will employees whose employment can be terminated at any time. Your Reference  
13 Committee notes that our AMA is already on the record supporting the 2024 “Physician  
14 and Patient Safety Act” as requested by the resolution. Therefore, your Reference  
15 Committee recommends that Resolution 228 be adopted.

16  
17 (10) RESOLUTION 230 — PROTECTING PATIENTS FROM  
18 INAPPROPRIATE DENTIST AND DENTAL HYGIENIST  
19 SCOPE OF PRACTICE EXPANSION

20  
21 RECOMMENDATION:

22  
23 Madam Speaker, your Reference Committee recommends  
24 that Resolution 230 be adopted.

25  
26 **HOD ACTION: Resolution 230 adopted.**

27  
28 RESOLVED, that our American Medical Association advocacy efforts recognize the threat  
29 posed to patient safety when dentists and dental hygienists are authorized to practice  
30 medicine and administer procedures outside their level of education and training (New  
31 HOD Policy); and be it further

32  
33 RESOLVED, that our AMA actively oppose regulatory and legislative efforts authorizing  
34 dentists and dental hygienists to practice outside their level of education and training.  
35 (Directive to Take Action)

36  
37 Your Reference Committee heard testimony in support of Resolution 230. Testimony  
38 emphasized that patient safety is threatened when health care professionals, including  
39 dentists and dental hygienists, practice outside the scope of their education and training.  
40 Your Reference Committee heard that Resolution 230 aligns with our AMA’s existing  
41 campaign supporting physician-led care and opposing inappropriate scope expansions.  
42 Therefore, your Reference Committee recommends that Resolution 230 be adopted.

1 (11) RESOLUTION 231 — SUPPORTING THE  
2 ESTABLISHMENT OF RARE DISEASE ADVISORY  
3 COUNCILS

4  
5 RECOMMENDATION:

6  
7 Madam Speaker, your Reference Committee recommends  
8 that Resolution 231 be adopted.

9  
10 **HOD ACTION: Resolution 231 referred.**

11  
12 RESOLVED, that our American Medical Association will support state legislation for the  
13 establishment of Rare Disease Advisory Councils in each state (New HOD Policy).

14  
15 Your Reference Committee heard mixed testimony on Resolution 231. Your Reference  
16 Committee heard that Rare Disease Advisory Councils give the rare disease community  
17 a stronger voice in state government and support patients and their caregivers. Your  
18 Reference Committee heard that Rare Disease Advisory Councils are uniquely positioned  
19 to add gravitas to the needs of patients with rare diseases and the health care  
20 professionals that care for them. Additional testimony noted that Rare Disease Advisory  
21 Councils play an important role in filling gaps in knowledge surrounding this patient  
22 population and emphasized that it is important that these Councils are given the support  
23 they need to expand to all states (27 states already have these Councils), giving rare  
24 disease patients across the U.S. a strong and unified voice. However, your Reference  
25 Committee also heard testimony in support of referral. Testimony asked for further study  
26 on the involvement of specialists and medical specialty associations in Rare Disease  
27 Advisory Councils and expressed concern that Rare Disease Advisory Councils can  
28 become a mechanism for the pharmaceutical industry – rather than patients and their  
29 health care team – to further exert influence on the policymaking process. However, your  
30 Reference Committee heard mostly supportive testimony and also notes that adoption of  
31 Resolution 231 would not prevent our AMA from working with state and specialty  
32 associations to ensure the appropriate design of Rare Disease Advisory Councils.  
33 Therefore, your Reference Committee recommends that Resolution 231 be adopted.

34  
35 (12) RESOLUTION 232 — MEDICARE ADVANTAGE PART B  
36 DRUG COVERAGE

37  
38 RECOMMENDATION:

39  
40 Madam Speaker, your Reference Committee recommends  
41 that Resolution 232 be adopted.

42  
43 **HOD ACTION: Resolution 232 adopted.**

44  
45 RESOLVED, that our American Medical Association will advocate with Congress, through  
46 the appropriate oversight committees, and with the Centers for Medicare & Medicaid  
47 Services (CMS) to require that Medicare Advantage (MA) plans cover physician-  
48 administered drugs and biologicals in such a way that the patient out of pocket cost is the  
49 same or less than the amount that a patient with traditional Medicare plus a Medigap plan  
50 would pay. (Directive to Take Action)

1 Your Reference Committee heard supportive testimony on Resolution 232. Your  
2 Reference Committee heard that Resolution 232 addresses significant concerns  
3 regarding the equity of drug coverage in Medicare Advantage plans. Your Reference  
4 Committee heard that by supporting this resolution, our AMA would enhance its ability to  
5 advocate for more equitable drug coverage policies within these plans. Testimony noted  
6 that the disparities in out-of-pocket costs for drugs under Medicare Advantage plans lead  
7 to inequitable health outcomes, particularly for less affluent patients. Testimony  
8 highlighted that by advocating for changes to these plans, our AMA is effectively  
9 positioned to influence future Centers for Medicare & Medicaid Services rules. Though  
10 one individual testified that this increased coverage could lead to the erosion of Traditional  
11 Medicare plans, most of the testimony supported this resolution. Therefore, your  
12 Reference Committee recommends that Resolution 232 be adopted.

13  
14 (13) RESOLUTION 235 — ESTABLISH A CYBER-SECURITY  
15 RELIEF FUND

16  
17 RECOMMENDATION A:

18  
19 Madam Speaker, your Reference Committee recommends  
20 that Resolution 235 be adopted.

21  
22 **HOD ACTION: Resolution 235 adopted.**

23  
24 RESOLVED, that our American Medical Association, through appropriate channels,  
25 advocate for a ‘Cyber Security Relief Fund’ to be established by Congress (Directive to  
26 Take Action); and be it further

27  
28 RESOLVED, that the “Cyber Security Relief Fund” be funded through contributions from  
29 health insurance companies and all payers - as a mandated requirement by each of the  
30 payer (Directive to Take Action); and be it further

31  
32 RESOLVED, that the “Cyber Security Relief Fund” only be utilized for ‘uninterrupted’  
33 payments to all providers- in a structured way, in the event of future cyber-attacks affecting  
34 payments. (Directive to Take Action)

35  
36 Your Reference Committee heard mixed but mostly supportive testimony on Resolution  
37 235. Your Reference Committee heard about the importance of having a safety net to  
38 ensure that providers are paid by major insurers even if a cyber-attack should occur.  
39 Testimony also highlighted that cyber-attacks have continued to escalate and become  
40 more complex. Your Reference Committee heard that the recent ransomware attack on  
41 Change Healthcare caused thousands of physician payments to be withheld for weeks or  
42 months, resulting in devastating consequences to thousands of families because of  
43 inability to fulfill the payroll needs of the physicians and their employees. However, your  
44 Reference Committee also heard that this resolution should be referred for study so that  
45 this complex issue can be more thoroughly researched. Nevertheless, your Reference  
46 Committee heard significantly more positive testimony for this resolution than testimony in  
47 support of referral. Therefore, your Reference Committee recommends that Resolution  
48 235 be adopted.

1 (14) RESOLUTION 238 — AMA SUPPORTS EFFORTS TO  
2 FUND OVERDOSE PREVENTION SITES  
3

4 RECOMMENDATION:  
5

6 Madam Speaker, your Reference Committee recommends  
7 that Resolution 238 be adopted.  
8

9 **HOD ACTION: Resolution 238 adopted.**

10  
11 RESOLVED, that our American Medical Association support legislation or regulation that  
12 would fund overdose prevention sites. (New HOD Policy)  
13

14 Your Reference Committee heard supportive testimony on Resolution 238. Your  
15 Reference Committee heard about the benefits of overdose prevention sites (also known  
16 as safe injection sites or harm reduction centers) which include providing sterile supplies  
17 and administering naloxone in the event of an opioid-related overdose. Your Reference  
18 Committee heard testimony that overdose prevention sites have prevented thousands of  
19 deaths and have been successful in helping individuals access treatment for their  
20 substance use disorder. Your Reference Committee heard clear support for removing  
21 barriers to funding for these centers. Therefore, your Reference Committee recommends  
22 that Resolution 238 be adopted.  
23

24 (15) RESOLUTION 248 — SUSTAIN FUNDING FOR HRSA  
25 (HEALTH RESOURCES SERVICES AND  
26 ADMINISTRATION) 340B GRANT-FUNDED PROGRAMS  
27

28 RECOMMENDATION:  
29

30 Madam Speaker, your Reference Committee recommends  
31 that Resolution 248 be adopted.  
32

33 **HOD ACTION: Resolution 248 referred for decision.**

34  
35 RESOLVED, that our American Medical Association amend Policy H-110.985 340B Drug  
36 Discount Program by addition as follows:  
37

38 Our AMA: (1) will advocate for 340B Drug Discount Program (340B program)  
39 transparency, including an accounting of covered entities' 340B savings and the  
40 percentage of 340B savings used directly to care for underinsured patients and patients  
41 living on low-incomes; (2) will support recommendations to equip the Health Resources  
42 and Services Administration (HRSA) with more authority, resources and staff to conduct  
43 needed 340B program oversight; (3) recognizes the 340B program does not support the  
44 extent of care provided by ineligible physician practices to the medically indigent or  
45 underserved, and work with HRSA to establish 340B eligibility for all practices  
46 demonstrating a commitment to serving low-income and underserved patients; (4) will  
47 support a revised 340B drug discount program covered entity eligibility formula, which  
48 appropriately captures the level of outpatient charity care provided by hospitals, as well  
49 as standalone community practices; and (5) will confer with national medical specialty  
50 societies on providing policymakers with specific recommended covered entity criteria for

1 the 340B drug discount program; and (6) supports 340B programs funded by HRSA  
2 grants in their utilization of the program as legislatively intended. (Modify Current HOD  
3 Policy)

4  
5 Your Reference Committee heard minimal testimony on Resolution 248. Your Reference  
6 Committee heard supportive testimony from the authors of the resolution for the overall  
7 need for support of 340B programs. Your Reference Committee also heard testimony  
8 reflecting concerns about abuses of 340B programs and expressed that our AMA should  
9 not categorically support 340B programs because there are bad actors in this space.  
10 Therefore, your Reference Committee recommends that Resolution 248 be adopted.

11  
12 (16) RESOLUTION 250 — ENDORSEMENT OF THE  
13 UNIFORM HEALTH-CARE DECISIONS ACT

14  
15 RECOMMENDATION:

16  
17 Madam Speaker, your Reference Committee recommends  
18 that Resolution 250 be adopted.

19  
20 **HOD ACTION: Resolution 250 referred.**

21  
22 RESOLVED, that our American Medical Association amend policy D-140.968,  
23 "Standardized Advance Directives," to read as follows:

24  
25 Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and  
26 adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL)  
27 in 2023, and work with our state medical societies to advocate for its adoption in the states.  
28 (Modify Current HOD Policy)

29  
30 Your Reference Committee heard mixed testimony on Resolution 250. Your Reference  
31 Committee heard that our AMA policy supported the 1993 Uniform Health-Care Decisions  
32 Act and that a new, updated Uniform Health Care Decisions Act was adopted in 2023 by  
33 the Uniform Laws Commission. Your Reference Committee heard that the new Act  
34 modernizes and expands the Act to reflect changes in how health care is delivered. Your  
35 Reference Committee also heard that this updated model legislation tackles complex  
36 issues that will impact medical practice, and that further study is needed as well as  
37 concerns around the separate advance directives specifically for mental health. However,  
38 your Reference Committee heard significantly more supportive testimony that highlighted  
39 all the work that our AMA has already done in this space. Therefore, your Reference  
40 Committee recommends that Resolution 250 be adopted.

1 **RECOMMENDED FOR ADOPTION AS AMENDED**

2  
3 (17) BOARD OF TRUSTEES REPORT 09 — COUNCIL ON  
4 LEGISLATION SUNSET REVIEW OF 2014 HOUSE  
5 POLICIES

6  
7 RECOMMENDATION A:

8  
9 Madam Speaker, your Reference Committee recommends  
10 that the Recommendation of Board of Trustees Report 9 be  
11 amended by addition to read as follows:

12  
13 The Board of Trustees recommends that the House of  
14 Delegates policies listed in Appendix 1 to this report be  
15 acted upon in the manner indicated, except for Policy  
16 45.975, which should be retained, and the remainder of this  
17 report be filed.

18  
19 RECOMMENDATION B:

20  
21 Madam Speaker, your Reference Committee recommends  
22 that the Recommendation of Board of Trustees Report 9 be  
23 adopted as amended and that the remainder of the report  
24 be filed.

25  
26 RECOMMENDATION C:

27  
28 Madam Speaker, your Reference Committee recommends  
29 that Clause 3 of Policy H-185.951 be amended by addition  
30 and deletion to read as follows:

31  
32 3. Our AMA will request a change in Centers for Medicare &  
33 Medicaid Services' regulations to allow a nurse, under  
34 physician supervision, to visit a patient who cannot travel,  
35 has no family who can reliably test, or is unable to test on  
36 ~~his/her~~ their own to obtain and perform a protime/INR  
37 without restrictions.

1 RECOMMENDATION D:  
2

3 Madam Speaker, your Reference Committee recommends  
4 that Clause 1 of Policy H-355.975 be amended by addition  
5 and deletion to read as follows:  
6

7 1. Our AMA communicates to legislators the fundamental  
8 unfairness of the civil judicial system as it now exists,  
9 whereby a jury, rather than a forum of similarly educated  
10 peers, determines if a physician has violated the standards  
11 of care and such results are communicated to the National  
12 Practitioner Data Bank; and impresses on our national  
13 legislators that only when a physician has been disciplined  
14 by ~~his/her~~ their state licensing agency should ~~his/her~~ their  
15 name appear on the National Practitioner Data Bank.  
16

17 RECOMMENDATION E:  
18

19 Madam Speaker, your Reference Committee recommends  
20 that Clause 1 of Policy H-40.967 be amended by addition  
21 and deletion to read as follows:  
22

23 1. Our AMA endorses voluntary physician participation in  
24 the military reserve components' medical programs as a  
25 means of actively aiding national defense while preserving  
26 the right of the individual physician to practice ~~his/her~~ their  
27 profession without interruption in peace time.  
28

29 **HOD ACTION: Recommendations in Board of Trustees**  
30 **Report 9 adopted as amended and the remainder of the**  
31 **Report filed.**  
32

33 The Board of Trustees recommends that the House of Delegates policies that are listed in  
34 the appendix to this report be acted upon in the manner indicated and the remainder of  
35 this report be filed.  
36

37 Your Reference Committee heard testimony that Board of Trustees Report 9 should be  
38 adopted with two noted amendments. Your Reference Committee heard that some  
39 policies recommended to be retained were not updated to comply with AMA Policy H-  
40 65.942, which calls for gender-neutral language in AMA policy. Your Reference  
41 Committee agrees and therefore recommends that AMA Policies H-185.951, H-355.975,  
42 and H-40.967, which include the reference to "his" and "her," be amended accordingly.  
43 Your Reference Committee heard additional testimony that H-45.975 includes policy that  
44 remains relevant regarding the substitution of third-class medical certificate with a driver's  
45 license. Your Reference Committee agrees and therefore recommends that H-45.975  
46 should be retained.



1 (18) BOARD OF TRUSTEES REPORT 12 – AMA EFFORTS  
2 ON MEDICARE PAYMENT REFORM

3  
4 RECOMMENDATION A:

5  
6 Madam Speaker, your Reference Committee recommends  
7 that Board of Trustees Report 12 be amended by addition  
8 of the following Recommendations to read as follows:

9  
10 1) Our AMA increase media awareness around the 2024  
11 AMA Annual meeting about the need for Medicare Payment  
12 Reform, eliminating budget neutrality reductions, and  
13 instituting annual cost of living increases.

14 2) Our AMA step up its public relations campaign to get  
15 more buy-in from the general public about the need for  
16 Medicare payment reform.

17 3) Our AMA increase awareness to all physicians about the  
18 efforts of our AMA on Medicare Payment Reform.

19 4) Our AMA advocate for abolition of all MIPS penalties in  
20 light of the current inadequacies of Medicare payments.

21  
22 RECOMMENDATION B:

23  
24 Madam Speaker, your Reference Committee recommends  
25 that Board of Trustees Report 12 be adopted as amended  
26 and the remainder of the Report be filed.

27  
28 **HOD ACTION: Recommendations in Board of Trustees**  
29 **Report 12 adopted as amended and the remainder of the**  
30 **Report filed.**

31  
32 Your Reference Committee heard testimony acknowledging and expressing appreciation  
33 for our AMA's strong advocacy activities outlined in BOT Report 12 to fix the broken  
34 Medicare physician payment system. Testimony emphasized, however, the need for  
35 increased dialogue and public communication about our AMA's ongoing advocacy for  
36 Medicare payment reform, a more effective use of social media platforms, and other public  
37 engagement strategies to mobilize broad public support and understanding of this  
38 pressing issue. Those testifying addressed the challenges physicians face due to  
39 inadequate reimbursement rates, a broken Medicare payment system, and highlighted the  
40 need for immediate reform to ensure the sustainability of medical practices across the  
41 nation. Your Reference Committee heard unanimous and passionate support for adding  
42 a recommendation to BOT Report 12 that would call for greater public attention to be  
43 generated that clearly articulates and bolsters the urgency of enacting Medicare payment  
44 reform. The recommendation calls on our AMA to increase media awareness, step up our  
45 AMA's public relations campaign, increase awareness to all physicians about the efforts  
46 of our AMA on Medicare payment reform, and advocate for abolition of all MIPS penalties.  
47 Your Reference Committees agrees with the unanimous sentiments of those testifying  
48 and recommends adding the proffered recommendation to BOT Report 12.

1 (19) BOARD OF TRUSTEES REPORT 14 — PHYSICIAN  
2 ASSISTANT AND NURSE PRACTITIONER MOVEMENT  
3 BETWEEN SPECIALTIES  
4

5 RECOMMENDATION A:  
6

7 Madam Speaker, your Reference Committee recommends  
8 that the third Recommendation of Board of Trustees Report  
9 14 be amended by addition and deletion to read as follows:  
10

11 3. That the AMA encourage hospitals and other health care  
12 entities employing nurse practitioners and physician  
13 assistants to ensure that the ~~nurse-practitioner's~~ certification  
14 aligns with the specialty in which they will practice. (New  
15 HOD Policy)  
16

17 RECOMMENDATION B:  
18

19 Madam Speaker, your Reference Committee recommends  
20 that Board of Trustees Report 14 be amended by addition  
21 of a fifth Recommendation to read as follows:  
22

23 5. Our AMA continue to support research into the cost and  
24 quality of primary care delivered by nurse practitioners and  
25 physician assistants. (New HOD Policy)  
26

27 RECOMMENDATION C:  
28

29 Madam Speaker, your Reference Committee recommends  
30 that Board of Trustees Report 14 be amended by addition  
31 of a sixth Recommendation to read as follows:  
32

33 6. That our AMA continue to support research into the  
34 distribution and impact of nurse practitioners and physician  
35 assistants on primary care in underserved areas. (New HOD  
36 Policy)  
37

38 RECOMMENDATION D:  
39

40 Madam Speaker, your Reference Committee recommends  
41 that Board of Trustees Report 14 be amended by addition  
42 of a seventh Recommendation to read as follows:  
43

44 7. That our AMA continue to support expansion of access to  
45 physicians in under resourced areas. (New HOD Policy)

1 RECOMMENDATION E:  
2

3 Madam Speaker, your Reference Committee recommends  
4 that Board of Trustees Report 14 be adopted as amended  
5 and the remainder of the Report be filed.  
6

7 **HOD ACTION: Recommendations one and two of Board of**  
8 **Trustees Report 14 referred.**

9  
10 **HOD ACTION: Recommendations in Board of Trustees**  
11 **Report 14 adopted as amended and the remainder of the**  
12 **Report filed.**  
13

14 The Board of Trustees recommends that the following policy be adopted, and the  
15 remainder of the report be filed:  
16

- 17 1. That the American Medical Association (AMA) support workforce research, including  
18 surveys by state medical and nursing boards, that specifically focus on gathering  
19 information on nurse practitioners and physician assistants practicing in specialty care,  
20 their certification(s), alignment of their certification to their specialty, and whether they  
21 have switched specialties during their career. (New HOD Policy)
- 22 2. That the AMA support research that evaluates the impact of specialty switching by  
23 nurse practitioners and physician assistants on the cost and quality of patient care.  
24 (New HOD Policy)
- 25 3. That the AMA encourage hospitals and other health care entities employing nurse  
26 practitioners to ensure that the nurse practitioner's certification aligns with the specialty  
27 in which they will practice. (New HOD Policy)
- 28 4. That the AMA continue educating policymakers and lawmakers on the education,  
29 training, and certification of nurse practitioners and physician assistants, including the  
30 concept of specialty switching. (New HOD Policy)

31  
32 Your Reference Committee heard supportive testimony for Board of Trustees Report 14.  
33 Your Reference Committee heard that while the concept of specialty switching by nurse  
34 practitioners and physician assistants is well known, there are little publicly available data  
35 on this issue. The Board Report, therefore, calls on our AMA to support research in this  
36 area to fill this knowledge gap, including through workforce surveys and studies, as well  
37 as research that evaluates the impact of specialty switching by nurse practitioners and  
38 physician assistants on the cost and quality of patient care. Your Reference Committee  
39 heard some testimony urging referral of Recommendations 1 and 2 of the Board of  
40 Trustees Report which call on our AMA to support such studies. However, your Reference  
41 Committee heard, on balance, testimony that favored adoption of all the  
42 Recommendations found in the Report instead of referral. Your Reference Committee also  
43 received an amendment, supported by others, that calls on our AMA to continue  
44 supporting research related to nurse practitioners practicing in primary care. This  
45 amendment is consistent with existing AMA policy and AMA's ongoing advocacy related  
46 to scope of practice. Therefore, Your Reference Committee recommends that Board of  
47 Trustees Report 14 be adopted as amended, and the remainder of the report be filed.

1 (20) BOARD OF TRUSTEES REPORT 16 — SUPPORT FOR  
2 MENTAL HEALTH COURTS

3  
4 RECOMMENDATION A:

5  
6 Madam Speaker, your Reference Committee recommends  
7 that the third Recommendation of Board of Trustees Report  
8 16 be amended by addition and deletion to read as follows:

9  
10 (3) encourages diversion and treatment programs drug  
11 courts to that rely upon evidence-based models of care,  
12 including all medications used for ~~opioid~~ treatment of  
13 substance use disorder, for those who the judge or court  
14 determine would benefit from intervention, including  
15 treatment, rather than incarceration; and

16  
17 RECOMMENDATION B:

18  
19 Madam Speaker, your Reference Committee recommends  
20 that Board of Trustees Report 16 be adopted as amended  
21 and the remainder of the Report be filed.

22  
23 **HOD ACTION: Recommendations in Board of Trustees**  
24 **Report 16 adopted as amended and the remainder of the**  
25 **Report filed.**

26  
27 The Board of Trustees recommends that existing policy – Policy H-100.955, entitled,  
28 “Support for Drug Courts” – be amended by addition and deletion in lieu of Resolution 202  
29 as follows:

30  
31 Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans  
32 Courts, Sobriety Courts, and Similar Programs

33  
34 Our AMA:

- 35  
36 1. supports the establishment and use of diversion and treatment programs drug courts,  
37 including drug courts, mental health courts, veterans courts, sobriety courts, and other  
38 types of similar programs, as an effective method of intervention within a  
39 comprehensive system of community-based supports and services for individuals with  
40 a mental illness or substance use disorder involved in the justice system ~~addictive~~  
41 ~~disease who are convicted of nonviolent crimes;~~  
42 2. encourages legislators and court systems to establish diversion and treatment  
43 programs drug courts at the state and local level in the United States; and  
44 3. encourages diversion and treatment programs drug courts to rely upon evidence-  
45 based models of care, including medications for opioid use disorder, for those who the  
46 judge or court determine would benefit from intervention, including treatment, rather  
47 than incarceration; and  
48 4. supports individuals enrolled in diversion or treatment programs not be removed from  
49 a program solely because of evidence showing that an individual used illegal drugs  
50 while enrolled. (Modify HOD Policy)

1 Your Reference Committee heard supportive testimony for the recommendations of Board  
2 of Trustees Report 16. Your Reference Committee heard testimony that our current AMA  
3 policy and ongoing advocacy initiatives support increased access to evidence-based  
4 treatment for mental illness and substance use disorders. Testimony also encouraged  
5 support for access to medication for opioid use disorder and other substance use  
6 disorders. Your Reference Committee heard that if there are evidence-based programs  
7 for mental health and substance use disorders that can benefit individuals who would  
8 otherwise be incarcerated, those diversion programs should be strongly considered. Your  
9 Reference Committee received a minor technical amendment to this effect that was widely  
10 supported. Therefore, your Reference Committee recommends that the recommendations  
11 in Board of Trustees Report 16 be adopted as amended, and the remainder of the report  
12 be filed.

13  
14 (21) BOARD OF TRUSTEES REPORT 17 — DRUG POLICY  
15 REFORM

16  
17 RECOMMENDATION A:

18  
19 Madam Speaker, your Reference Committee recommends  
20 that the first Recommendation of Board of Trustees Report  
21 17 amended by addition and deletion to read as follows:

22  
23 ~~1. That the American Medical Association (AMA) will~~  
24 ~~continue to monitor the legal and public health effects of~~  
25 ~~state and federal policies to reclassify criminal offenses for~~  
26 ~~drug possession for personal use; (New HOD Policy)~~

27  
28 1. That our American Medical Association (AMA) support  
29 elimination of criminal penalties for drug possession for  
30 personal use as part of a larger set of related public health  
31 and legal reforms designed to improve carefully selected  
32 outcomes.

33  
34 RECOMMENDATION B:

35  
36 Madam Speaker, your Reference Committee recommends  
37 that the second Recommendation of Board of Trustees  
38 Report 17 be amended by addition to read as follows:

39  
40 2. That the AMA will support federal and state efforts to  
41 automatically expunge, at no cost to the individual, criminal  
42 records for drug possession for personal use upon  
43 completion of a sentence or penalty; (New HOD Policy) and

1 RECOMMENDATION C:  
2

3 Madam Speaker, your Reference Committee recommends  
4 that the third Recommendation in Board of Trustees Report  
5 17 be amended by addition to read as follows:  
6

7 3. That the AMA support programs that provide  
8 comprehensive substance use disorder treatment and  
9 social support to people who use or possess illicit drugs for  
10 personal use as an alternative to incarceration-based  
11 penalties, including for persons under parole, probation,  
12 pre-trial, or other civic, criminal, or judicial supervision. (New  
13 HOD Policy)  
14

15 RECOMMENDATION D:  
16

17 Madam Speaker, your Reference Committee recommends  
18 that Board of Trustees Report 14 be amended by addition of  
19 a fourth Recommendation to read as follows:  
20

21 4. Concurrently, that our AMA support robust policies and  
22 funding that facilitate people's access to evidence-based  
23 prevention, early intervention, treatment, harm reduction,  
24 and other supportive services – with an emphasis on youth  
25 and racially and ethnically minoritized people – based on  
26 individualized needs and with availability in all communities.  
27

28 RECOMMENDATION E:  
29

30 Madam Speaker, your Reference Committee recommends  
31 that Board of Trustees Report 17 be adopted as amended  
32 and the remainder of the Report be filed.  
33

34 **HOD ACTION: Recommendations in Board of Trustees**  
35 **Report 17 adopted as amended and the remainder of the**  
36 **Report filed.**  
37

38 The Board of Trustees recommends that the following recommendations be adopted in  
39 lieu of Resolution 203 and the remainder of the report be filed:  
40

- 41 1. That the American Medical Association (AMA) will continue to monitor the legal and  
42 public health effects of state and federal policies to reclassify criminal offenses for drug  
43 possession for personal use; (New HOD Policy)
- 44 2. That the AMA will support federal and state efforts to expunge, at no cost to the  
45 individual, criminal records for drug possession for personal use upon completion of a  
46 sentence or penalty; (New HOD Policy) and
- 47 3. That the AMA support programs that provide comprehensive substance use disorder  
48 treatment and social support to people who use or possess illicit drugs for personal  
49 use as an alternative to incarceration-based penalties for persons under parole,  
50 probation, pre-trial, or other civic, criminal, or judicial supervision. (New HOD Policy)

1 Your Reference Committee heard supportive testimony on the spirit of Board of Trustees  
2 Report 17. However, your Reference Committee heard limited testimony in support of  
3 continuing to monitor the effects of state and federal policies to decriminalize drug  
4 possession for personal use. Instead, most of the testimony heard by your Reference  
5 Committee called on our AMA to directly support decriminalization of drug possession for  
6 personal use as part of a larger set of public health and legal reforms. Your Reference  
7 Committee also heard wide-ranging concerns about racial and other inequities regarding  
8 Black and Brown individuals who are disproportionately incarcerated in the nation's jails  
9 and prisons for drug possession offenses. Testimony also highlighted that individuals who  
10 served a sentence or experienced other penalties for drug possession for personal use  
11 should have those penalties automatically expunged at the completion of their sentence.  
12 Your Reference Committee received amendments reflecting both concerns. Therefore,  
13 your Reference Committee recommends that Board of Trustees Report 17 be adopted as  
14 amended, and the remainder of the report be filed.

15  
16 (22) BOARD OF TRUSTEES REPORT 18 — SUPPORTING  
17 HARM REDUCTION

18  
19 RECOMMENDATION A:

20  
21 Madam Speaker, your Reference Committee recommends  
22 that Recommendation two of Board of Trustees Report 18 be  
23 amended by addition and deletion to read as follows:

24  
25 ~~2. That the AMA oppose the concept, promotion, or practice~~  
26 ~~of “safe smoking” with respect to inhalation of tobacco,~~  
27 ~~cannabis or any illicit substance; (New HOD Policy)~~

28  
29 2. That the AMA support decriminalization of harm reduction  
30 supplies that reduce the likelihood of injection drug use and  
31 mitigate health risks of all types of drug use, including  
32 injection drug use and smoking.

33  
34 RECOMMENDATION B:

35  
36 Madam Speaker, your Reference Committee recommends  
37 that Board of Trustees Report 18 be adopted as amended  
38 and the remainder of the Report be filed.

39  
40 **HOD ACTION: Recommendations in Board of Trustees**  
41 **Report 18 adopted as amended and the remainder of the**  
42 **Report filed.**

43  
44 The Board of Trustees recommends that the following new policy be adopted in lieu of  
45 Resolution 204, and that the remainder of the report be filed.

- 46  
47 1. That the American Medical Association (AMA) support efforts to decriminalize the  
48 possession of non-prescribed buprenorphine for personal use by individuals who  
49 lack access to a physician for the treatment of opioid use disorder; (New HOD  
50 Policy)

- 1 2. That the AMA oppose the concept, promotion, or practice of “safe smoking” with  
 2 respect to inhalation of tobacco, cannabis or any illicit substance; (New HOD  
 3 Policy)  
 4 3. That the AMA encourage additional study whether “safer smoking supplies” may  
 5 be a potential harm reduction measure to reduce harms from the nation’s overdose  
 6 and death epidemic; and (New HOD Policy)  
 7 4. That the AMA reaffirm Policy D-95.987, “Prevention of Drug-Related Overdose.”  
 8 (Reaffirm AMA Policy)  
 9

10 Your Reference Committee heard supportive testimony on Board of Trustees Report 18.  
 11 Your Reference Committee heard supportive testimony on the benefits of increasing  
 12 access to buprenorphine for the treatment of opioid use disorder (OUD) through multiple  
 13 means, including support for decriminalizing non-prescribed buprenorphine for personal  
 14 use. Your Reference Committee also heard significant testimony noting that there is no  
 15 such thing as safe smoking. However, your Reference Committee also heard testimony  
 16 noting support for access to harm reduction supplies that reduce the likelihood of injection  
 17 drug use and mitigate the health risks of all types of drug use and received an amendment  
 18 to this effect. Therefore, your Reference Committee recommends that Board of Trustees  
 19 Report 18 be adopted as amended, and the remainder of the report be filed.  
 20

21 (23) RESOLUTION 201 — RESEARCH CORRECTING  
 22 POLITICAL MISINFORMATION AND DISINFORMATION  
 23 ON SCOPE OF PRACTICE  
 24

25 RECOMMENDATION A:

26  
 27 Madam Speaker, your Reference Committee recommends  
 28 that the second Resolve of Resolution 201 be amended by  
 29 addition and deletion to read as follows:  
 30

31 RESOLVED, that our AMA Board of Trustees report its  
 32 findings and recommendations by the ~~1-24~~ A-25 meeting to  
 33 the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings  
 34 to the extent possible into our AMA’s advocacy efforts on  
 35 scope of practice. (Directive to Take Action)  
 36  
 37

38 RECOMMENDATION B:

39  
 40 Madam Speaker, your Reference Committee recommends  
 41 that Resolution 201 be adopted as amended.  
 42

43 **HOD ACTION: Resolution 201 adopted as amended.**  
 44

45 RESOLVED, that our American Medical Association perform a comprehensive literature  
 46 review on current research on correcting political misinformation and disinformation and  
 47 conduct field research on ways to correct political misinformation and disinformation  
 48 amongst policymakers as it pertains to scope of practice (Directive to Take Action); and  
 49 be it further



1 RESOLVED, that our AMA Board of Trustees report its findings and recommendations by  
2 the I-24 meeting to the HOD on correcting political misinformation and disinformation and  
3 that our AMA incorporate these findings to the extent possible into our AMA's advocacy  
4 efforts on scope of practice. (Directive to Take Action)  
5

6 Your Reference Committee heard overwhelmingly supportive testimony on Resolution  
7 201. There was consensus that our AMA's existing scope of practice campaign would  
8 benefit from targeted research on political misinformation and effective messaging in  
9 scope of practice advocacy. Your Reference Committee also heard that, to ensure there  
10 is enough time to pursue the research sought by this Resolution and prepare a report, the  
11 Board of Trustees report on the findings of this research should be due at the 2025 AMA  
12 Annual Meeting rather than the 2024 AMA Interim Meeting. Therefore, your Reference  
13 Committee recommends that Resolution 201 be adopted as amended.  
14

15 (24) RESOLUTION 204 — STAFFING RATIOS IN THE  
16 EMERGENCY DEPARTMENT  
17

18 RECOMMENDATION A:  
19

20 Madam Speaker, your Reference Committee recommends  
21 that the first Resolve of Resolution 204 be amended by  
22 addition and deletion to read as follows:  
23

24 RESOLVED, that our American Medical Association seek  
25 federal legislation or regulation prohibiting staffing ratios  
26 that do not allow for proper physician supervision of non-  
27 physician practitioners NPPs in the Emergency  
28 Department (Directive to Take Action); and be it further  
29

30 RECOMMENDATION B:  
31

32 Madam Speaker, your Reference Committee recommends  
33 that the second Resolve of Resolution 204 be amended by  
34 addition and deletion to read as follows:  
35

36 ~~RESOLVED, that our AMA seek federal legislation or~~  
37 ~~regulation that would require all Emergency Departments to~~  
38 ~~be staffed 24-7 by a qualified physician. (Directive to Take~~  
39 ~~Action)~~  
40

41 **RESOLVED, that our AMA support that all Emergency**  
42 **Departments be staffed 24-7 by a qualified physician.**  
43 **(New HOD policy)**  
44

45 RECOMMENDATION C:  
46

47 Madam Speaker, your Reference Committee recommends  
48 that Resolution 204 be adopted as amended.  
49

50 **HOD ACTION: Resolution 204 adopted as amended.**

1 RESOLVED, that our American Medical Association seek federal legislation or regulation  
2 prohibiting staffing ratios that do not allow for proper supervision of NPPs in the  
3 Emergency Department (Directive to Take Action); and be it further

4  
5 RESOLVED, that our AMA seek federal legislation or regulation that would require all  
6 Emergency Departments to be staffed 24-7 by a qualified physician. (Directive to Take  
7 Action)

8  
9 Your Reference Committee heard mixed testimony on Resolution 204. Your Reference  
10 Committee heard significant testimony in support of federal law prohibiting staffing ratios  
11 that do not allow for proper supervision of non-physicians in the emergency department;  
12 this included an amendment to clarify that such supervision must be done by a physician.  
13 Regarding the second Resolved clause, your Reference Committee heard testimony  
14 opposing the independent practice of non-physicians and promoting physician-led, team-  
15 based, care in the emergency department. While some testimony indicated that there is  
16 no shortage of emergency medicine physicians and that it would not be a hardship on the  
17 profession to ensure that a physician was onsite to ensure proper supervision of  
18 emergency care services, other testimony indicated that a 24/7 physician supervision  
19 requirement would be impossible for some rural and underserved hospitals and could lead  
20 to hospital closures. Your Reference Committee also heard significant testimony noting  
21 that a Board of Trustees report is currently being drafted for the AMA 2024 Interim Meeting  
22 and that this report will directly address the issue of possible rural exceptions to  
23 requirements for 24/7 physician supervision in emergency departments. Your Reference  
24 Committee understands that this pending Board report will be influential in the  
25 development of AMA policy when it comes to physician supervision in emergency  
26 departments. Therefore, your Reference Committee recommends that the first Resolved  
27 clause be adopted as amended and the second Resolved clause be referred.

28  
29 (25) RESOLUTION 206 — INDIAN HEALTH SERVICE YOUTH  
30 REGIONAL TREATMENT CENTERS

31  
32 RECOMMENDATION A:

33  
34 Madam Speaker, your Reference Committee recommends  
35 that Resolution 206 be amended by addition and deletion to  
36 read as follows:

37  
38 RESOLVED, that our American Medical Association  
39 support the expansion of Indian Health Service Youth  
40 Regional Treatment Centers, recognizing them as ~~a model~~  
41 ~~for~~ culturally-rooted, evidence-based behavioral health and  
42 substance use disorder treatment centers for, and prompt  
43 referral of eligible American Indian/Alaskan Native (AI/AN)  
44 youth to Youth Regional Treatment Centers (YRTCs) for  
45 community directed care. (New HOD Policy)

1 RECOMMENDATION B:  
2

3 Madam Speaker, your Reference Committee recommends  
4 that Resolution 206 be adopted as amended.  
5

6 **HOD ACTION: Resolution 206 adopted as amended.**  
7

8 **RESOLVED**, that our American Medical Association support the expansion of Indian  
9 Health Service Youth Regional Treatment Centers, recognizing them as a model for  
10 culturally-rooted, evidence-based behavioral health treatment, and prompt referral of  
11 eligible AI/AN youth to Youth Regional Treatment Centers (YRTC) for community-  
12 directed care. (New HOD Policy)

13  
14 Your Reference Committee heard supportive testimony on Resolution 206. Your  
15 Reference Committee heard that American Indian/Alaskan Native (AI/AN) populations  
16 benefit from culturally rooted care for mental illness and substance use disorders.  
17 Testimony also stated that the AI/AN population would benefit from greater access to  
18 evidence-based care for mental illness and substance use disorders. Your Reference  
19 Committee also heard testimony concerning whether the programs supported by the  
20 Indian Health Service all are “models,” and received multiple amendments suggesting the  
21 removal of this language in the resolution, but heard nothing to suggest any hesitation  
22 surrounding supporting the treatment programs in general. Therefore, your Reference  
23 Committee recommends that Resolution 206 be adopted as amended.  
24

25 (26) RESOLUTION 207 — BIOSIMILAR USE RATES AND  
26 PREVENTION OF PHARMACY BENEFIT MANAGER  
27 ABUSE  
28

29 RECOMMENDATION A:  
30

31 Madam Speaker, your Reference Committee recommends  
32 that the first Resolve of Resolution 207 be deleted.  
33

34 RECOMMENDATION B:  
35

36 Madam Speaker, your Reference Committee recommends  
37 that Resolution 207 be adopted as amended.  
38

39 **HOD ACTION: An Alternate first Resolve added to**  
40 **Resolution 207 to read as follows:**

41  
42 **RESOLVED**, that our **AMA supports coverage structures**  
43 **that: increase use of lower cost biosimilars when clinically**  
44 **appropriate, share savings between payers and patients**  
45 **physicians, and reduce patient costs.**  
46

47 **HOD ACTION: The third Resolve of Resolution 207**  
48 **referred.**

1                   **HOD ACTION: Resolution 207 adopted as amended.**

2  
3                   RESOLVED, that our American Medical Association support economic incentives to  
4 increase physician use of less expensive biosimilars instead of their reference biologics  
5 (New HOD Policy); and be it further

6  
7                   RESOLVED, that our AMA encourage the Federal Trade Commission (FTC) and  
8 Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive  
9 contracts signed between biologics originators and PBMs to ensure they do not impede  
10 biosimilar development and uptake. (New HOD Policy)

11  
12                  Your Reference Committee heard mixed testimony on Resolution 207. Your Reference  
13 Committee heard support for the concept of decreasing patient cost by prescribing less  
14 expensive medication and ensuring fair competition for biosimilars. However, your  
15 Reference Committee also heard that financial compensation for physicians should not be  
16 a factor in what physicians ultimately prescribe, rather the patient's health should be the  
17 only determining factor. Further testimony suggested that removing the reference to  
18 economic incentives would strengthen the resolution. Therefore, your Reference  
19 Committee recommends that Resolution 207 be adopted as amended.

20  
21                  (27)    **RESOLUTION 208 — IMPROVING SUPPLEMENTAL**  
22                            **NUTRITION PROGRAMS**

23  
24                            RECOMMENDATION A:

25  
26                            Madam Speaker, your Reference Committee recommends  
27 that Resolution 208 be amended by addition and deletion  
28 to read as follows:

29  
30                            RESOLVED, that our American Medical Association  
31 supports ~~regulatory and legal reforms to extending~~  
32 ~~multieligibility~~ for USDA Food Assistance to enrolled  
33 members of federally-recognized American Indian and  
34 Alaska Native Tribes and Villages to all federal feeding  
35 programs, ~~such as, but not limited to, Supplemental~~  
36 ~~Nutrition Assistance Program (SNAP) and Food Distribution~~  
37 ~~Program on Indian Reservations (FDPIR).~~ (New HOD  
38 Policy)

39  
40                            RECOMMENDATION B:

41  
42                            Madam Speaker, your Reference Committee recommends  
43 that Resolution 208 be adopted as amended.

44  
45                   **HOD ACTION: Resolution 208 adopted as amended.**

1 RESOLVED, that our American Medical Association support regulatory and legal reforms  
2 to extend multieligibility for USDA Food Assistance to enrolled members of federally-  
3 recognized American Indian and Alaska Native Tribes and Villages to all federal feeding  
4 programs, such as, but not limited to, Supplemental Nutrition Assistance Program (SNAP)  
5 and Food Distribution Program on Indian Reservations (FDPIR). (New HOD Policy)  
6

7 Your Reference Committee heard testimony in favor of Resolution 208. Your Reference  
8 Committee heard that food insecurity is a public health crisis, especially among American  
9 Indian and Alaska Native (AI/AN) persons, and that such individuals experience food  
10 insecurity at twice the rate of their white counterparts. Your Reference Committee further  
11 heard that US nutrition programs for AI/AN persons, including the Food Distribution  
12 Program on Indian Reservations (FDPIR) and the recently launched Indian Health Service  
13 (IHS) Produce Prescription Pilot Program, differ from other nutrition programs because  
14 they include staple foods and ingredients commonly used in pre-contact AI/AN societies  
15 and food systems. Moreover, your Reference Committee heard that federally recognized  
16 AI/AN Tribes and Villages without a reservation or land base, and the 2.8 million AI/AN  
17 persons in urban areas (greater than the population on Tribal lands), are all ineligible for  
18 federal nutrition assistance programs for AI/AN persons. However, your Reference  
19 Committee heard that amendments to the resolution would help clarify its intent and  
20 implementation. Specifically, your Reference Committee heard that the language in the  
21 resolution, referring to “multieligibility” for all United States Department of Agriculture food  
22 programs, is not clear and that amended language is needed to make the resolution’s  
23 intent and its implementation stronger. Therefore, your Reference Committee  
24 recommends that Resolution 208 be adopted as amended.

1 (28) RESOLUTION 214 — SUPPORT FOR PAID SICK LEAVE

2  
3 RECOMMENDATION A:

4  
5 Madam Speaker, your Reference Committee recommends  
6 that Resolution 214 be amended by addition to read as  
7 follows:

8  
9 RESOLVED, that our American Medical Association amend  
10 Policy H-440.823, “Paid Sick Leave,” as follows:

11  
12 Paid Sick Leave H-440.823

13  
14 Our AMA: (1) recognizes the public health benefits of paid  
15 sick leave and other discretionary paid time off; (2) supports  
16 employer policies that allow employees to accrue paid time  
17 off and to use such time to care for themselves or a family  
18 member; ~~and~~ (3) supports employer policies that provide  
19 employees with unpaid sick days to use to care for  
20 themselves or a family member where providing paid leave  
21 is overly burdensome; and (4) advocates for federal and  
22 state policies that guarantee employee access to protected  
23 paid sick leave without unduly burdening small businesses.  
24 (Modify Current HOD Policy)

25  
26 RECOMMENDATION B:

27  
28 Madam Speaker, your Reference Committee recommends  
29 that Resolution 214 be adopted as amended.

30  
31 **HOD ACTION: Resolution 214 adopted as amended.**

32  
33 RESOLVED, that our American Medical Association amend Policy H-440.823, “Paid Sick  
34 Leave,” as follows:

35  
36 Paid Sick Leave H-440.823

37  
38 Our AMA: (1) recognizes the public health benefits of paid sick leave and other  
39 discretionary paid time off; (2) supports employer policies that allow employees to accrue  
40 paid time off and to use such time to care for themselves or a family member; ~~and~~ (3)  
41 supports employer policies that provide employees with unpaid sick days to use to care  
42 for themselves or a family member where providing paid leave is overly burdensome; and  
43 (4) advocates for federal and state policies that guarantee employee access to protected  
44 paid sick leave. (Modify Current HOD Policy)

45  
46 Your Reference Committee heard mixed testimony on Resolution 214. Your Reference  
47 Committee heard that paid leave is a matter of public health and that it is necessary for  
48 patients to have reasonable periods of leave to care for themselves and immediate family  
49 members. Testimony also noted that that more than half of the lowest-paid workers cannot  
50 get time off for an illness. However, your Reference Committee also heard that it can be

1 extremely difficult for small physician practices, and small businesses in general, to  
2 provide paid sick leave for their employees. Therefore, your Reference Committee  
3 recommends that Resolution 214 be adopted as amended.

4  
5 (29) RESOLUTION 215 — AMERICAN INDIAN AND ALASKA  
6 NATIVE LANGUAGE REVITALIZATION AND ELDER  
7 CARE

8  
9 RECOMMENDATION A:

10  
11 Madam Speaker, your Reference Committee recommends  
12 that the first Resolve of Resolution 215 be amended by  
13 addition and deletion to read as follows:

14  
15 RESOLVED, that our American Medical Association  
16 recognize that access to language concordant services for  
17 American Indian and Alaska Native (AI/AN) patients will  
18 require ~~targeted~~ investment ~~as in~~ Indigenous languages in  
19 North America ~~are threatened due to a complex history of~~  
20 ~~removal and assimilation by state and federal actors~~ (New  
21 HOD Policy); and be it further

22  
23 RECOMMENDATION B:

24  
25 Madam Speaker, your Reference Committee recommends  
26 that the third Resolve of Resolution 215 be amended by  
27 addition and deletion to read as follows:

28  
29 RESOLVED, that our AMA ~~collaborate with stakeholders,~~  
30 ~~including but not limited to the National Indian Council on~~  
31 ~~Aging and Association of American Indian Physicians,~~ to  
32 identify support the development of best practices for AI/AN  
33 elder care to ensure this group is provided culturally-  
34 competent healthcare outside of the umbrella of the Indian  
35 Health Service. (Directive to Take Action)

36  
37 RECOMMENDATION C:

38  
39 Madam Speaker, your Reference Committee recommends  
40 that Resolution 215 be adopted as amended.

41  
42 **HOD ACTION: Resolution 215 adopted as amended.**

43  
44 RESOLVED, that our American Medical Association recognize that access to language  
45 concordant services for AI/AN patients will require targeted investment as Indigenous  
46 languages in North America are threatened due to a complex history of removal and  
47 assimilation by state and federal actors (New HOD Policy); and be it further

48  
49 RESOLVED, that our AMA support federal-tribal funding opportunities for American Indian  
50 and Alaska Native language revitalization efforts, especially those that increase health

1 information resources and access to language-concordant health care services for  
2 American Indian and Alaska Native elders living on or near tribal lands (New HOD Policy);  
3 and be it further

4  
5 RESOLVED, that our AMA collaborate with stakeholders, including but not limited to the  
6 National Indian Council on Aging and Association of American Indian Physicians, to  
7 identify best practices for AI/AN elder care to ensure this group is provided culturally-  
8 competent healthcare outside of the umbrella of the Indian Health Service. (Directive to  
9 Take Action)

10  
11 Your Reference Committee heard mostly supportive testimony on Resolution 215. Your  
12 Reference Committee heard that the population of American Indian/Alaska Native (AI/AN)  
13 elders are the stewards of hundreds of Indigenous cultures, languages, and traditional  
14 knowledge systems. Your Reference Committee further heard that AI/AN elders  
15 experience significant health and socioeconomic inequities including the lowest life  
16 expectancy of all racial/ethnic groups in the U.S. and a high uninsurance rate. Moreover,  
17 your Reference Committee heard that while AI/AN elders receive primary care through the  
18 Indian Health Service (IHS), underfunding and understaffing has forced IHS to rely on  
19 non-IHS facilities for more specialized elder care, including hospice and respite care,  
20 which necessitates AI/AN elders having to navigate unknown health systems not  
21 respectful of their cultural values and traditions. Your Reference Committee further heard  
22 that culturally competent care is vital for health outcomes and is even more critical for  
23 older adults with changes in cognition due to delirium and dementia. Furthermore, your  
24 Reference Committee heard that our AMA has long-standing policy that supports  
25 improving health care for American Indians, both those living on reservations and outside  
26 reservation lands, in order to decrease health inequities for these individuals. Additional  
27 testimony in support noted that amendments would help clean up some language in the  
28 resolution to make it less controversial and allow for more flexibility in implementing its  
29 intent. Your Reference Committee appreciates the importance of the issues identified in  
30 this resolution and agrees that amendments would be helpful. Therefore, your Reference  
31 Committee recommends that Resolution 215 be adopted as amended.



1 (30) RESOLUTION 216 — THE AMA SUPPORTS H.R. 7225,  
2 THE BIPARTISAN “ADMINISTRATIVE LAW JUDGES  
3 COMPETITIVE SERVICE RESTORATION ACT”  
4

5 RECOMMENDATION A:  
6

7 Madam Speaker, your Reference Committee recommends  
8 that Resolution 216 be amended by addition and deletion  
9 read as follows:  
10

11 RESOLVED, that our American Medical Association  
12 support H.R. 7225, the bipartisan “Administrative Law  
13 Judges Competitive Service Restoration Act” that supports  
14 the merit-based processes for the selection of all  
15 Medicare/Medicaid Administrative Law Judges. (New HOD  
16 Policy)  
17

18 RECOMMENDATION B:  
19

20 Madam Speaker, your Reference Committee recommends  
21 that Resolution 216 be adopted as amended.  
22

23 RECOMMENDATION C:  
24

25 Madam Speaker, your Reference Committee recommends  
26 that the title of Resolution 216 be changed to read as  
27 follows:  
28

29 **MERIT-BASED SELECTION OF ADMINISTRATIVE LAW JUDGES**  
30

31 **HOD ACTION: Resolution 216 adopted as amended with a**  
32 **change of title.**  
33

34 **MERIT-BASED SELECTION OF ADMINISTRATIVE LAW**  
35 **JUDGES**  
36

37 RESOLVED, that our American Medical Association support H.R. 7225, the bipartisan  
38 “Administrative Law Judges Competitive Service Restoration Act” that supports the merit-  
39 based process for the selection of all Medicare/Medicaid Administrative Law Judges. (New  
40 HOD Policy)  
41

42 Your Reference Committee heard supportive testimony on Resolution 216. Your  
43 Reference Committee heard that the selection process for Administrative Law Judges  
44 (ALJs) is important for ensuring impartial and competent adjudication in Medicare and  
45 Medicaid disputes. Your Reference Committee also heard that current regulations  
46 significantly impact the quality of decisions made by ALJs and that a merit-based selection  
47 process is important to maintain high standards. However, your Reference Committee  
48 heard that referencing a specific bill in our policy is not consistent with our AMA's standard  
49 practice. Testimony noted that our AMA avoids using specific bill numbers in policy to  
50 maintain flexibility and avoid endorsing particular legislative texts that may change over

1 time. An amendment was provided that removed the specific legislation included in the  
2 Resolution. Therefore, your Reference Committee recommends that Resolution 216  
3 should be adopted as amended with a change in title.

4  
5 (31) RESOLUTION 219 — BUNDLING FOR MATERNITY  
6 CARE SERVICES

7  
8 RECOMMENDATION A:

9  
10 Madam Speaker, your Reference Committee recommends  
11 that Resolution 219 be amended by addition and deletion to  
12 read as follows:

13  
14 RESOLVED, that our American Medical Association  
15 ~~advocates for~~ supports the separate payment of services  
16 not accounted for in the valuation of the maternity global  
17 codes and opposes the inappropriate bundling of related  
18 services. (Directive to Take Action)

19  
20 RECOMMENDATION B:

21  
22 Madam Speaker, your Reference Committee recommends  
23 that Resolution 219 be adopted as amended.

24  
25 **HOD ACTION: Resolution 219 adopted as amended.**

26  
27 RESOLVED, that our American Medical Association advocates for the separate payment  
28 of services not accounted for in the valuation of the maternity global codes and opposes  
29 the inappropriate bundling of related services. (Directive to Take Action)

30  
31 Your Reference Committee heard supportive testimony on Resolution 219. Your  
32 Reference Committee heard that better recognition and reimbursement for  
33 comprehensive maternity care that extends beyond what is covered by the global obstetric  
34 codes is needed. Testimony highlighted that many critical services provided during  
35 pregnancy, such as increased screenings, intensive counseling for genetic tests, group  
36 prenatal care, social assessment and management of social determinants of health, and  
37 the management of labor to avoid cesarean sections are not adequately accounted for in  
38 the current coding system. Your Reference Committee also heard that our AMA is actively  
39 engaging in a comprehensive review of maternity care practices through a Current  
40 Procedural Terminology (CPT) workgroup, which is expected to propose significant  
41 changes to the existing coding system to better reflect current medical practices and  
42 address stakeholder needs. A minor amendment was also offered on this resolution.  
43 Testimony noted that this minor amendment was needed to align with how the CPT  
44 process works. Therefore, your Reference Committee recommends that Resolution 219  
45 be adopted as amended.

1 (32) RESOLUTION 220 — RESTORATIVE JUSTICE FOR THE  
2 TREATMENT OF SUBSTANCE USE DISORDERS

3  
4 RECOMMENDATION A:

5  
6 Madam Speaker, your Reference Committee recommends  
7 that the first Resolve of Resolution 220 be amended by  
8 addition and deletion to read as follows:

9  
10 RESOLVED, that our American Medical Association (1)  
11 continues to support the right of incarcerated individuals to  
12 receive appropriate care for substance use disorders, (2)  
13 supports efforts providing incentives for incarcerated  
14 individuals to participate overcome substance use  
15 disorders, such as participation in a treatment or diversion  
16 program as a condition for early release, and (3) supports  
17 providing access to social services and family therapy  
18 during and after incarceration (New HOD Policy); and be it  
19 further

20  
21 RECOMMENDATION B:

22  
23 Madam Speaker, your Reference Committee recommends  
24 that the second Resolve of Resolution 220 be amended by  
25 addition to read as follows:

26  
27 RESOLVED, that our AMA (1) recognizes that  
28 criminalization of substance use disproportionately impacts  
29 minoritized and disadvantaged communities due to  
30 structural racism and implicit bias, (2) acknowledges  
31 inequitable sentencing structures, such as towards crack  
32 cocaine versus opioids, have contributed to unjust  
33 imprisonments, and (3) supports stigma reduction, implicit  
34 bias and antiracism training for medical professionals  
35 working in correctional facilities. (New HOD Policy)

36  
37 RECOMMENDATION C:

38  
39 Madam Speaker, your Reference Committee recommends  
40 that Resolution 220 be adopted as amended.

41  
42 **HOD ACTION: Resolution 220 adopted as amended.**

43  
44 RESOLVED, that our American Medical Association (1) continues to support the right of  
45 incarcerated individuals to receive appropriate care for substance use disorders, (2)  
46 supports providing incentives for incarcerated individuals to overcome substance use  
47 disorders, such as participation in treatment as a condition for early release, and (3)  
48 supports providing access to social services and family therapy during and after  
49 incarceration (New HOD Policy); and be it further

1 RESOLVED, that our AMA (1) recognizes that criminalization of substance use  
2 disproportionately impacts minoritized and disadvantaged communities due to structural  
3 racism and implicit bias, (2) acknowledges inequitable sentencing structures, such as  
4 towards crack cocaine versus opioids, have contributed to unjust imprisonments, and (3)  
5 supports implicit bias and antiracism training for medical professionals working in  
6 correctional facilities. (New HOD Policy)

7  
8 Your Reference Committee heard mostly supportive testimony on Resolution 220. Your  
9 Reference Committee heard about the benefits of evidence-based treatment for  
10 substance use disorders while in jail or prison. Testimony also highlighted inequitable  
11 treatment for racially and ethnically diverse populations while incarcerated. However, your  
12 Reference Committee heard concerns about coercing individuals into treatment while also  
13 hearing testimony that jails and prisons are sub-optimal places to receive treatment for a  
14 substance use disorder. Your Reference Committee appreciates the input from our  
15 colleagues in the U.S. Public Health Service in supporting access to evidence-based care  
16 for substance use disorders. Your Reference Committee agrees with both points.  
17 Therefore, your Reference Committee recommends that Resolution 220 be adopted as  
18 amended.

19  
20 (33) RESOLUTION 222 — STUDYING AVENUES FOR  
21 PARITY IN MENTAL HEALTH & SUBSTANCE USE  
22 COVERAGE

23  
24 RECOMMENDATION A:

25  
26 Madam Speaker, your Reference Committee recommends  
27 that Resolution 222 be amended by addition and deletion  
28 to read as follows:

29  
30 RESOLVED, that our American Medical Association  
31 increase advocacy efforts towards the National Association  
32 of Insurance Commissioners (NAIC) and state and federal  
33 policymakers continue to advocate for meaningful financial  
34 and other study potential penalties for insurers that do for  
35 not complying with mental health and substance use parity  
36 laws; and be it further (Directive to Take Action)

37  
38 RECOMMENDATION B:

39  
40 Madam Speaker, your Reference Committee recommends  
41 that Resolution 222 be adopted as amended.

42  
43 **HOD ACTION: A second Resolve added to Resolution 222**  
44 **to read as follows:**

45  
46 **RESOLVED, that our American Medical Association work**  
47 **with state medical societies to advocate to state**  
48 **departments of insurance for meaningful enforcement of**  
49 **penalties for insurers that do not comply with mental**  
50 **health and substance use parity laws.**

**HOD ACTION: Resolution 222 adopted as amended.**

RESOLVED, that our American Medical Association study potential penalties to insurers for not complying with mental health and substance use parity laws. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 222. Your Reference Committee heard testimony expressing deep frustration that mental health and substance use disorder parity laws are not meaningfully enforced despite more than a decade of parity violations by health insurance companies. Your Reference Committee also heard testimony that even when parity laws are enforced, the penalties are too small and ineffectual to prevent future violations. Your Reference Committee heard testimony that our AMA's state and federal advocacy has called for meaningful penalties to be imposed against health insurers and other payers that violate mental health substance use disorder parity laws. Testimony noted that while there could be benefits from an additional study of gaps in enforcement and potential penalties, there is greater benefit to our AMA focusing its resources on continued advocacy, and received an amendment expressing this. Therefore, your Reference Committee recommends that Resolution 222 be adopted as amended.

(34) RESOLUTION 224 — ANTIDISCRIMINATION  
PROTECTIONS FOR LGBTQ+ YOUTH IN FOSTER  
CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 224 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~collaborate with state medical societies and other appropriate stakeholders to support~~ policies on the federal and state levels that establish nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity (New HOD Policy); and be it further

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49

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 224 be deleted.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 224 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~encourage~~ supports child welfare ~~agencyies to implement~~ practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b) ~~adopt programs to~~ prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve recruitment of foster families that are affirming of LGBTQ+ youth; and (d) allow gender diverse youth to be placed in residential foster homes that are willing to accept their gender identity. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 224 be adopted as amended.

**HOD ACTION: The second Resolve of Resolution 224 referred.**

**HOD ACTION: Resolution 224 adopted as amended.**

RESOLVED, that our American Medical Association collaborate with state medical societies and other appropriate stakeholders to support policies on the federal and state levels that establish nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity (New HOD Policy); and be it further  
RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Foster Care Analysis and Reporting System only when strong privacy protections exist (New HOD Policy); and be it further  
RESOLVED, that our AMA encourage child welfare agencies to implement practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b) adopt programs to prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve recruitment of foster families that are affirming

1 of LGBTQ+ youth; and (d) allow gender diverse youth to be placed in residential foster  
2 homes that are willing to accept their gender identity. (New HOD Policy)

3  
4 Your Reference Committee heard mixed testimony on Resolution 224. Your Reference  
5 Committee heard that this was a timely issue and emphasized the unique vulnerability of  
6 LGBTQ+ youth in foster care. However, your Reference Committee also heard that this  
7 resolution would support the collection of sexual orientation data by the Adoption and  
8 Foster Care Analysis and Reporting System (AFCARS). Testimony highlighted that the  
9 collection of sexual orientation data by AFCARS was proposed by the federal government  
10 back in 2016, however, this portion of the proposed rule was never implemented and in  
11 2020 was ultimately rejected. Your Reference Committee heard that since then, there has  
12 been a divide in the community concerning whether these data should be collected.  
13 Testimony noted that most LGBTQ+ groups believe that this information should be  
14 collected by the federal government to enhance recruitment of foster homes, promote  
15 visibility for marginalized groups, help to analyze youth outcomes, and address disparities.  
16 However, your Reference Committee also heard that many state and local child welfare  
17 agencies believe that AFCARS is not the appropriate vehicle to collect this information,  
18 that it was unclear how this information in a Federal Government database would result in  
19 support services for children, and that this information should be tracked separately from  
20 AFCARS. Further, testimony noted that state and local child welfare agencies track  
21 information about a youth's or provider's sexual orientation and noted that this information  
22 can be collected as part of the title IV-E agency's casework and should be documented in  
23 the case file. Additional testimony, though supportive of the concepts in the resolution,  
24 noted concern that the resolution could out a child's gender identity/sexual orientation in  
25 the foster process before the child is ready, causing harm to the child. Your Reference  
26 Committee heard that due to this divide in the community, our AMA should not adopt the  
27 second resolved since our AMA does not have a fully informed position on this topic. Your  
28 Reference Committee also heard that the first and third resolves should be slightly  
29 amended to broaden them so that they are more applicable across all the work that our  
30 AMA does. Your Reference Committee also notes a grammatical error in the third  
31 resolved. Therefore, your Reference Committee recommends that Resolution 224 be  
32 adopted as amended.

1 (35) RESOLUTION 229 — OPPOSITION TO LEGALIZATION  
2 OF PSILOCYBIN

3  
4 RECOMMENDATION A:

5  
6 Madam Speaker, your Reference Committee recommends  
7 that Resolution 229 be amended by addition and deletion to  
8 read as follows:

9  
10 RESOLVED, that our American Medical Association oppose  
11 any legislative efforts ~~relatable~~related to legalization of  
12 Psilocybin/Psilocin or its related substances use, except  
13 those which have received FDA approval or those  
14 prescribed in the context of approved investigational  
15 studies. (New HOD Policy) and be it further

16  
17 RECOMMENDATION B:

18  
19 Madam Speaker, your Reference Committee recommends  
20 that Resolution 229 be amended by addition of a second  
21 Resolve clause to read as follows:

22  
23 RESOLVED, that our AMA support decriminalization of  
24 possession of psychedelics, entactogens, or related  
25 substances for personal use.

26  
27 RECOMMENDATION C:

28  
29 Madam Speaker, your Reference Committee recommends  
30 that Resolution 229 be adopted as amended.

31  
32 RECOMMENDATION D:

33  
34 Madam Speaker, your Reference Committee recommends  
35 that that the title of Resolution 229 be changed to read as  
36 follows:

37  
38 **PSILOCYBIN AND PSYCHEDELICS**

39  
40 **HOD ACTION: Resolution 229 adopted as amended with a**  
41 **change of title.**

42  
43 **PSILOCYBIN AND PSYCHEDELICS**

44  
45 RESOLVED, that our American Medical Association oppose any legislative efforts  
46 relatable to legalization of Psilocybin/Psilocin or its related substances use. (New HOD  
47 Policy)



1 Your Reference Committee heard mixed testimony on Resolution 229. Your Reference  
2 Committee heard clear support for the Food and Drug Administration (FDA) approval  
3 process and investigational clinical trials to identify whether new treatments would be  
4 efficacious for patients. Your Reference Committee heard concerns that some drugs have  
5 been legalized or otherwise supported through the state legislative process rather than  
6 evidence-based approaches. Your Reference Committee also heard opposition to the  
7 original resolution from multiple delegations noting that comprehensive opposition to the  
8 legalization of psilocybin was too broad of a stance for our AMA—particularly given that  
9 there is some evidence of potential positive benefits of some uses of psilocybin to treat  
10 certain conditions. Testimony supporting referral was limited. Your Reference Committee  
11 heard no opposition to the amendment calling for decriminalization of possession of  
12 psychedelics, entactogens, or related substances for personal use. Therefore, your  
13 Reference Committee recommends that Resolution 229 be adopted as amended.

14  
15 (36) RESOLUTION 233 — PROHIBITING MANDATORY  
16 WHITE BAGGING

17  
18 RECOMMENDATION A:

19  
20 Madam Speaker, your Reference Committee recommends  
21 that Resolution 233 be amended by addition to read as  
22 follows:

23  
24 RESOLVED, that our American Medical Association urge  
25 state and federal policymakers to enact legislation to  
26 prohibit the mandatory use of white bagging policies that  
27 condition coverage of a clinician-administered drug, such as  
28 an IV infusion, on the drug being dispensed from a  
29 pharmacy benefit manager-affiliated mail order pharmacy.  
30 (Directive to Take Action).

31  
32 RECOMMENDATION B:

33  
34 Madam Speaker, your Reference Committee recommends  
35 that Resolution 233 be adopted as amended.

36  
37 **HOD ACTION: Resolution 233 adopted as amended.**

38  
39 RESOLVED, that our American Medical Association urge state and federal policymakers  
40 to enact legislation to prohibit the mandatory use of white bagging (Directive to Take  
41 Action).

42  
43 Your Reference Committee heard supportive testimony on Resolution 233. Your  
44 Reference Committee heard that the practice of “white bagging” when mandatory,  
45 excludes payment for medically necessary drugs from any physician that is not under  
46 common ownership with the insurer or Pharmacy Benefits Managers (PBMs). Your  
47 Reference Committee also heard testimony that emphasized the potential negative  
48 outcomes from this practice including the severe risk of limiting access, disruptions of care,  
49 and drug waste. Your Reference Committee also heard testimony that noted the  
50 importance of defining white bagging more definitively and received amendments to this

1 effect which received support. Therefore, Your Reference Committee recommends that  
2 Resolution 233 be adopted as amended.

3  
4 (37) RESOLUTION 234 — STATE PRESCRIPTION DRUG  
5 AFFORDABILITY BOARDS - STUDY

6  
7 RECOMMENDATION A:

8  
9 Madam Speaker, your Reference Committee recommends  
10 that the second Resolve of Resolution 234 be deleted.

11  
12 RECOMMENDATION B:

13  
14 Madam Speaker, your Reference Committee recommends  
15 that Resolution 234 be adopted as amended.

16  
17 **HOD ACTION: Resolution 234 adopted as amended.**

18  
19 RESOLVED, that our American Medical Association conduct a study to determine how  
20 upper payment limits (UPLs) established by state prescription drug affordability boards  
21 (PDABs) will impact reimbursement for physician-administered drugs and what impact  
22 state UPLs will have on patient access to care (Directive to Take Action); and be it further

23  
24 RESOLVED, that our AMA report the results of the study on UPLs to the House of  
25 Delegates at A-25. (Directive to Take Action)

26  
27 Your Reference Committee heard limited but supportive testimony on Resolution 234.  
28 Your Reference Committee heard support for our AMA to conduct an economic impact  
29 study of state prescription drug affordability boards on physician practices and patients'  
30 access to treatment. Your Reference Committee appreciates the offer from the  
31 resolution's author to contribute to that study. Your Reference Committee also heard that  
32 the proposed requirement in this resolution to report the study's results to the House of  
33 Delegates at A-25, is redundant because our AMA already has established mechanisms  
34 for reporting such studies. Therefore, your Reference Committee recommends that  
35 Resolution 234 be adopted as amended.

1 (38) RESOLUTION 239 — REQUIRING STORES THAT SELL  
2 TOBACCO PRODUCTS TO DISPLAY NYS QUITLINE  
3 INFORMATION  
4

5 RECOMMENDATION A:  
6

7 Madam Speaker, your Reference Committee recommends  
8 that Resolution 239 be amended by addition and deletion  
9 read as follows:  
10

11 RESOLVED, that our American Medical Association seek  
12 federal legislation and/or regulation requiring all stores  
13 licensed to sell tobacco or nicotine products to display easily  
14 visible information about the CDC ~~hotline~~ national tobacco  
15 cessation quitline portals and telephone hotlines 1-800-  
16 QUIT-NOW, in multiple languages and/or the corresponding  
17 information for a given ~~the corresponding~~ state or territory.  
18 (Directive to Take Action)  
19

20 RECOMMENDATION B:  
21

22 Madam Speaker, your Reference Committee recommends  
23 that Resolution 239 be adopted as amended.  
24

25 RECOMMENDATION C:  
26

27 Madam Speaker, your Reference Committee recommends  
28 that the title of Resolution 239 be changed to read as  
29 follows:  
30

31 **REQUIRING STORES THAT SELL TOBACCO**  
32 **PRODUCTS TO DISPLAY THE NATIONAL TOLLFREE**  
33 **QUIT NOW HOTLINE.**  
34

35 **HOD ACTION: Resolution 239 adopted as amended with a**  
36 **change of title.**  
37

38 **REQUIRING STORES THAT SELL TOBACCO PRODUCTS**  
39 **TO DISPLAY THE NATIONAL TOLLFREE QUIT NOW**  
40 **HOTLINE.**  
41

42 RESVOLVED, that our American Medical Association seek federal legislation and/or  
43 regulation requiring all stores licensed to sell tobacco or nicotine products to display easily  
44 visible information about the CDC hotline 1-800-QUIT-NOW in multiple languages and/or  
45 the information for the corresponding state or territory. (Directive to Take Action)  
46

47 Your Reference Committee heard limited testimony in support of Resolution 239. Your  
48 Reference Committee heard that some states' Tobacco Control Programs allow tobacco  
49 products to contain a Quitline phone number and website on them. Your Reference

1 Committee also heard that our AMA takes a strong stand against smoking and favors  
2 aggressively pursuing all avenues of educating the public on the hazards of using tobacco  
3 products and the continuing high costs of this serious but preventable problem. Moreover,  
4 your Reference Committee heard that, in light of the continuing and urgent need to assist  
5 individuals in smoking cessation, our AMA policy states that physicians should assume a  
6 leadership role in establishing national policy on this topic and assume the primary task of  
7 educating the public and their patients about the danger of tobacco use (especially  
8 cigarette smoking). Your Reference Committee further heard that our AMA also strongly  
9 supports federal and state efforts related to tobacco cessation and has policy supporting  
10 the use of the federally funded CDC National Tobacco Quitline network and ongoing  
11 media campaigns to help Americans quit using tobacco. Your Reference Committee also  
12 heard that adopting Resolution 239 would be consistent with existing AMA policy but that  
13 amendments were needed to change the title to remove the reference to New York State's  
14 Quitline, to add a reference to national portals and hotlines, and to make implementation  
15 of the resolution less costly and easier to implement. Therefore, your Reference  
16 Committee recommends that Resolution 239 be adopted as amended with a change in  
17 title.

18  
19 (39) RESOLUTION 242 — CANCER CARE IN INDIAN  
20 HEALTH SERVICES FACILITIES

21  
22 RECOMMENDATION A:

23  
24 Madam Speaker, your Reference Committee recommends  
25 that the first Resolve of Resolution 242 be amended by  
26 addition and deletion to read as follows:

27  
28 RESOLVED, that our American Medical Association  
29 ~~actively advocate~~ support ~~for~~ the federal government  
30 continuing to ~~continue~~ ~~enhancing~~ and ~~developing~~  
31 alternative pathways for American Indian and Alaska Native  
32 patients to access the full spectrum of health cancer care,  
33 including and cancer-directed therapies within and outside  
34 of the established Indian Health Service (IHS) system (New  
35 HOD Policy)(Directive to Take Action); and be it further

1 RECOMMENDATION B:  
2

3 Madam Speaker, your Reference Committee recommends  
4 that the second Resolve of Resolution 242 be amended by  
5 addition and deletion to read as follows:  
6

7 RESOLVED, that our AMA (a) support collaborative  
8 research efforts to better understand the limitations of IHS  
9 health cancer care, including barriers to access, disparities  
10 in treatment outcomes, and areas for improvement and (b)  
11 encourage cancer linkage studies between the IHS and the  
12 CDC to better evaluate regional cancer rates, health  
13 outcomes, and potential treatment deficiencies among  
14 American Indian and Alaska Native populations, including  
15 with respect to cancer care. (New HOD Policy)~~(Directive to~~  
16 ~~Take Action)~~  
17

18 RECOMMENDATION C:  
19

20 Madam Speaker, your Reference Committee recommends  
21 that Resolution 242 be amended by addition of a third  
22 Resolve clause to read as follows:  
23

24 RESOLVED, That our AMA support federal and other efforts  
25 to increase funding for and provide technical assistance to  
26 develop and expand accessible specialty care services at  
27 IHS, Tribal, and Urban Indian Health Programs and  
28 associated facilities, including by contracting with other  
29 physician practices. (New HOD Policy)  
30

31 RECOMMENDATION D:  
32

33 Madam Speaker, your Reference Committee recommends  
34 that Resolution 242 be adopted as amended.  
35

36 RECOMMENDATION E:  
37

38 Madam Speaker, your Reference Committee recommends  
39 that the title of Resolution 242 be changed to read as  
40 follows:  
41

42 **HEALTH CARE ACCESS FOR AMERICAN INDIANS AND**  
43 **ALASKA NATIVES**  
44

45 **HOD ACTION: Resolution 242 adopted as amended with a**  
46 **change of title.**  
47

48 **HEALTH CARE ACCESS FOR AMERICAN INDIANS AND**  
49 **ALASKA NATIVES**

1 RESOLVED, that our American Medical Association actively advocate for the federal  
2 government to continue enhancing and developing alternative pathways for American  
3 Indian and Alaska Native patients to access the full spectrum of cancer care and cancer-  
4 directed therapies outside of the established Indian Health Service system (Directive to  
5 Take Action); and be it further

6  
7 RESOLVED, that our AMA (a) support collaborative research efforts to better understand  
8 the limitations of IHS cancer care, including barriers to access, disparities in treatment  
9 outcomes, and areas for improvement and (b) encourage cancer linkage studies between  
10 the IHS and the CDC to better evaluate regional cancer rates, outcomes, and potential  
11 treatment deficiencies among American Indian and Alaska Native populations. (Directive  
12 to Take Action)

13  
14 Your Reference Committee heard supportive testimony on Resolution 242. Your  
15 Reference Committee heard that it is imperative for our AMA to support increasing access  
16 to cancer care in Indian Health Service facilities because cancer is the leading cause of  
17 death among American Indian and Alaska Native (AI/AN) persons in the United States.  
18 Testimony also noted that AI/AN individuals have very limited access to comprehensive  
19 cancer care centers and often face prohibitively expensive care requirements which leads  
20 to worse health outcomes for this population. Your Reference Committee also heard that  
21 federal Indian Health Service (IHS) facilities do not offer on-site cancer care or provide  
22 payment for cancer treatment, unlike other federal health programs like the Department  
23 of Veterans Affairs (VA), unless funds are available for referral. Moreover, your Reference  
24 Committee heard that for the ten most populated AI/AN reservations, the median travel  
25 distance to a National Cancer Institute (NCI) cancer center is 186.5 miles, and the median  
26 travel time is 3.37 hours, and that such barriers to cancer screening and treatment can  
27 often result in worse health outcomes. However, your Reference Committee also heard  
28 concerns about adopting disease-specific cancer care policies for AI/AN populations  
29 rather than broader language that continues to support access to all care and access to  
30 all specialty-specific care. Your Reference Committee heard that adopting more general  
31 policy would provide more flexibility to our AMA to advocate for improvements to AI/AN  
32 health outcomes and access to health care, including cancer care. Your Reference  
33 Committee also heard that a new resolve clause on increasing funding and technical  
34 assistance to develop and expand accessible specialty care services at IHS, Tribal, and  
35 Urban Indian Health Programs and associated facilities would be a worthwhile addition  
36 and received a proposed amendment regarding this issue. Therefore, your Reference  
37 Committee recommends that Resolution 242 be adopted as amended.

1 (40) RESOLUTION 247 — PROHIBIT HEALTH BENEFIT  
2 PLANS FROM CHARGING COST SHARING FOR  
3 COVERED PROSTATE CANCER SCREENING  
4

5 RECOMMENDATION A:  
6

7 Madam Speaker, your Reference Committee recommends  
8 that Resolution 247 be amended by addition and deletion  
9 read as follows:

10  
11 RESOLVED, that our American Medical Association  
12 support ~~advocate~~ for federal legislation requiring that health  
13 benefit plans may not charge any form of cost sharing for  
14 covered prostate cancer screening.  
15

16 RECOMMENDATION B:  
17

18 Madam Speaker, your Reference Committee recommends  
19 that Resolution 247 be adopted as amended.  
20

21 **HOD ACTION: Resolution 247 adopted as amended.**  
22

23 RESOLVED, that our American Medical Association advocate for federal legislation  
24 requiring that health benefit plans may not charge any form of cost sharing for covered  
25 prostate cancer screening. (Directive to Take Action)  
26

27 Your Reference Committee heard mixed testimony on Resolution 247. Your Reference  
28 Committee heard that this resolution aims to address disparities in cancer screening  
29 coverage, specifically for prostate cancer, which lacks a federal mandate for no-cost  
30 screening unlike breast, cervical, and colorectal cancers. Your Reference Committee  
31 heard that prostate cancer screening using Prostate-Specific Antigen (PSA) tests is vital  
32 for early detection and significantly improves survival rates, yet cost-sharing remains a  
33 barrier for many patients. Testimony highlighted that several states have already  
34 implemented policies to remove cost-sharing for prostate cancer screening, reflecting a  
35 growing recognition of the need for equitable screening practices. However, some minor  
36 amendments were offered to broaden the resolution. Therefore, your Reference  
37 Committee recommends that Resolution 247 be adopted as amended.

1 (41) RESOLUTION 249 — PEDIATRIC SPECIALTY  
2 MEDICAID REIMBURSEMENT

3  
4 RECOMMENDATION A:

5  
6 Madam Speaker, your Reference Committee recommends  
7 that the second Resolve be amended by addition and  
8 deletion to read as follows:

9  
10 ~~RESOLVED, that our AMA include in its advocacy on~~  
11 ~~budget neutrality that improvements in Medicaid payment~~  
12 ~~rates are made without invoking budget neutrality (Directive~~  
13 ~~to Take Action); and be it further~~

14  
15 RESOLVED, That our AMA advocate for payment parity  
16 with Medicare for the same or similar services provided to  
17 pediatric patients under Medicaid; and be it further

18  
19 RECOMMENDATION B:

20  
21 Madam Speaker, your Reference Committee recommends  
22 that the third Resolve be amended by deletion to read as  
23 follows:

24  
25 RESOLVED, that our AMA work with ~~pediatric~~ specialty  
26 societies to develop a value-based payment model that  
27 makes pediatric specialist practices sustainable and  
28 promotes access to care and health equity among the  
29 pediatric patients (Directive to Take Action); and be it further

30  
31 RECOMMENDATION C:

32  
33 Madam Speaker, your Reference Committee recommends  
34 that the fourth Resolve be amended by addition and deletion  
35 to read as follows:

36  
37 RESOLVED, that our AMA work with interested state parties  
38 stakeholders to support the implementation of the value-  
39 based payment model for pediatric specialists in state  
40 Medicaid programs., (Directive to Take Action) and be it  
41 further

42  
43 RECOMMENDATION D:

44  
45 Madam Speaker, your Reference Committee recommends  
46 that Resolution 249 be amended by addition of a fifth  
47 Resolve to read as follows:



1 RESOLVED, That our AMA advocate for any demonstration  
2 projects undertaken to modernize Medicaid payment using  
3 value based payment models developed by the AMA and  
4 pediatric specialty societies be exempt from Medicaid  
5 demonstration project budget neutrality requirements.  
6

7 RECOMMENDATION E:  
8

9 Madam Speaker, your Reference Committee recommends  
10 that Resolution 249 be adopted as amended.  
11

12 **HOD ACTION: Resolution 249 adopted as amended.**  
13

14 RESOLVED, that our American Medical Association make increasing Medicaid  
15 reimbursement for pediatric specialists a significant part of its plan for continued progress  
16 toward health equity (Directive to Take Action); and be it further  
17

18 RESOLVED, that our AMA include in its advocacy on budget neutrality that improvements  
19 in Medicaid payment rates are made without invoking budget neutrality (Directive to Take  
20 Action); and be it further  
21

22 RESOLVED, that our AMA work with pediatric specialty societies to develop a value-  
23 based payment model that makes pediatric specialist practices sustainable and promotes  
24 access to care and health equity among the pediatric patients (Directive to Take Action);  
25 and be it further  
26

27 RESOLVED, that our AMA work with state stakeholders to support the implementation of  
28 the value-based payment model for pediatric specialists in state Medicaid programs.  
29 (Directive to Take Action)  
30

31 Your Reference Committee heard testimony in support of Resolution 249. Testimony  
32 addressed issues with Medicaid reimbursement rates for pediatric subspecialists and its  
33 implications on health equity. Your Reference Committee heard that there are disparities  
34 in reimbursement that currently disincentivize specialists from entering pediatric fields.  
35 Your Reference Committee was offered an amendment that requested that our AMA  
36 advocate for payment parity with Medicare to incentivize more specialists to enter this  
37 field, which received support. Additionally, testimony emphasized the need to develop and  
38 implement value-based payment models designed to make pediatric specialist practices  
39 sustainable and promote broader access to care, ultimately supporting health equity  
40 among pediatric patients. Therefore, your Reference Committee recommends that  
41 Resolution 249 be adopted as amended.

1 (42) RESOLUTION 252 — MODEL LEGISLATION TO  
2 PROTECT THE FUTURE OF MEDICINE

3  
4 RECOMMENDATION A:

5  
6 Madam Speaker, your Reference Committee recommends  
7 that Resolution 252 be amended by addition and deletion to  
8 read as follows:

9  
10 Resolved, that our American Medical Association create  
11 model state ~~and national~~ legislation to protect the ability of  
12 medical schools and residency/fellowship training programs  
13 to have diversity, equity, and inclusion (DEI) and related  
14 initiatives for their students, employees, and faculty to  
15 ensure the education and implementation of optimized  
16 healthcare.

17  
18 RECOMMENDATION B:

19  
20 Madam Speaker, your Reference Committee recommends  
21 that Resolution 252 be adopted as amended.

22  
23 **HOD ACTION: Resolution 252 adopted as amended.**

24  
25 Resolved, that our American Medical Association create model state and national  
26 legislation to protect the ability of medical schools and residency/fellowship training  
27 programs to have diversity, equity, and inclusion (DEI) and related initiatives for their  
28 students, employees, and faculty.

29  
30 Your Reference Committee heard mixed but mostly supportive testimony on Resolution  
31 252. Your Reference Committee heard about the importance of diversity, equity, and  
32 inclusion (DEI) in medical school. Testimony noted the value of having DEI in medical  
33 school settings and highlighted that in certain states, DEI is not supported. Testimony also  
34 noted bills in Congress and at the state level that would restrict GME funding if schools  
35 mandate DEI initiatives. Your Reference Committee also heard that our AMA has strong  
36 policy that supports diversity in medical education including through scholarship programs,  
37 loan repayment programs, pipeline programs, early and diverse recruiting methods and  
38 more. Testimony also highlighted that our AMA has policy calling on our AMA to advocate  
39 for resources to establish and maintain DEI offices at medical schools that are staff-  
40 managed with student and physician guidance as well as committed to community  
41 engagement. However, your Reference Committee also heard that our AMA does not  
42 create federal model legislation and was offered an amendment to that effect. An  
43 additional amendment was received that tied this resolution to the implementation of  
44 optimized healthcare and was not opposed. Therefore, your Reference Committee  
45 recommends that Resolution 252 be adopted as amended.

1 (43) 253 — ADDRESSING THE FAILED IMPLEMENTATION  
2 OF THE NO SURPRISES ACT IDR PROCESS  
3

4 RECOMMENDATION A:  
5

6 Madam Speaker, your Reference Committee recommends  
7 that Resolution 253 be adopted.  
8

9 RECOMMENDATION B:  
10

11 Madam Speaker, your Reference Committee recommends  
12 that the title of Resolution 253 be changed to read as  
13 follows:  
14

15 **ADDRESSING THE FAILED IMPLEMENTATION OF THE**  
16 **NO SURPRISES ACT INDEPENDENT DISPUTE**  
17 **RESOLUTION PROCESS**  
18

19 **HOD ACTION: Resolution 253 adopted with a change of**  
20 **title.**  
21

22 **ADDRESSING THE FAILED IMPLEMENTATION OF THE NO**  
23 **SURPRISES ACT INDEPENDENT DISPUTE RESOLUTION**  
24 **PROCESS**  
25

26 Resolved, that our American Medical Association advocate for the federal departments  
27 to immediately and correctly implement the fair and timely Independent Dispute  
28 Resolution (IDR) process as stipulated by the No Surprises Act including advocating  
29 specifically for the following:  
30

- 31 1. Specific requirements for insurers: Insurers must be required to make IDR loss  
32 payments directly to physicians, clarify IDR eligibility on explanation of benefit forms,  
33 and be prohibited from falsely claiming ineligibility due to network status or incorrect  
34 venue claims;  
35
- 36 2. Operational improvements in the IDR process: IDR entities must not close claims  
37 based on unverified insurer claims, an adequate number of IDR entities must be  
38 certified, and a structured timeline must be set for IDR entity selection and payment  
39 process (Directive to Take Action).  
40

41 Your Reference Committee heard supportive testimony on Resolution 253. Your  
42 Reference Committee heard testimony recognizing that passage of this resolution would  
43 complement continued advocacy by our AMA in this space to promote enforcement of the  
44 No Surprises Act and specifically enforcement of the Independent Dispute Resolution  
45 provisions. Therefore, your Reference Committee recommends that Resolution 253 be  
46 adopted.

1 **RECOMMENDED FOR ADOPTION IN LIEU OF**

2  
3 (44) **BOARD OF TRUSTEES REPORT 13 — PROHIBITING**  
4 **COVENANTS NOT-TO-COMPETE**

5  
6 **RECOMMENDATION:**

7  
8 Madam Speaker, your Reference Committee recommends  
9 that Alternate Recommendations for Board of Trustees  
10 Report 13 be adopted in lieu of the Recommendations in  
11 Board of Trustees Report 13 and the remainder of the  
12 Report be filed.

13  
14 1. That the AMA oppose all restrictive covenants between  
15 employers and physician employees and regularly update  
16 its state restrictive covenant legislative template. (New HOD  
17 Policy)

18  
19 2. That our AMA continue to assist interested state medical  
20 associations and specialty societies in developing strategies  
21 for physician employee retention. (New HOD Policy)

22  
23 **HOD ACTION: Alternate Recommendations for Board of**  
24 **Trustees Report 13 adopted in lieu of the**  
25 **Recommendations in Board of Trustees Report 13 and the**  
26 **remainder of the Report filed.**

27  
28 The Board of Trustees recommends that the following policy be adopted, and the  
29 remainder of the report be filed:

30  
31 1. That the American Medical Association (AMA) continue to assist interested state  
32 medical associations in developing fair and reasonable strategies regarding  
33 restrictive covenants between physician employers and physician employees  
34 including regularly updating the AMA's state restrictive covenant legislative  
35 template. (New HOD Policy)

36  
37 Your Reference Committee heard mixed testimony on the recommendations of Board of  
38 Trustees Report 13. Your Reference Committee heard supportive testimony that noted  
39 the numerous recommendations concerning how non-competes might be modified in  
40 ways that promote physician mobility and access to patient care while continuing to protect  
41 the legitimate business interests of physician practice owners. However, your Reference  
42 Committee also heard a wealth of testimony against adoption and instead urged our AMA  
43 to ban all physician non-competes between employers and physician employees. This  
44 testimony emphasized many reasons to support a ban on all physician non-competes,  
45 including harm to patient care and trapping physicians in detrimental working conditions.  
46 Testimony also noted that non-competes are not effective in achieving the desired goals  
47 of physician employers.

48  
49 Your Reference Committee believes that the weight of testimony supported a ban on all  
50 physician non-competes. Your Reference Committee also heard that our AMA must do

1 everything in its power to support and protect independent physician practices including  
2 continuing to assist interested state medical associations and national medical specialty  
3 societies develop strategies for physician employee retention. Therefore, your Reference  
4 Committee recommends that Alternate Recommendations be adopted in lieu of Board of  
5 Trustees Report 13.

6  
7 (45) RESOLUTION 210 — SUPPORT FOR PHYSICIANS  
8 PURSUING COLLECTIVE BARGAINING AND  
9 UNIONIZATION

10 RESOLUTION 236 — SUPPORT OF PHYSICIANS  
11 PURSUING COLLECTIVE BARGAINING AND  
12 UNIONIZATION

13  
14 RECOMMENDATION A:

15  
16 Madam Speaker, your Reference Committee recommends  
17 that Resolution 210 be amended by addition and deletion to  
18 read as follows:

19  
20 RESOLVED, that our American Medical Association  
21 ~~convenes an updated study of~~ opportunities for the AMA or  
22 physician associations to support physicians initiating and  
23 navigating a collective bargaining process, including but not  
24 limited to unionization. (Directive to Take Action)

25  
26 RECOMMENDATION B:

27  
28 Madam Speaker, your Reference Committee recommends  
29 that amended Resolution 210 be adopted in lieu of  
30 Resolution 236.

31  
32 **HOD ACTION: Resolution 210 adopted in lieu of Resolution**  
33 **236.**

34  
35 **RESOLUTION 210**

36  
37 RESOLVED, that our American Medical Association convenes an updated study of  
38 opportunities for the AMA or physician associations to support physicians initiating a  
39 collective bargaining process, including but not limited to unionization. (Directive to Take  
40 Action)

41  
42 **RESOLUTION 236**

43  
44 RESOLVED, that our American Medical Association investigate avenues for the AMA and  
45 other physician associations to aid physicians in initiating and navigating collective  
46 bargaining efforts, encompassing but not limited to unionization. (Directive to Take Action)

47  
48 Your Reference Committee heard testimony largely in support of Resolutions 210 and  
49 236, both of which call on our AMA to research ways that physician associations might  
50 support physicians in the collective bargaining process, including but not limited to

1 unionization. Your Reference Committee also heard significant testimony indicating that  
2 collective bargaining is an important and timely issue given that physicians are  
3 increasingly becoming employed by large hospitals and health systems. While your  
4 Reference Committee heard some testimony that opposed the formation of unions,  
5 significant testimony stressed that collective bargaining or unionization can help employed  
6 physicians overcome a lack of individual bargaining power and negotiate with employers  
7 for improved working conditions and to safeguard quality patient care. Testimony  
8 emphasized that, considering the shifting landscape in this space, a study on AMA's role  
9 in supporting physicians navigating the collective bargaining process would be useful for  
10 AMA members. Your Reference Committee also heard some concerns that these  
11 Resolutions are not ripe for adoption given that there is a pending Council on Ethics and  
12 Judicial Affairs (CEJA) report on collective bargaining due at the 2024 AMA Interim  
13 Meeting. Your Reference Committee understands that this CEJA report can and will be  
14 considered in the study sought by Resolution 210 and 236 and will complement it. As  
15 such, your Reference Committee recommends that Resolution 210 be adopted as  
16 amended in lieu of Resolution 236.  
17

1 (46) RESOLUTION 213 — ACCESS TO COVERED BENEFITS  
2 WITH AN OUT OF NETWORK ORDERING PHYSICIAN  
3 RESOLUTION 245 — PATIENT ACCESS TO COVERED  
4 BENEFITS ORDERED BY OUT-OF-NETWORK  
5 PHYSICIANS  
6

7 RECOMMENDATION A:  
8

9 Madam Speaker, your Reference Committee recommends  
10 that the first Resolve of Resolution 245 be amended by  
11 addition and deletion to read as follows:  
12

13 RESOLVED, that our American Medical Association  
14 develop model legislation to protect patients managed by  
15 out-of-network physicians by prohibiting insurance plans  
16 from denying payment for covered services, including  
17 imaging, laboratory testing, referrals, medications, and  
18 other medically-necessary services for patients under their  
19 commercial insurance, ~~even if it is an HMO or point of~~  
20 service plan based solely on the network participation of the  
21 ordering physician while preserving evidence based high  
22 quality care and healthcare affordability (Directive to Take  
23 Action); and be it further  
24

25 RECOMMENDATION B:  
26

27 Madam Speaker, your Reference Committee recommends  
28 that the second Resolve of Resolution 245 be amended by  
29 addition to read as follows:  
30

31 RESOLVED, that our AMA collaborate with other physician  
32 organizations to develop resources, toolkits, and education  
33 to support out-of-network care models. (Directive to Take  
34 Action)  
35

36 RECOMMENDATION C:  
37

38 Madam Speaker, your Reference Committee recommends  
39 that amended Resolution 245 be adopted in lieu of  
40 Resolution 213.  
41

42 **HOD ACTION: Amended Resolution 245 adopted in lieu of**  
43 **Resolution 213.**  
44

45 **RESOLUTION 213**

46  
47 RESOLVED, that our American Medical Association develop model legislation to protect  
48 patients in direct primary care plans and non-network plans thus furthering the ability of  
49 direct primary care physicians and other out-of-network physicians to provide covered  
50 services, including imaging, laboratory testing, referrals, medications, and other medically-

1 necessary services for patients under their commercial insurance, even if it is an HMO or  
2 point of service plan (Directive to Take Action); and be it further

3  
4 RESOLVED, that our AMA develop resources, tool kits, education, and internal experts to  
5 support direct primary care and other out-of-network models. (Directive to Take Action)

6  
7 **RESOLUTION 245**

8  
9 RESOLVED, that our American Medical Association develop model legislation to protect  
10 patients managed by out-of-network physicians by prohibiting insurance plans from  
11 denying payment for covered services, based solely on the network participation of the  
12 ordering physician (Directive to Take Action); and be it further

13  
14 RESOLVED, that our AMA develop resources, toolkits, and education to support out-of-  
15 network care models. (Directive to Take Action)

16  
17 Your Reference Committee heard testimony largely in support of Resolutions 245 and  
18 213, both which have the goal of ensuring that patients being cared for by out-of-network  
19 physicians, including those in direct primary care practices, can access insurance  
20 coverage for care ordered by their out-of-network physicians. Testimony noted that such  
21 services could include imaging, laboratory testing, referrals, medications, and other  
22 medically necessary services. Your Reference Committee heard that such coverage  
23 would provide needed autonomy to physicians and patients from insurance companies in  
24 determining the best care and treatment for their patients. Your Reference Committee also  
25 heard some concerns about risks and nuances in value-based care models that the  
26 Committee believes should be considered in the development of model legislation. Your  
27 Reference Committee was offered an amendment, which was supported by the  
28 Resolution's authors, that would clarify that the goal of the resolution is the development  
29 of state model legislation and provide the opportunity for our AMA to support federal  
30 efforts. Therefore, your Reference Committee recommends that Resolution 245 be  
31 adopted as amended in lieu of Resolution 213.



- 1 (47) RESOLUTION 217 — PROTECTING ACCESS TO IVF  
2 TREATMENT  
3 RESOLUTION 226 — PROTECTING ACCESS TO IVF  
4 TREATMENT

5  
6 RECOMMENDATION A:

7  
8 Madam Speaker, your Reference Committee recommends  
9 that the second Resolve of Resolution 217 be amended by  
10 addition to read as follows:

11  
12 RESOLVED, that our AMA work with other interested  
13 organizations to oppose any civil or criminal legislation or  
14 ballot measures or court rulings that (a) would equate  
15 gametes (oocytes and sperm) or embryos with children,  
16 and/or (b) would otherwise restrict or interfere with  
17 evidence-based care for Assisted Reproductive Technology  
18 (ART) (New HOD Policy); and be it further

19  
20 RECOMMENDATION B:

21  
22 Madam Speaker, your Reference Committee recommends  
23 that the third Resolve of Resolution 217 be amended by  
24 addition and deletion to read as follows:

25  
26 RESOLVED, that our AMA, through the AMA Task Force to  
27 Preserve the Patient-Physician Relationship, report back at  
28 I-24—A-25, on the status of, and AMA's activities  
29 surrounding, proposed ballot measures or legislation, and  
30 pending court rulings, ~~and legislation~~ that (a) would equate  
31 gametes or embryos with children and/or (b) would  
32 otherwise restrict or interfere with evidence-based care for  
33 Assisted Reproductive Technology (ART). (Directive to  
34 Take Action)

35  
36 RECOMMENDATION C:

37  
38 Madam Speaker, your Reference Committee recommends  
39 that amended Resolution 217 be adopted in lieu of  
40 Resolution 226.

41  
42 **HOD ACTION: Amended Resolution 217 adopted in lieu of**  
43 **Resolution 226.**

44  
45 **RESOLUTION 217**

46  
47 RESOLVED, that our American Medical Association oppose any legislation or ballot  
48 measures that could criminalize in-vitro fertilization (New HOD Policy); and be it further

1 RESOLVED, that our AMA work with other interested organizations to oppose any  
2 legislation or ballot measures or court rulings that equate gametes (oocytes and sperm)  
3 or embryos with children (New HOD Policy); and be it further  
4

5 RESOLVED, that our AMA report back at A-25, on the status of, and AMA's activities  
6 surrounding, ballot measures, court rulings, and legislation that equate embryos with  
7 children. (Directive to Take Action)  
8

9 **RESOLUTION 226**

10 RESOLVED, that our American Medical Association oppose any legislation that could  
11 criminalize in-vitro fertilization (New HOD Policy); and be it further  
12

13 RESOLVED, that our AMA work with other interested organizations to oppose Court  
14 rulings that equate gametes (oocytes and sperm) or embryos with children. (Directive to  
15 Take Action)  
16

17 Your Reference Committee heard strong and unanimous testimony supporting the first  
18 and second resolved clauses of Resolution 217 and in support of an amendment to  
19 broaden the scope of the Resolution. Your Reference Committee heard about the  
20 importance of our AMA opposing legislation, ballot measures, and court rulings that could  
21 criminalize in-vitro fertilization (IVF) or equate gametes or embryos with children. Your  
22 Reference Committee also heard that a recent state Supreme Court decision that  
23 recognized embryos as children sets a dangerous precedent and threatens access to  
24 evidence-based reproductive care. Your Reference Committee also heard limited  
25 testimony suggesting that the resolution should be expanded to include opposing the  
26 "personhood" of fetuses as well as embryos and gametes, but alternative testimony noted  
27 that this was beyond the scope of the evidence presented in the resolution. Your  
28 Reference Committee notes that our AMA has strong and extensive policy opposing  
29 limitations and bans on access to evidence-based reproductive health services, including  
30 abortion, that already enables our AMA to oppose governmental interference in the  
31 practice of medicine due to legal recognition of fetal "personhood." Your Reference  
32 Committee also heard testimony that the third resolved clause requiring a report back is  
33 duplicative of existing policy and activities. Your Reference Committee heard that  
34 monitoring governmental interference in IVF is being already being undertaken by the  
35 AMA Task Force to Preserve the Patient-Physician Relationship, which was formed by the  
36 House of Delegates in 2022 and has 20 representatives from state and specialty medical  
37 associations and ten representatives from AMA Councils. Testimony in support of the third  
38 resolved emphasized the need for a report on Task Force's activities. Your Reference  
39 Committee notes that existing AMA policy already directs the Task Force to report back  
40 on its activities on an annual basis. Testimony also noted that Resolutions 217 and 226  
41 were very similar and as such, only one of the resolutions was needed. Therefore, your  
42 Reference Committee recommends that Resolution 217 be adopted as amended in lieu  
43 of Resolution 226.

1 (48) RESOLUTION 251 — STREAMLINE PAYER QUALITY  
2 METRICS  
3

4 RECOMMENDATION:  
5

6 Madam Speaker, your Reference Committee recommends  
7 that Alternate Resolution 251 be adopted in lieu of  
8 Resolution 251.  
9

10 RESOLVED, that our American Medical Association will  
11 continue to advocate for improvements in private payers'  
12 quality programs.  
13

14 **HOD ACTION: Alternate Resolution 251 adopted in lieu of**  
15 **Resolution 251.**  
16

17 RESOLVED, that our American Medical Association work with the Centers for Medicare  
18 and Medicaid Services and major national insurance carriers to align each year's patient  
19 quality metrics across their respective programs. (Directive to Take Action)  
20

21 Your Reference Committee heard mixed testimony on Resolution 251. Your Reference  
22 Committee heard that this resolution seeks to address the inconsistencies in quality  
23 benchmarks set by Medicare and various third-party insurance carriers, which create  
24 challenges for primary care physicians in tracking, analyzing, and meeting these  
25 measures. Your Reference Committee heard that while the Centers for Medicare and  
26 Medicaid Services (CMS) does not control the quality metrics set by private payers, it is  
27 crucial for our AMA to advocate for alignment in these quality programs to reduce  
28 administrative burdens and ensure fair evaluation of physician performance. However,  
29 your Reference Committee heard that alternatives needed to be made to this resolution  
30 so that the spirit of the resolution is maintained while at same time appropriately shifting  
31 the focus towards advocating for improvements in private payers' quality programs without  
32 placing the onus on CMS. Testimony noted that these alternatives would allow our AMA  
33 to effectively work towards consistency, compliance, communication, and access in quality  
34 measurement standards, enhancing both physician practice sustainability and patient care  
35 outcomes. Therefore, your Reference Committee recommends that Alternate Resolution  
36 251 be adopted in lieu of Resolution 251.

1 **RECOMMENDED FOR REFERRAL**

- 2  
3 (49) BOARD OF TRUSTEES REPORT 15 — AUGMENTED  
4 INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND  
5 USE IN HEALTH CARE  
6 RESOLUTION 202 — USE OF ARTIFICIAL  
7 INTELLIGENCE AND ADVANCED TECHNOLOGY BY  
8 THIRD PARTY PAYORS TO DENY HEALTH  
9 INSURANCE CLAIMS  
10 RESOLUTION 246 — AUGMENTED INTELLIGENCE IN  
11 HEALTH CARE

12  
13 **RECOMMENDATION:**

14  
15 Madam Speaker, your Reference Committee recommends  
16 that Board of Trustees Report 15, Resolution 202, and  
17 Resolution 246 be referred for report back at the 2024  
18 Interim Meeting of the House of Delegates.

19  
20 **HOD ACTION: Board of Trustees Report 15, Resolution**  
21 **202, and Resolution 246 referred for report back at the**  
22 **2024 Interim Meeting of the House of Delegates.**

23  
24 **BOARD OF TRUSTEES REPORT 15**

25  
26 The Board of Trustees recommends that the following be adopted in lieu of Resolution  
27 206-I-23 and that the remainder of the report be filed:

28  
29 **AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN**  
30 **HEALTH CARE**

31  
32 **General Governance**

- 33 • Health care AI must be designed, developed, and deployed in a manner which is  
34 ethical, equitable, responsible, and transparent.
- 35 • Use of AI in health care delivery requires clear national governance policies to  
36 regulate its adoption and utilization, ensuring patient safety, and mitigating  
37 inequities. Development of national governance policies should include  
38 interdepartmental and interagency collaboration.
- 39 • Compliance with national governance policies is necessary to develop AI in an  
40 ethical and responsible manner to ensure patient safety, quality, and continued  
41 access to care. Voluntary agreements or voluntary compliance is not sufficient.
- 42 • Health care AI requires a risk-based approach where the level of scrutiny,  
43 validation, and oversight should be proportionate to the potential overall of  
44 disparate harm and consequences the AI system might introduce. [See also  
45 Augmented Intelligence in [Health Care H-480.939](#) at (1)]
- 46 • Clinical decisions influenced by AI must be made with specified human intervention  
47 points during the decision-making process. As the potential for patient harm  
48 increases, the point in time when a physician should utilize their clinical judgment  
49 to interpret or act on an AI recommendation should occur earlier in the care plan.

- 1 • Health care practices and institutions should not utilize AI systems or technologies  
2 that introduce overall or disparate risk that is beyond their capabilities to mitigate.  
3 Implementation and utilization of AI should avoid exacerbating clinician burden and  
4 should be designed and deployed in harmony with the clinical workflow.
- 5 • Medical specialty societies, clinical experts, and informaticists are best positioned  
6 and should identify the most appropriate uses of AI-enabled technologies relevant  
7 to their clinical expertise and set the standards for AI use in their specific domain.  
8 [See Augmented Intelligence in Health Care [H-480.940](#) at (2)]  
9

#### 10 When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and 11 Technologies

- 12 •
- 13 • When AI is used in a manner which directly impacts patient care, access to care,  
14 or medical decision making, that use of AI should be disclosed and documented  
15 to both physicians and/or patients in a culturally and linguistically appropriate  
16 manner. The opportunity for a patient or their caregiver to request additional review  
17 from a licensed clinician should be made available upon request.
- 18 • When AI is used in a manner which directly impacts patient care, access to care,  
19 medical decision making, or the medical record, that use of AI should be  
20 documented in the medical record.
- 21 • AI tools or systems cannot augment, create, or otherwise generate records,  
22 communications, or other content on behalf of a physician without that physician's  
23 consent and final review.
- 24 • When health care content is generated by generative AI, including by large  
25 language models, it should be clearly disclosed within the content that was  
26 generated by an AI enabled technology.
- 27 • When AI or other algorithmic-based systems or programs are utilized in ways that  
28 impact patient access to care, such as by payors to make claims determinations  
29 or set coverage limitations, use of those systems or programs must be disclosed  
30 to impacted parties.
- 31 • The use of AI-enabled technologies by hospitals, health systems, physician  
32 practices, or other entities, where patients engage directly with AI should be clearly  
33 disclosed to patients at the beginning of the encounter or interaction with the AI-  
34 enabled technology.  
35

#### 36 What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled 37 Systems and Technologies

- 38 •
- 39 • When AI-enabled systems and technologies are utilized in health care, the  
40 following information should be disclosed by the AI developer to allow the  
41 purchaser and/or user (physician) to appropriately evaluate the system or  
42 technology prior to purchase or utilization:
  - 43 ○ Regulatory approval status
  - 44 ○ Applicable consensus standards and clinical guidelines utilized in design,  
45 development, deployment, and continued use of the technology
  - 46 ○ Clear description of problem formulation and intended use accompanied  
47 by clear and detailed instructions for use
  - 48 ○ Intended population and intended practice setting

- 1 ○ Clear description of any limitations or risks for use, including possible  
2 disparate impact
- 3 ○ Description of how impacted populations were engaged during the AI  
4 lifecycle
- 5 ○ Detailed information regarding data used to train the model:
- 6 ■ Data provenance
- 7 ■ Data size and completeness
- 8 ■ Data timeframes
- 9 ■ Data diversity
- 10 ■ Data labeling accuracy
- 11 ○ Validation Data/Information and evidence of:
- 12 ■ Clinical expert validation in intended population and practice setting  
13 and intended clinical outcomes
- 14 ■ Constraint to evidence-based outcomes and mitigation of  
15 “hallucination” or other output error
- 16 ■ Algorithmic validation
- 17 ■ External validation processes for ongoing evaluation of the model  
18 performance, e.g., accounting for AI model drift and degradation
- 19 ■ Comprehensiveness of data and steps taken to mitigate biased  
20 outcomes
- 21 ■ Other relevant performance characteristics, including but not limited  
22 to performance characteristics at peer institutions/similar practice  
23 settings
- 24 ■ Post-market surveillance activities aimed at ensuring continued  
25 safety, performance, and equity
- 26 ○ Data Use Policy
- 27 ■ Privacy
- 28 ■ Security
- 29 ■ Special considerations for protected populations or groups put at  
30 increased risk
- 31 ○ Information regarding maintenance of the algorithm, including any use of  
32 active patient data for ongoing training
- 33 ○ Disclosures regarding the composition of design and development team,  
34 including diversity and conflicts of interest, and points of physician  
35 involvement and review
- 36
- 37 ● Purchasers and/or users (physicians) should carefully consider whether or not to  
38 engage with AI-enabled health care technologies if this information is not disclosed  
39 by the developer. As the risk of AI being incorrect increases risks to patients (such  
40 as with clinical applications of AI that impact medical decision making), disclosure  
41 of this information becomes increasingly important. [See also Augmented  
42 Intelligence in Health Care [H-480.939](#)]
- 43
- 44 Generative Augmented Intelligence
- 45
- 46 ● Generative AI should: (a) only be used where appropriate policies are in place  
47 within the practice or other health care organization to govern its use and help  
48 mitigate associated risks; and (b) follow applicable state and federal laws and  
49 regulations (e.g., HIPAA41 compliant Business Associate Agreement).

- 1 • Appropriate governance policies should be developed by health care organizations  
2 and account for and mitigate risks of:
  - 3 ○ Incorrect or falsified responses; lack of ability to readily verify the accuracy  
4 of responses or the sources used to generate the response
  - 5 ○ Training data set limitations that could result in responses that are out of  
6 date or otherwise incomplete or inaccurate for all patients or specific  
7 populations
  - 8 ○ Lack of regulatory or clinical oversight to ensure performance of the tool
  - 9 ○ Bias, discrimination, promotion of stereotypes, and disparate impacts on  
10 access or outcomes
  - 11 ○ Data privacy
  - 12 ○ Cybersecurity
  - 13 ○ Physician liability associated with the use of generative AI tools
- 14 • Health care organizations should work with their AI and other health information  
15 technology (health IT) system developers to implement rigorous data validation  
16 and verification protocols to ensure that only accurate, comprehensive, and bias  
17 managed datasets inform generative AI models, thereby safeguarding equitable  
18 patient care and medical outcomes. [See Augmented Intelligence in Health Care  
19 [H-480.940](#) at (3)(d)]
- 20 • Use of generative AI should incorporate physician and staff education about the  
21 appropriate use, risks, and benefits of engaging with generative AI. Additionally,  
22 physicians should engage with generative AI tools only when adequate information  
23 regarding the product is provided to physicians and other users by the developers  
24 of those tools.
- 25 • Clinicians should be aware of the risks of patients engaging with generative AI  
26 products that produce inaccurate or harmful medical information (e.g., patients  
27 asking chatbots about symptoms) and should be prepared to counsel patients on  
28 the limitations of AI driven medical advice.
- 29 • Governance policies should prohibit the use of confidential, regulated, or  
30 proprietary information as prompts for generative AI to generate content.
- 31 • Data and prompts contributed by users should primarily be used by developers to  
32 improve the user experience and AI tool quality and not simply increase the AI  
33 tool's market value or revenue generating potential.

#### 34 35 Physician Liability for Use of Augmented Intelligence-Enabled Technologies

- 37 • Current AMA policy states that liability and incentives should be aligned so that the  
38 individual(s) or entity(ies) best positioned to know the AI system risks and best  
39 positioned to avert or mitigate harm do so through design, development, validation,  
40 and implementation. [See Augmented Intelligence in Health Care [H-480.939](#)]
  - 41 ○ Where a mandated use of AI systems prevents mitigation of risk and harm,  
42 the individual or entity issuing the mandate must be assigned all applicable  
43 liability.
  - 44 ○ Developers of autonomous AI systems with clinical applications (screening,  
45 diagnosis, treatment) are in the best position to manage issues of liability  
46 arising directly from system failure or misdiagnosis and must accept this  
47 liability with measures such as maintaining appropriate medical liability  
48 insurance and in their agreements with users.

- 1 ○ Health care AI systems that are subject to non-disclosure agreements  
2 concerning flaws, malfunctions, or patient harm (referred to as gag clauses)  
3 must not be covered or paid and the party initiating or enforcing the gag  
4 clause assumes liability for any harm.
- 5 ● When physicians do not know or have reason to know that there are concerns  
6 about the quality and safety of an AI-enabled technology, they should not be held  
7 liable for the performance of the technology in question.

## 8 9 Data Privacy and Augmented Intelligence

- 10 ● Entity Responsibility:
  - 11 ○ Entities should make information available about the intended use of  
12 generative AI in health care and identify the purpose of its use. Individuals  
13 should know how their data will be used or reused, and the potential risks  
14 and benefits.
  - 15 ○ Individuals should have the right to opt-out, update, or forget use of their  
16 data in generative AI tools. These rights should encompass AI training data  
17 and disclosure to other users of the tool.
  - 18 ○ Generative AI tools should not reverse engineer, reconstruct, or reidentify  
19 an individual's originally identifiable data or use identifiable data for  
20 nonpermitted uses, e.g., when data are permitted to conduct quality and  
21 safety evaluations. Preventive measures should include both legal  
22 frameworks and data model protections, e.g., secure enclaves, federated  
23 learning, and differential privacy.
- 24 ● User Education:
  - 25 ○ Users should be provided with training specifically on generative AI.  
26 Education should address:
    - 27 ■ legal, ethical, and equity considerations;
    - 28 ■ risks such as data breaches and re-identification;
    - 29 ■ potential pitfalls of inputting sensitive and personal data; and
    - 30 ■ the importance of transparency with patients regarding the use of  
31 generative AI and their data.

32 [See [H-480.940](#), Augmented Intelligence in Health Care, at (4) and (5)]

## 33 34 35 36 Augmented Intelligence Cybersecurity

- 37 ● AI systems must have strong protections against input manipulation and malicious  
38 attacks.
- 39 ● Entities developing or deploying health care AI should regularly monitor for  
40 anomalies or performance deviations, comparing AI outputs against known and  
41 normal behavior.
- 42 ● Independent of an entity's legal responsibility to notify a health care provider or  
43 organization of a data breach, that entity should also act diligently in identifying  
44 and notifying the individuals themselves of breaches that impact their personal  
45 information.
- 46 ● Users should be provided education on AI cybersecurity fundamentals, including  
47 specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber  
48



1 attackers, and the user's role in mitigating threats and reporting suspicious AI  
2 behavior or outputs.

#### 3 4 Payor Use of Augmented Intelligence and Automated Decision-Making Systems 5

- 6 • Use of automated decision-making systems that determine coverage limits, make  
7 claim determinations, and engage in benefit design should be publicly reported,  
8 based on easily accessible evidence-based clinical guidelines (as opposed to  
9 proprietary payor criteria), and disclosed to both patients and their physician in a  
10 way that is easy to understand.
- 11 • Payors should only use automated decision-making systems to improve or  
12 enhance efficiencies in coverage and payment automation, facilitate administrative  
13 simplification, and reduce workflow burdens. Automated decision-making systems  
14 should never create or exacerbate overall or disparate access barriers to needed  
15 benefits by increasing denials, coverage limitations, or limiting benefit offerings.  
16 Use of automated decision-making systems should not replace the individualized  
17 assessment of a patient's specific medical and social circumstances and payors'  
18 use of such systems should allow for flexibility to override automated decisions.  
19 Payors should always make determinations based on particular patient care needs  
20 and not base decisions on algorithms developed on "similar" or "like" patients.
- 21 • Payors using automated decision-making systems should disclose information  
22 about any algorithm training and reference data, including where data were  
23 sourced and attributes about individuals contained within the training data set (e.g.,  
24 age, race, gender). Payors should provide clear evidence that their systems do not  
25 discriminate, increase inequities, and that protections are in place to mitigate bias.
- 26 • Payors using automated decision-making systems should identify and cite peer-  
27 reviewed studies assessing the system's accuracy measured against the  
28 outcomes of patients and the validity of the system's predictions.
- 29 • Any automated decision-making system recommendation that indicates limitations  
30 or denials of care, at both the initial review and appeal levels, should be  
31 automatically referred for review to a physician (a) possessing a current and valid  
32 non-restricted license to practice medicine in the state in which the proposed  
33 services would be provided if authorized and (b) be of the same specialty as the  
34 physician who typically manages the medical condition or disease or provides the  
35 health care service involved in the request prior to issuance of any final  
36 determination. Prior to issuing an adverse determination, the treating physician  
37 must have the opportunity to discuss the medical necessity of the care directly with  
38 the physician who will be responsible for determining if the care is authorized.
- 39 • Individuals impacted by a payor's automated decision-making system, including  
40 patients and their physicians, must have access to all relevant information  
41 (including the coverage criteria, results that led to the coverage determination, and  
42 clinical guidelines used).
- 43 • Payors using automated decision-making systems should be required to engage  
44 in regular system audits to ensure use of the system is not increasing overall or  
45 disparate claims denials or coverage limitations, or otherwise decreasing access  
46 to care. Payors using automated decision-making systems should make statistics  
47 regarding systems' approval, denial, and appeal rates available on their website  
48 (or another publicly available website) in a readily accessible format with patient  
49 population demographics to report and contextualize equity implications of

1 automated decisions. Insurance regulators should consider requiring reporting of  
2 payor use of automated decision-making systems so that they can be monitored  
3 for negative and disparate impacts on access to care. Payor use of automated  
4 decision-making systems must conform to all relevant state and federal laws.

- 5 • (New HOD Policy)

## 6 7 **RESOLUTION 202**

8  
9 RESOLVED, that our American Medical Association adopt as policy that Commercial  
10 third-party payors, Medicare, Medicaid, Workers Compensation, Medicare Advantage and  
11 other health plans ensure they are making medical necessity determinations based on the  
12 circumstances of the specific patient rather than by using an algorithm, software, or  
13 Artificial Intelligence (AI) that does not account for an individual's circumstances (New  
14 HOD Policy); and be it further

15  
16 RESOLVED, that our AMA adopt as policy that coverage denials based on a medical  
17 necessity determination must be reviewed by a physician in the same specialty or by  
18 another appropriate health care professional for non-physician health care providers.  
19 (New HOD Policy)

## 20 21 **RESOLUTION 246**

22  
23 RESOLVED, that our American Medical Association amend its augmented intelligence  
24 policy to align with the following:

### 25 26 **Augmented Intelligence in Health Care**

27  
28 The American Medical Association supports the use of augmented intelligence (AI) when  
29 used appropriately to support physician decision-making, enhance patient care, improve  
30 administrative functions, and improve public health without reducing the importance of  
31 physician decision-making. Augmented intelligence also should be used in ways that  
32 reduce physician burden and increase professional satisfaction. Sufficient safeguards  
33 should be in place to assign appropriate liability inherent in augmented intelligence to the  
34 software developers and not to those with no control over the software content and  
35 integrity, such as physicians and other users. Ultimately, it is the physician's responsibility  
36 to uphold the standard of care.

37  
38 The American Medical Association adopts the following principles for augmented  
39 intelligence in health care:

- 40
- 41 1. Augmented intelligence should be the preferred health care term over artificial  
42 intelligence as it should be used to augment care by providing information for  
43 consideration. Augmented intelligence, whether assistive or fully autonomous, is  
44 intended to co-exist with human decision-making and should not be used to replace  
45 physician reasoning and knowledge.
  - 46 2. Physicians should not be mandated to use augmented intelligence without having  
47 input or feedback into how the tool is used either individually or as a medical staff.
  - 48 3. Augmented intelligence must not replace or diminish the patient-physician  
49 relationship.

- 1 4. Algorithms developed to augment user intelligence must be designed for the benefit,  
2 safety, and privacy of the patient. The AMA should research opportunities to place  
3 practicing physicians on public and private panels, work groups, and committees that  
4 will evaluate products as they are developed.
- 5 5. Sellers and distributors of augmented intelligence should disclose that it has met all  
6 state and federal legal and regulatory compliance with regulations such as, but not  
7 limited to, those of HIPAA, the U.S. Department of Health and Human Services, and  
8 the U.S. Food and Drug Administration.
- 9 6. Use of augmented intelligence, machine learning, and clinical decision support has  
10 inherent known risks. These risks should be recognized, and legal and ethical  
11 responsibility for the use and output of these products must be assumed by, including  
12 but not limited to, developers, distributors, and users with each entity owning  
13 responsibility for its respective role in the development, dissemination,  
14 implementation, and use of products used in clinical care.
- 15 7. Users should have clear guidelines for how and where to report any identified  
16 anomalies. Additionally, as with all technology, there should be a national database  
17 for reporting errors that holds developers accountable for correcting identified issues.
- 18 8. Before using augmented intelligence, physicians and all users should receive  
19 adequate training and have educational materials available for reference, especially  
20 in instances where the technology is not intuitive and there are periods of nonuse.
- 21 9. Physicians should inquire about whether the AI used is a “continuously learning  
22 system” versus a “locked system.” A locked system is more appropriate for clinical  
23 care, although a hybrid system may be appropriate as long as the clinical output is  
24 based on locked training sets. A locked system gives a predictable output, whereas a  
25 continuous learning system will change over time.
- 26 10. Algorithms and other information used to derive the information presented as  
27 augmented intelligence to physicians and other clinicians should:  
28
  - 29 a. Be developed transparently in a way that is accessible, explainable, and  
30 understandable to clinicians and patients and details the benefits and limitations  
31 of the clinical decision support, and/or augmented intelligence
  - 32 b. Have reproducible and explainable outputs
  - 33 c. Function in a way that promotes health equities while eliminating potential biases  
34 that exacerbate health disparities
  - 35 d. Use best practices for user-centered design that allows for efficient and  
36 satisfactory use of the technology;
  - 37 e. Safeguard patient information by employing privacy and security standards that  
38 comply with HIPAA and state privacy regulations
  - 39 f. Have a feedback loop that allows users who identify potential safety hazards to  
40 easily report problems and malfunctions as well as opportunities to report methods  
41 for improvements; and
  - 42 g. Contain a level of compatibility to allow use of information between hardware and  
43 software made by different manufacturers.
- 44
- 45 11. Medical students and residents need to learn about the opportunities and limitations  
46 of augmented intelligence as they are prepared for future medical practice.
- 47 12. The AMA will advocate, through legislation or regulation, for payment to physicians for  
48 utilization of artificial intelligence tools that have additional cost or require additional  
49 time.

1 13. Recognizing the rapid pace of change in augmented intelligence, it is important to  
2 continually assess and update the AMA's principles at regular intervals. (Modify  
3 Current HOD Policy)  
4

5 Your Reference Committee heard mixed testimony on the recommendations in BOT  
6 Report 15. Your Reference Committee heard testimony acknowledging the extensive  
7 vetting process the recommendations in BOT Report 15 underwent by the Board, Council  
8 on Legislation, various AMA business units, multiple specialty societies with expertise in  
9 AI, and external AI experts. Testimony also acknowledged that the recommendations were  
10 carefully drafted to supplement and build upon existing AMA AI policy, notably H-480.940  
11 and H-480.939 on Augmented Intelligence in Health Care, and D-480.956 on the Use of  
12 Augmented Intelligence for Prior Authorization, along with our AMA's Privacy  
13 Principles. Testimony further commended the Board for its thoughtful analysis but  
14 expressed concerns over omissions in the report regarding the use of AI in the  
15 development of scientific literature and the feasibility of some of the transparency and  
16 disclosures recommendations. Testimony expressed concerns that the disclosure and  
17 transparency recommendations would pose additional burdens on physicians. Your  
18 Reference Committee heard testimony regarding Resolutions 202 and 246, as well as  
19 considered the substantive on-line comments, which noted that BOT 15 did not address  
20 some of the issues raised in these resolutions and comments. Testimony was further  
21 heard recommending that BOT 15 should be referred along with Resolutions 202 and 246  
22 for further consideration. Your Reference Committees agrees and recommends referral of  
23 BOT 15 and Resolutions 202 and 246 as well as the online forum comments for report  
24 back at I-24.  
25

26 (50) RESOLUTION 218 — DESIGNATION OF  
27 DESCENDANTS OF ENSLAVED AFRICANS IN  
28 AMERICA  
29

30 RECOMMENDATION:  
31

32 Madam Speaker, your Reference Committee recommends  
33 that Resolution 218 be referred.  
34

35 **HOD ACTION: Resolution 218 referred.**  
36

37 **RESOLVED**, that our American Medical Association work with appropriate organizations  
38 including, but not limited to, the Association of American Medical Colleges to adopt and  
39 define the term Descendants of Enslaved Africans in America and separate it from the  
40 generic terms African American and Black in glossaries and on medical school  
41 applications. (Directive to Take Action)  
42

43 Your Reference Committee heard mixed testimony on Resolution 218. Your Reference  
44 Committee heard that descendants of Enslaved Africans in America are a unique  
45 population and that it is important to disaggregate data to make sure everyone is  
46 recognized and that the data influencing policies, programs, and solutions are accurate.  
47 However, testimony also highlighted that over the last four years our AMA has been  
48 working with the Association of American Medical Colleges and the Accreditation Council  
49 for Graduate Medical Education through the Physician Data Collaborative (PDC) to  
50 establish best practices for data sharing and standards for sociodemographic data,

1 including race, ethnicity, and more. Your Reference Committee heard that these efforts  
2 will enable meaningful, collaborative research to better understand the dynamics of the  
3 physician workforce continuum. Your Reference Committee also heard that the Office of  
4 Management and Budget recently concluded an extensive national consultation process  
5 concerning updating race and ethnicity standards, which our AMA provided comments on,  
6 and which found that further research is needed to fully understand the implications of a  
7 designation for “descendants of enslaved Africans in America” because individuals and  
8 civil rights groups disagreed on whether or how to implement this potential revision. Your  
9 Reference Committee heard that although the resolution has merit, our AMA needs more  
10 time to understand its nuances and implications and to collaborate with our partners  
11 through the PDC to discuss and fully consider the short and long-term implications of these  
12 changes. Therefore, your Reference Committee recommends that Resolution 218 be  
13 referred.

14  
15 (51) RESOLUTION 243 — DISAGGREGATION OF  
16 DEMOGRAPHIC DATA FOR INDIVIDUALS OF  
17 FEDERALLY RECOGNIZED TRIBES

18  
19 RECOMMENDATION:

20  
21 Madam Speaker, your Reference Committee recommends  
22 that Resolution 243 be referred.

23  
24 **HOD ACTION: Resolution 243 referred.**

25  
26 RESOLVED, that our American Medical Association add “Enrolled Member of a Federally  
27 Recognized Tribe” on all AMA demographic forms (Directive to Take Action); and be it further  
28 further

29  
30 RESOLVED, that our AMA advocate for the use of “Enrolled Member of a Federally  
31 Recognized Tribe” as an additional category in all uses of demographic data including but  
32 not limited to medical records, government data collection and research, and within  
33 medical education (Directive to Take Action); and be it further

34  
35 RESOLVED, that our AMA support the Association of American Medical Colleges (AAMC)  
36 inclusion of “Enrolled Member of a Federally Recognized Tribe” on all AAMC demographic  
37 forms (New HOD Policy); and be it further

38  
39 RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical  
40 Education (ACGME) to include “Enrolled Member of a Federally Recognized Tribe” on all  
41 ACGME demographic forms. (Directive to Take Action)

42  
43  
44 Your Reference Committee heard mixed testimony on Resolution 243. Your Reference  
45 Committee heard that over the last four years our AMA has been working with the  
46 Association of American Medical Colleges and the Accreditation Council for Graduate  
47 Medical Education through the Physician Data Collaborative (PDC) to establish best  
48 practices for data sharing and standards for sociodemographic data, including race,  
49 ethnicity, and more. Your Reference Committee heard that these efforts will enable  
50 meaningful, collaborative research to better understand the dynamics of the physician

1 workforce continuum. Your Reference Committee also heard that the Office of  
2 Management and Budget (OMB) recently concluded an extensive national consultation  
3 process concerning updating race and ethnicity standards, which our AMA commented  
4 on. Testimony highlighted that the OMB ultimately decided to “remove the phrase ‘who  
5 maintains tribal affiliation or community attachment’ in the American Indian/Alaska Native  
6 (AI/AN) definition....to improve estimates of the AI/AN population in Federal  
7 statistics.” However, your Reference Committee also heard that there may be value in  
8 collecting data of members of a federally recognized tribe because it is a legal designation  
9 and not a racial category and therefore not subject to the recent U.S. Supreme Court  
10 decisions banning the use of race in holistic college admissions processes. Your  
11 Reference Committee heard that a potential disadvantage is that there are state  
12 recognized tribes and tribes which have lost their federal recognition who would be  
13 excluded from this data category. Your Reference Committee also heard that our AMA  
14 believed it would be beneficial to study the implications of this designation to ensure that  
15 our policy is more comprehensive and does not exclude AI/AN individuals because their  
16 tribe is not federally recognized. Testimony also noted that more time is needed to  
17 understand the nuances and implications of this resolution and to collaborate with our  
18 partners through the PDC to discuss and fully consider the short and long-term  
19 implications of these changes. Therefore, your Reference Committee recommends that  
20 Resolution 243 be referred.

1 **RECOMMENDED FOR NOT ADOPTION**

2  
3 (52) RESOLUTION 225 — HUMANITARIAN EFFORTS TO  
4 RESETTLE REFUGEES

5  
6 RECOMMENDATION:

7  
8 Madam Speaker, your Reference Committee recommends  
9 that Resolution 225 not be adopted.

10  
11 **HOD ACTION: Resolution 225 not adopted.**

12  
13 **RESOLVED**, that our American Medical Association support increases and oppose  
14 decreases to the annual refugee admissions cap in the United States. (New HOD Policy)

15  
16 Your Reference Committee heard mixed testimony on Resolution 225. Your Reference  
17 Committee heard that increasing refugee admission caps is an important social justice  
18 issue that will allow more individuals to enter into the United States and begin a new life  
19 here. Testimony stated that the United States should be doing more to ensure the  
20 wellbeing and safety of refugees all around the world and that this was one small step to  
21 help. However, your Reference Committee also heard that the United States is struggling  
22 to find adequate funding for necessities for citizens of the United States and that we do  
23 not have the ability to provide further monetary assistance to additional asylum seekers at  
24 this time. Additionally, testimony stated that our AMA is not an organization that focuses  
25 on immigration and does not have the background, expertise, or bandwidth to handle  
26 advocacy in this space. Furthermore, your Reference Committee heard that engaging with  
27 immigration policy at this time could be politically turbulent and could endanger our AMA's  
28 advocacy on other issues. Therefore, your Reference Committee recommends that  
29 Resolution 225 not be adopted.

1 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**

2  
3 (53) RESOLUTION 237 — ENCOURAGING THE PASSAGE  
4 OF THE PREVENTIVE HEALTH SAVINGS ACT (S.114)

5  
6 RECOMMENDATION:

7  
8 Madam Speaker, your Reference Committee recommends  
9 that AMA Policies D-155.994, H-425.988, H-460.894, and  
10 H-425.987 be reaffirmed in lieu of Resolution 237.

11  
12 **HOD ACTION: AMA Policies D-155.994, H-425.988, H-**  
13 **460.894, and H-425.987 reaffirmed in lieu of Resolution 237.**

14  
15 RESOLVED, that our American Medical Association encourages continued advocacy to  
16 federal and state legislatures of the importance of more accurately and effectively  
17 measuring the health and economic impacts of investing in preventive health services to  
18 improve health and reduce healthcare spending costs in the long term. (Directive to Take  
19 Action); and be it further

20  
21 RESOLVED, that our AMA reaffirm the following policy: D-155.994, “Value-Based  
22 Decision Making in the Health Care System” to encourage legislation and efforts to allow  
23 the Congressional Budget Office to more effectively project long-term budget deficit  
24 reductions and costs associated with legislation related to preventive health services.  
25 (Reaffirm HOD Policy)

26  
27 Your Reference Committee heard mixed testimony on Resolution 237. Your Reference  
28 Committee heard that the Congressional Budget Office (CBO) was established to provide  
29 objective, nonpartisan information to support the U.S. budget process and aid Congress  
30 in making effective budget and economic policy and that the CBO is directed to estimate  
31 and project the cost of legislation approved by Congressional committees for a specified  
32 period of time, usually 10 years. In addition, your Reference Committee heard that 70  
33 percent of U.S. health care expenditures is spent on the management and treatment of  
34 chronic disease, and that while much of the political debate around health care in the  
35 United States has focused primarily on insurance coverage and access, there has been  
36 little discussion around a true transformation of the health system, beginning with  
37 measurements of the impacts of preventive health policy. Your Reference Committee also  
38 heard an amendment offered to add a reference to “primary care” in the resolution which  
39 did not receive much support. Your Reference Committee also heard that the House of  
40 Representatives passed legislation, in a bipartisan vote, to direct the CBO to expand the  
41 scoring window to estimate the budgetary effects of legislation related to preventive health  
42 care services and that our AMA already sent a letter in support of this legislation to House  
43 leadership. Your Reference Committee further heard that our AMA already has policy, as  
44 noted in the resolution, that recognizes the value and importance of preventive services,  
45 and supports legislation and efforts that allow the CBO to more effectively project long-  
46 term budget deficit reductions and costs associated with preventive health services. Your  
47 Reference Committee heard testimony in favor of reaffirmation of these policies in lieu of  
48 adoption. Therefore, your Reference Committee recommends that existing AMA policies  
49 D-155.994, H-425.988, H-460.894, and H-425.987 be reaffirmed in lieu of Resolution 237.



1           **Value-Based Decision-Making in the Health Care System D-155.994**

2           1. Our AMA will advocate for third-party payers and purchasers to make cost data  
3           available to physicians in a useable form at the point of service and decision-  
4           making, including the cost of each alternate intervention, and the insurance  
5           coverage and cost-sharing requirements of the respective patient.

6           2. Our AMA encourages efforts by the Congressional Budget Office to more  
7           comprehensively measure the long-term as well as short-term budget deficit  
8           reductions and costs associated with legislation related to the prevention of health  
9           conditions and effects as a key step in improving and promoting value-based  
10          decision-making by Congress.

11  
12           **The US Preventive Services Task Force Guide to Clinical Preventive Services**  
13           **H-425.988**

14          It is the policy of the AMA: (1) to continue to work with the federal government,  
15          specialty societies, and others, to develop guidelines for, and effective means of  
16          delivery of, clinical preventive services; and (2) to continue our efforts to develop  
17          and encourage continuing medical education programs in preventive medicine.

18  
19           **Value of Preventive Services H-460.894**

20          Our AMA: (1) encourages committees that make preventive services  
21          recommendations to: (a) follow processes that promote transparency and clarity  
22          among their methods; (b) develop evidence reviews and recommendations with  
23          enough specificity to inform cost-effectiveness analyses; (c) rely on the very best  
24          evidence available, with consideration of expert consensus only when other  
25          evidence is not available; (d) work together to identify preventive services that are  
26          not supported by evidence or are not cost-effective, with the goal of prioritizing  
27          preventive services; and (e) consider the development of recommendations on  
28          both primary and secondary prevention; (2) encourages relevant national medical  
29          specialty societies to provide input during the preventive services recommendation  
30          development process; (3) encourages comparative-effectiveness research on  
31          secondary prevention to provide data that could support evidence-based decision  
32          making; and (4) encourages public and private payers to cover preventive services  
33          for which consensus has emerged in the recommendations of multiple guidelines-  
34          making groups.

35  
36           **Preventive Medicine Services H-425.987**

37          1. Our AMA supports (A) continuing to work with the appropriate national medical  
38          specialty societies in evaluating and coordinating the development of practice  
39          parameters, including those for preventive services; (B) continuing to actively  
40          encourage the insurance industry to offer products that include coverage for  
41          general preventive services; and (C) appropriate reimbursement and coding for  
42          established preventive services.

43          2. Our AMA will seek legislation or regulation so that evidence-based screenings  
44          are paid for separately when provided as part of a comprehensive well-patient  
45          examination/review.

1 (54) RESOLUTION 244 — GRADUATE MEDICAL  
2 EDUCATION OPPORTUNITIES FOR AMERICAN INDIAN  
3 AND ALASKA NATIVE COMMUNITIES  
4

5 RECOMMENDATION:  
6

7 Madam Speaker, your Reference Committee recommends  
8 that AMA Policies H-350.977, H-350.976, and D-305.967 be  
9 reaffirmed in lieu of Resolution 244.

10  
11 **HOD ACTION: AMA Policies H-350.977, H-350.976, and D-**  
12 **305.967 reaffirmed in lieu of Resolution 244.**  
13

14 RESOLVED, that our American Medical Association supports policy and communication  
15 efforts to (1) advance legislative and regulatory policies and actions that establish,  
16 authorize, fund, and incentivize the creation of graduate medical education opportunities  
17 in IHS, Tribal-administered, and urban Indian health organizations and facilities and (2)  
18 establish associated partnerships with accredited medical schools and teaching hospitals  
19 (New HOD Policy); and be it further  
20

21 RESOLVED, that our AMA supports collaboratively working with Tribal nations, Tribal  
22 organizations, academic medical centers, policy professionals, medical schools, teaching  
23 hospitals, coalition builders, and other stakeholders to advocate to Congress, The White  
24 House, the Department of Health and Human Services, and other government entities to  
25 establish dedicated graduate medical education funding and programs that benefit Tribal  
26 communities, increase physician training sites, and reduce physician shortages,  
27 particularly among underserved populations. (New HOD Policy)  
28

29 Your Reference Committee heard mixed testimony on Resolution 244. Your Reference  
30 Committee heard about the importance of graduate medical education (GME) funding and  
31 the need for increased support of GME within the Indian Health Service (IHS). Testimony  
32 noted the increased health needs of the American Indian and Alaska Native (AI/AN)  
33 population and the serious need for more physician providers within these communities.  
34 However, your Reference Committee also heard that our AMA already has existing policy  
35 that guides our AMA to advance legislative and regulatory policies that bolster and fund  
36 graduate medical education opportunities in IHS, Tribal-administered, and urban Indian  
37 health organizations and facilities. Furthermore, testimony noted that our current policy  
38 also already addresses the importance of the creation and maintenance of partnerships  
39 in this space. Your Reference Committee also heard that our AMA is already engaged in  
40 this work and has signed onto multiple letters requesting more funding for IHS GME.  
41 Testimony also highlighted that our AMA has supported bills like the IHS Workforce Parity  
42 Act and asked for additional IHS GME funding and support in Statements for the Record,  
43 letters to the Administration, and comment letters. Your Reference Committee also heard  
44 that our AMA is consistently advocating for more holistic GME funding, including IHS GME  
45 funding. Your Reference Committee also notes that duplicative policy would potentially  
46 cause confusion. Therefore, your Reference Committee recommends that existing AMA  
47 policies H-350.977, H-350.976, and D-305-967 be reaffirmed in lieu of Resolution 244.

**Indian Health Service H-350.977**

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

1 (7) Our AMA will encourage the development of funding streams to promote  
2 rotations and learning opportunities at Indian Health Service, Tribal, and Urban  
3 Indian Health Programs.  
4

#### 5 **Improving Health Care of American Indians H-350.976**

6 Our AMA recommends that: (1) All individuals, special interest groups, and levels  
7 of government recognize the American Indian people as full citizens of the U.S.,  
8 entitled to the same equal rights and privileges as other U.S. citizens.

9 (2) The federal government provide sufficient funds to support needed health  
10 services for American Indians.

11 (3) State and local governments give special attention to the health and health-  
12 related needs of nonreservation American Indians in an effort to improve their  
13 quality of life.

14 (4) American Indian religions and cultural beliefs be recognized and respected by  
15 those responsible for planning and providing services in Indian health programs.

16 (5) Our AMA recognize the "medicine man" as an integral and culturally necessary  
17 individual in delivering health care to American Indians.

18 (6) Strong emphasis be given to mental health programs for American Indians in  
19 an effort to reduce the high incidence of alcoholism, homicide, suicide, and  
20 accidents.

21 (7) A team approach drawing from traditional health providers supplemented by  
22 psychiatric social workers, health aides, visiting nurses, and health educators be  
23 utilized in solving these problems.

24 (8) Our AMA continue its liaison with the Indian Health Service and the National  
25 Indian Health Board and establish a liaison with the Association of American Indian  
26 Physicians.

27 (9) State and county medical associations establish liaisons with intertribal health  
28 councils in those states where American Indians reside.

29 (10) Our AMA supports and encourages further development and use of innovative  
30 delivery systems and staffing configurations to meet American Indian health needs  
31 but opposes overemphasis on research for the sake of research, particularly if  
32 needed federal funds are diverted from direct services for American Indians.

33 (11) Our AMA strongly supports those bills before Congressional committees that  
34 aim to improve the health of and health-related services provided to American  
35 Indians and further recommends that members of appropriate AMA councils and  
36 committees provide testimony in favor of effective legislation and proposed  
37 regulations.  
38

#### 39 **The Preservation, Stability and Expansion of Full Funding for Graduate 40 Medical Education D-305.967**

41 1. Our AMA will actively collaborate with appropriate stakeholder organizations,  
42 (including Association of American Medical Colleges, American Hospital  
43 Association, state medical societies, medical specialty societies/associations) to  
44 advocate for the preservation, stability and expansion of full funding for the direct  
45 and indirect costs of graduate medical education (GME) positions from all existing  
46 sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).

47 2. Our AMA will actively advocate for the stable provision of matching federal funds  
48 for state Medicaid programs that fund GME positions.

- 1 3. Our AMA will actively seek congressional action to remove the caps on Medicare  
2 funding of GME positions for resident physicians that were imposed by the  
3 Balanced Budget Amendment of 1997 (BBA-1997).
- 4 4. Our AMA will strenuously advocate for increasing the number of GME positions  
5 to address the future physician workforce needs of the nation.
- 6 5. Our AMA will oppose efforts to move federal funding of GME positions to the  
7 annual appropriations process that is subject to instability and uncertainty.
- 8 6. Our AMA will oppose regulatory and legislative efforts that reduce funding for  
9 GME from the full scope of resident educational activities that are designated by  
10 residency programs for accreditation and the board certification of their graduates  
11 (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
- 12 7. Our AMA will actively explore additional sources of GME funding and their  
13 potential impact on the quality of residency training and on patient care.
- 14 8. Our AMA will vigorously advocate for the continued and expanded contribution  
15 by all payers for health care (including the federal government, the states, and  
16 local and private sources) to fund both the direct and indirect costs of GME.
- 17 9. Our AMA will work, in collaboration with other stakeholders, to improve the  
18 awareness of the general public that GME is a public good that provides essential  
19 services as part of the training process and serves as a necessary component of  
20 physician preparation to provide patient care that is safe, effective and of high  
21 quality.
- 22 10. Our AMA staff and governance will continuously monitor federal, state and  
23 private proposals for health care reform for their potential impact on the  
24 preservation, stability and expansion of full funding for the direct and indirect costs  
25 of GME.
- 26 11. Our AMA: (a) recognizes that funding for and distribution of positions for GME  
27 are in crisis in the United States and that meaningful and comprehensive reform is  
28 urgently needed; (b) will immediately work with Congress to expand medical  
29 residencies in a balanced fashion based on expected specialty needs throughout  
30 our nation to produce a geographically distributed and appropriately sized  
31 physician workforce; and to make increasing support and funding for GME  
32 programs and residencies a top priority of the AMA in its national political agenda;  
33 and (c) will continue to work closely with the Accreditation Council for Graduate  
34 Medical Education, Association of American Medical Colleges, American  
35 Osteopathic Association, and other key stakeholders to raise awareness among  
36 policymakers and the public about the importance of expanded GME funding to  
37 meet the nation's current and anticipated medical workforce needs.
- 38 12. Our AMA will collaborate with other organizations to explore evidence-based  
39 approaches to quality and accountability in residency education to support  
40 enhanced funding of GME.
- 41 13. Our AMA will continue to strongly advocate that Congress fund additional  
42 graduate medical education (GME) positions for the most critical workforce needs,  
43 especially considering the current and worsening maldistribution of physicians.
- 44 14. Our AMA will advocate that the Centers for Medicare and Medicaid Services  
45 allow for rural and other underserved rotations in Accreditation Council for  
46 Graduate Medical Education (ACGME)-accredited residency programs, in  
47 disciplines of particular local/regional need, to occur in the offices of physicians  
48 who meet the qualifications for adjunct faculty of the residency program's  
49 sponsoring institution.

- 1 15. Our AMA encourages the ACGME to reduce barriers to rural and other  
2 underserved community experiences for graduate medical education programs  
3 that choose to provide such training, by adjusting as needed its program  
4 requirements, such as continuity requirements or limitations on time spent away  
5 from the primary residency site.
- 6 16. Our AMA encourages the ACGME and the American Osteopathic Association  
7 (AOA) to continue to develop and disseminate innovative methods of training  
8 physicians efficiently that foster the skills and inclinations to practice in a health  
9 care system that rewards team-based care and social accountability.
- 10 17. Our AMA will work with interested state and national medical specialty societies  
11 and other appropriate stakeholders to share and support legislation to increase  
12 GME funding, enabling a state to accomplish one or more of the following: (a) train  
13 more physicians to meet state and regional workforce needs; (b) train physicians  
14 who will practice in physician shortage/underserved areas; or (c) train physicians  
15 in undersupplied specialties and subspecialties in the state/region.
- 16 18. Our AMA supports the ongoing efforts by states to identify and address  
17 changing physician workforce needs within the GME landscape and continue to  
18 broadly advocate for innovative pilot programs that will increase the number of  
19 positions and create enhanced accountability of GME programs for quality  
20 outcomes.
- 21 19. Our AMA will continue to work with stakeholders such as Association of  
22 American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family  
23 Physicians, American College of Physicians, and other specialty organizations to  
24 analyze the changing landscape of future physician workforce needs as well as  
25 the number and variety of GME positions necessary to provide that workforce.
- 26 20. Our AMA will explore innovative funding models for incremental increases in  
27 funded residency positions related to quality of resident education and provision of  
28 patient care as evaluated by appropriate medical education organizations such as  
29 the Accreditation Council for Graduate Medical Education.
- 30 21. Our AMA will utilize its resources to share its content expertise with  
31 policymakers and the public to ensure greater awareness of the significant societal  
32 value of graduate medical education (GME) in terms of patient care, particularly  
33 for underserved and at-risk populations, as well as global health, research and  
34 education.
- 35 22. Our AMA will advocate for the appropriation of Congressional funding in  
36 support of the National Healthcare Workforce Commission, established under  
37 section 5101 of the Affordable Care Act, to provide data and healthcare workforce  
38 policy and advice to the nation and provide data that support the value of GME to  
39 the nation.
- 40 23. Our AMA supports recommendations to increase the accountability for and  
41 transparency of GME funding and continue to monitor data and peer-reviewed  
42 studies that contribute to further assess the value of GME.
- 43 24. Our AMA will explore various models of all-payer funding for GME, especially  
44 as the Institute of Medicine (now a program unit of the National Academy of  
45 Medicine) did not examine those options in its 2014 report on GME governance  
46 and financing.
- 47 25. Our AMA encourages organizations with successful existing models to  
48 publicize and share strategies, outcomes and costs.

- 1 26. Our AMA encourages insurance payers and foundations to enter into  
2 partnerships with state and local agencies as well as academic medical centers  
3 and community hospitals seeking to expand GME.
- 4 27. Our AMA will develop, along with other interested stakeholders, a national  
5 campaign to educate the public on the definition and importance of graduate  
6 medical education, student debt and the state of the medical profession today and  
7 in the future.
- 8 28. Our AMA will collaborate with other stakeholder organizations to evaluate and  
9 work to establish consensus regarding the appropriate economic value of resident  
10 and fellow services.
- 11 29. Our AMA will monitor ongoing pilots and demonstration projects, and explore  
12 the feasibility of broader implementation of proposals that show promise as  
13 alternative means for funding physician education and training while providing  
14 appropriate compensation for residents and fellows.
- 15 30. Our AMA will monitor the status of the House Energy and Commerce  
16 Committee's response to public comments solicited regarding the 2014 IOM  
17 report, Graduate Medical Education That Meets the Nation's Health Needs, as well  
18 as results of ongoing studies, including that requested of the GAO, in order to  
19 formulate new advocacy strategy for GME funding, and will report back to the  
20 House of Delegates regularly on important changes in the landscape of GME  
21 funding.
- 22 31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to  
23 adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical  
24 Education teaching institutions to extend their cap-building window for up to an  
25 additional five years beyond the current window (for a total of up to ten years),  
26 giving priority to new residency programs in underserved areas and/or  
27 economically depressed areas.
- 28 32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic  
29 medical schools to thoroughly research match statistics and other career  
30 placement metrics when developing career guidance plans; (b) strongly advocate  
31 for and work with legislators, private sector partnerships, and existing and planned  
32 osteopathic and allopathic medical schools to create and fund graduate medical  
33 education (GME) programs that can accommodate the equivalent number of  
34 additional medical school graduates consistent with the workforce needs of our  
35 nation; and (c) encourage the Liaison Committee on Medical Education (LCME),  
36 the Commission on Osteopathic College Accreditation (COCA), and other  
37 accrediting bodies, as part of accreditation of allopathic and osteopathic medical  
38 schools, to prospectively and retrospectively monitor medical school graduates'  
39 rates of placement into GME as well as GME completion.
- 40 33. Our AMA encourages the Secretary of the U.S. Department of Health and  
41 Human Services to coordinate with federal agencies that fund GME training to  
42 identify and collect information needed to effectively evaluate how hospitals, health  
43 systems, and health centers with residency programs are utilizing these financial  
44 resources to meet the nation's health care workforce needs. This includes  
45 information on payment amounts by the type of training programs supported,  
46 resident training costs and revenue generation, output or outcomes related to  
47 health workforce planning (i.e., percentage of primary care residents that went on  
48 to practice in rural or medically underserved areas), and measures related to  
49 resident competency and educational quality offered by GME training programs.

1 34. Our AMA will publicize best practice examples of state-funded Graduate  
2 Medical Education positions and develop model state legislation where  
3 appropriate.



- 1 Madam Speaker, this concludes the report of Reference Committee B. I would like to
- 2 thank Landon Combs, MD, Cheryl Gibson Fountain, MD, Tilden Childs III, MD, Matthew
- 3 Burday, DO, Jennifer Hone, MD, Dayna Isaacs, MD, and all those who testified before the
- 4 Committee.

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