APPENDIX - REPORTS OF REFERENCE COMMITTEES
2023 Interim Meeting of the American Medical Association House of Delegates

Reference committee reports from the House of Delegates meeting are provided for the sake of convenience and because they are part of the record of each meeting.

The Proceedings reflect the official record of the actions taken by the House of Delegates and have precedence over reference committee reports, as the Proceedings are prepared using multiple sources, including a transcript of debate. Policies deriving from House actions are recorded in PolicyFinder, which is updated following each House of Delegates meeting.

Note: The original language of report recommendations and the original resolve clauses from resolutions are included in the reference committee reports with a gray background as in this example:

> The Board of Trustees recommends that the following be adopted in lieu of the resolution and the remainder of this report be filed.

In addition, where the reference committee proposes changes in addition to or different from changes proposed by the original item of business, those changes are shown with double underscore or ~~double strikethrough~~, and in some cases are highlighted in yellow.

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Interim 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 (I-23)

Report of Reference Committee B

Peter C. Amadio, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 06 – Universal Good Samaritan Statute
2. Board of Trustees Report 07 – Obtaining Professional Recognition for Medical Service Professionals
3. Resolution 205 – Cannabis Product Safety
4. Resolution 225 – Antipsychotic Medication Use for Hospice Patients
5. Resolution 234 – Pharmacy Benefit Manager (PBM) Control of Treating Disease States
6. Resolution 235 – Preventing Imminent Payment Cuts and Ensuring the Sustainability of the Medicare Program

RECOMMENDED FOR ADOPTION AS AMENDED

7. Resolution 201 – Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care
8. Resolution 204 – Improving PrEP & PEP Access
9. Resolution 216 – Saving Traditional Medicare
10. Resolution 218 – Youth Residential Treatment Program Regulation
11. Resolution 219 – Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)
12. Resolution 223 – Initial Consultation for Clinical Trials Under Medicare Advantage

RECOMMENDED FOR ADOPTION IN LIEU OF

13. Resolution 203 – Anti-Discrimination Protections for Housing Vouchers
14. Resolution 222 – Expansion of Remote Digital Laboratory Access Under CLIA
15. Resolution 224 – ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers

RECOMMENDED FOR REFERRAL

16. Resolution 206 – The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice
17. Resolution 207 – On-Site Physician Requirements for Emergency Departments

18. Resolution 215 – A Public Health-Centered Criminal Justice System
19. Resolution 217 – Addressing Work Requirements for J-1 Visa Waiver Physicians
20. Resolution 227 – Reforming Stark Law's Blanket Self-Referral Ban
21. Resolution 233 – Corporate Practice of Medicine Prohibition

RECOMMENDED FOR REFERRAL FOR DECISION

22. Resolution 226 – Delay Imminent Proposed Changes to U.S. Census Questions Regarding Disability
23. Resolution 229 – Facilitating Appropriate Reimbursement of Diagnostic Radiopharmaceuticals

RECOMMENDED FOR NOT ADOPTION

24. Resolution 220 – Merit-Based Process for the Selection of all Federal Administrative Law Judges

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

25. Resolution 202 – Protecting the Health of Patients Incarcerated in For-Profit Prisons
26. Resolution 208 – Non-Physician Practitioners Oversight and Training
27. Resolution 210 – Immigration Status in Medicaid and CHIP
28. Resolution 213 – Health Technology Accessibility for Aging Patients

Amendments

If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) BOT 6 - UNIVERSAL GOOD SAMARITAN STATUTE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 6 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 6 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 214-I-22 and that the remainder of the report be filed.

That Policy H-130.937, Delivery of Health Care by Good Samaritans be amended by addition:

5. Our AMA will develop model principles on Good Samaritan protections for physicians under state and federal laws that would encourage the prompt rendering of emergency care. (Modify Current HOD Policy)

Your Reference Committee heard unanimous support for Board of Trustees Report 6. Your Reference Committee agrees that more needs to be done to support strong protections of physicians responding as Good Samaritans, regardless of location within the United States and regardless of the type of medical emergency they are called upon to address. Your Reference Committee appreciates that our colleagues from across the Federation of Medicine have worked assiduously to support protection from liability for physicians acting as Good Samaritans who meet the specified standard of conduct and act in good faith. Your Reference Committee heard that the protections already enshrined in AMA policy and promoted through advocacy efforts to shield physician Good Samaritans from liability while rendering treatment responsive to the Covid-19 public health emergency, the opioid overdose epidemic, and in-flight medical emergencies, should extend, by means of a national Good Samaritan Statute, to all such physician-rendered care without regard to type of medical emergency or in which state it occurs. Therefore, your Reference Committee recommends that Board of Trustees Report 6 be adopted, and the remainder of the report be filed.

(2) BOT 7 - OBTAINING PROFESSIONAL RECOGNITION FOR MEDICAL SERVICE PROFESSIONALS

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 7 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 7 adopted and the remainder of the Report filed.

The Board of Trustees recommends that Alternate Resolution 232-I-22 be adopted to read as follows, and the remainder of the report be filed:

RESOLVED, That our American Medical Association support a unique standard occupational classification from the U.S. Bureau of Labor Statistics for medical services professionals. (New HOD Policy)

Your Reference Committee heard testimony unanimously supporting Board of Trustees Report 7 and recognizing the support that medical service professionals (MSPs) give to medical staff by performing core functions such as credentialing. Your Reference Committee heard that the duties performed by MSPs are more unique than what can be captured under U.S. Bureau of Labor Statistics (BLS) Standard Occupational Classifications (SOC) for human resources. Therefore, your Reference Committee recommends that Board of Trustees Report 7 be adopted, and the remainder of the report be filed.

(3) RESOLUTION 205 - CANNABIS PRODUCT SAFETY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 205 be <u>adopted</u>.

HOD ACTION: Resolution 205 <u>adopted</u>.

RESOLVED, that our American Medical Association draft state model legislation to help states implement the provisions of AMA policies H-95.924, Cannabis Legalization for Adult Use and H-95.936, Cannabis Warnings for Pregnant and Breastfeeding Women that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding. (Directive to Take Action)

Your Reference Committee heard supportive comments for this resolution. Your Reference Committee heard that our AMA policy already provides clear support for advocating that states include warnings for pregnant and breastfeeding women against using cannabis. Your Reference Committee heard testimony that numerous scientific and medical organizations, including the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists discourage pregnant and breastfeeding women from using cannabis. Testimony highlighted that our AMA can use current policy to draft model state legislation that accomplishes the intent of this Resolution. Your Reference Committee heard that any model legislation that our AMA creates should encompasses our AMA policies on cannabis that address the dangers associated with the use of cannabis (whether edibles, vapes or other forms) by children, young adults, those who are pregnant, and others covered by AMA policies. Your Reference Committee appreciates the testimony from multiple public health and specialty organizations detailing unique concerns relating to cannabis use and encourages our AMA to take those into account when drafting the model legislation. Moreover, your Reference Committee heard that our AMA may not require any state to adopt a model bill but instead works collaboratively with state medical societies to support state legislative efforts. Your

Reference Committee encourages states that have effective cannabis-related regulation and warning labels to share such information with our AMA to help inform the model bill drafting process. Therefore, your Reference Committee recommends that resolution 205 be adopted.

(4) RESOLUTION 225 - ANTIPSYCHOTIC MEDICATION USE FOR HOSPICE PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 225 be adopted.

HOD ACTION: Resolution 225 adopted.

RESOLVED, that our American Medical Association seek legislation or regulatory changes that exempt hospice patients from limitations on the use of antipsychotic medications for behavioral changes.

Your Reference Committee heard strong support for this resolution and ensuring access to medication for patients in skilled nursing facilities, including for patients enrolled in hospice. Your Reference Committee heard testimony expressing concern for patients prescribed antipsychotic and other medication as inappropriate sedation. Your Reference Committee heard testimony that was supportive of efforts to ensure antipsychotic and other medications are prescribed for legitimate medical purposes, including for patients enrolled in hospice care. Your Reference Committee is concerned by testimony indicating that patients enrolled in hospice have lost access to medications as a result of overly broad and misapplied policies. Testimony noted that our AMA can play a helpful role and take appropriate action to ensure that physicians' judgment takes precedence over broad policies that may be harmful to patients, including legislative or regulatory action. Therefore, your Reference Committee recommends that resolution 225 be adopted.

(5) RESOLUTION 234 - PHARMACY BENEFIT MANAGER (PBM) CONTROL OF TREATING DISEASE STATES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 234 be adopted.

HOD ACTION: Resolution 234 adopted.

Resolved, That our American Medical Association take a strong public stance against allowing payors and pharmacy benefit managers to divert patients to their own care teams for medical care and medication prescribing (New HOD Policy); and be it further

Resolved, That our AMA take immediate action (which may include legal or policy action) to assess and pursue appropriate measures designed to prevent payors and pharmacy benefit managers from diverting patients to their own care teams for medical care and medication prescribing (Directive to Take Action).

Your Reference Committee heard testimony in support of Resolution 234. Testimony reflected the frustration with pharmacy benefit managers (PBMs) ability to manipulate and effectively interfere with patient's preferred care plan. Substantial testimony was given supporting an amendment to existing policy that would essentially maintain the language of this resolution while reaffirming our AMA's existing position on prohibiting pharmacy actions that are unilateral medical decisions. Additionally, testimony reflected the active advocacy efforts aimed at PBM transparency that are ongoing. Therefore, your Reference Committee recommends that resolution 234 be adopted.

(6) RESOLUTION 235 - PREVENTING IMMINENT PAYMENT CUTS AND ENSURING THE SUSTAINABILITY OF THE MEDICARE PROGRAM

RECOMMENDATION:

Your Reference Committee recommends that Resolution 235 be adopted.

HOD ACTION: Resolution 235 adopted.

RESOLVED, that our American Medical Association prioritize preventing the imminent 3.4% Medicare payment cut from taking effect by any means available (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to prioritize reforming the Medicare payment system to ensure the continued economic viability of medical practice (New HOD Policy); and be it further

RESOLVED, that our AMA shall work towards achieving the highest sustainable annual Medicare payment increases possible, whether tied to the MEI, the CPI, or some other relevant measure of inflation that is sufficient to ensure that Medicare beneficiaries can receive robust access to care and that medical practices do not continue to encounter economic challenges as a result of insufficient payment updates (Directive to Take Action); and be it further

RESOLVED, that our AMA immediately create and disseminate, in major news outlets, a press release outlining the current problems within the Medicare system and how it will affect access to care with a call to action to help those with Medicare keep their physicians and the high-quality care they deserve. (Directive to Take Action)

Your Reference Committee heard strong unanimous testimony in support of resolution 235. However, your Reference Committee wishes to note that the American College of Physicians was incorrectly listed as a sponsor of this resolution. Your Reference Committee heard that Medicare payment reform is a clear and immediate necessity, and it is the focal point of our AMA's 2023 Recovery Plan. Your Reference Committee heard that there has been a substantial decline in Medicare physician payment rates, undermining the stability of physician practices and the health care system at large. Your Reference Committee heard that in response to these cuts, our AMA supported the introduction of H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which proposes annual payment updates aligned with the Medicare Economic Index (MEI). Testimony highlighted that our

AMA's advocacy extends beyond legislation to include a robust grassroots campaign encouraging stakeholders to support H.R. 2474, complemented by draft bills aimed at reforming budget neutrality policies. Testimony noted the urgency, underscored by the final rule for the 2024 Medicare physician fee schedule that includes a 3.4 percent payment cut, far below and not in accord with the MEI of 4.6 percent. Your Reference Committee heard at the 2023 Annual Meeting our AMA swiftly responded to our members' concerns regarding Medicare payment reform by reaffirming Policy Advocacy and Action for a Sustainable Medical Care System D-385.945. Our members have voiced that the absence of inflation-adjusted payment updates is unsustainable and threatens the closure of private practices and our AMA has taken swift action, including a significant increase in funding for advocacy, creating a sustained media strategy, and enhancing grassroots efforts to engage physicians and patients. Your Reference Committee heard that these actions reflect our AMA's commitment to achieving permanent physician payment reform. Furthermore, testimony stated that our AMA launched the Fix Medicare Now campaign, a substantial effort to raise awareness and advocacy, highlighted by the relaunch of the FixMedicareNow.org website. Testimony noted that the Senate Finance Committee's recent legislation to alleviate part of the 2024 payment cut acknowledges the issue and provides a temporary solution. Your Reference Committee heard that our AMA has initiated the Physician Practice Information survey to gather updated cost data from over 10,000 practices, which will inform the RBRVS and the MEI. Your Reference Committee heard that these concerted efforts demonstrate our AMA's multifaceted approach to addressing Medicare payment reform, indicating a strong commitment to achieving a reformed and equitable payment system. There was strong support for our AMA's current strategies and efforts, as well as a noted desire for continued and expanded engagement at both the legislative and grassroots levels to ensure the success of Medicare payment reforms. Additional testimony emphasized the importance of involving more physicians in discussions with their patients about Medicare issues. Your Reference Committee heard that this approach is seen as vital for gaining support from seniors, who are key stakeholders in this matter. There was a call for continued and urgent pressure to convert our AMA policies into actual legislation. Your Reference Committee heard that this step is crucial for making tangible changes in the Medicare payment system. Testimony noted that engaging the patient population, especially at the local level, is seen as an essential part of this strategy. Your Reference Committee heard that this engagement ensures that patient voices are heard and considered in the reform process. Therefore, your Reference Committee recommends that resolution 235 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(7) RESOLUTION 201 - OPPOSITION TO THE RESTRICTION AND CRIMINALIZATION OF APPROPRIATE USE OF PSYCHOTROPICS IN LONG TERM CARE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 201 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association work with key partners to advocate that CMS revise the existing measure for psychotropic prescribing in nursing homes to ensure nursing home residents have access to all medically appropriate care (Directive to Take Action); and be it further

RESOLVED, that our AMA ~~amend~~ reaffirm policy H-160.954~~. by insertion as follows: (1) Our AMA continues to take all reasonable and necessary steps to ensure that errors in medical decision making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal, state, and local government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Modify Current HOD Policy)~~

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 201 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 201 be changed to read as follows:

MEDICALLY APPROPRIATE PSYCHOTROPIC USE IN LONG TERM CARE FACILITIES

HOD ACTION: Resolution 201 adopted as amended with a change of title.

MEDICALLY APPROPRIATE PSYCHOTROPIC USE IN LONG TERM CARE FACILITIES

RESOLVED, that our American Medical Association work with key partners to advocate that CMS revise the existing measure for psychotropic prescribing in nursing homes to ensure nursing home residents have access to all medically appropriate care (Directive to Take Action); and be it further

RESOLVED, that our AMA amend policy H-160.954 by insertion as follows: (1) Our AMA continues to take all reasonable and necessary steps to ensure that errors in medical decision making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal, state, and local government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony on resolution 201. Your Reference Committee heard testimony that patients in long-term care facilities have suffered inappropriate tapering of psychotropic and other medication therapies as well as inappropriate diagnoses. Your Reference Committee agrees that medical care should not be second guessed by government policies that do not account for individualized patient care decision-making. Additional testimony detailed how nursing homes feel like they cannot provide psychotropic medicine because of fears resulting from current policies.

Your Reference Committee also heard strong support opposing the criminalization of medicine. Further testimony noted that this issue affects physicians and patients in multiple specialties across multiple states for a wide variety of medical issues. Your Reference Committee heard further testimony concerning ways in which our AMA has demonstrated its ability to stand up for physicians across the nation at the federal and state levels in multiple settings—including for reproductive rights, pain care, mental illness, and substance use disorders. Moreover, your Reference Committee heard that our AMA has multiple policies on opposing the criminalization of medical practice, including Policy D-5.999, “Preserving Access to Reproductive Health Services,” which is specific to—among other things—opposing “criminal and civil penalties or other retaliatory efforts” relating to the provision of reproductive health care; and policy H-120.960, “Protection for Physicians Who Prescribe Pain Medication,” which is specific to pain medicine.

However, additional testimony highlighted concerns about potential unintended consequences from calling on our AMA to oppose state governments from having jurisdiction over the regulation of the practice of medicine. Your Reference Committee was reminded that our House has extensive policy supporting strong state licensing authority, including “Protecting State Medical Licensing Boards from External Political Influence D-270.984,” which calls for our AMA to support minimizing “external interference with the independent functioning of state medical disciplinary and licensing boards.” Your Reference Committee points out that Policy H-275.998, “Physician Competence,” is one of many additional policies supporting state licensing boards’ disciplinary and other appropriate oversight roles. Your Reference Committee heard that there is a strong role for state regulation, and it was noted that it was important to leave a role for state medical boards. Further testimony noted that our AMA already opposes the criminalization of medical practice from inappropriate federal or state policies and will continue to do so. Therefore, your Refence Committee recommends that resolution 201 be adopted as amended and that existing AMA policy H-160.954 be reaffirmed.

Criminalization of Medical Judgment H-160.954
(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

(8) RESOLUTION 204 - IMPROVING PREP & PEP ACCESS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements between pharmacists and ~~with~~ physicians, based on AMA's model legislation related to collaborative drug therapy management.

RESOLVED, that our AMA support a requirement that any pharmacy-associated prescription of PREP/PEP needs to be in accordance with the current CDC PREP/PEP clinical practice guidelines within the physician-led team.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 204 be adopted as amended.

HOD ACTION: Resolution 204 adopted as amended.

RESOLVED, that our American Medical Association support efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements with physicians. (New HOD Policy)

Your Reference Committee heard testimony generally in favor of resolution 204. Specifically, your Reference Committee heard extensive testimony about the importance of PEP and PrEP and the need to ensure increased access to these important medications. Testimony noted that access to PrEP and PEP improves health outcomes and that consistent and timely access to these treatments are imperative. Overall, testimony largely agreed that collaborative practice agreements between pharmacists and physicians can be a viable means for improving access to PEP and PrEP, but your Reference Committee heard testimony voicing concerns about the extent to which collaborative practice agreements will ensure the appropriate respective roles of pharmacists and physicians.

Testimony sought guidance regarding what makes an appropriate collaborative practice agreement, and some encouraged referral of resolution 204 for this question. However, your Reference Committee heard that our AMA has developed model state legislation concerning collaborative practice agreements with pharmacists, *An Act to Authorize Pharmacists to Perform Collaborative Drug Therapy Management,* which provides parameters for establishing a collaborative drug therapy management agreement between pharmacists and physicians. An amendment was offered to reference this model legislation, thereby providing parameters for appropriate collaborative drug therapy management agreements between pharmacists and physicians. Therefore, your Reference Committee recommends that resolution 204 be adopted as amended.

(9) RESOLUTION 216 - SAVING TRADITIONAL MEDICARE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association continue its efforts to fix the flawed Medicare payment system for physicians recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes ~~that increase revenue streams, reduce waste and inefficiency~~, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians (Directive to Take Action); and be it further

~~**RESOLVED, That our AMA address Medicare plans overpayments by urging the Department of Justice to prosecute those found complicit in fraudulent activity (Directive to Take Action); and be it further**~~

~~**RESOLVED, That our AMA advocate for change in CMS risk adjustment methods to guarantee a level playing field by using a competitive bidding process to replace the current benchmark system for determining Medicare Advantage bonus payments (Directive to Take Action); and be it further**~~

~~**RESOLVED, That our AMA support the "Save Medicare ACT" which proposes renaming Medicare "Advantage" plans as "Alternative Private Health Plans". (New HOD Policy)**~~

RESOLVED, That our AMA acknowledges that the term "Medicare Advantage" can be misleading, as it implies a superiority or enhanced value over traditional Medicare, which may not accurately reflect the nature and challenges of these plans. (New HOD Policy)

RESOLVED, that AMA Policy H-330.886 be reaffirmed.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 216 be adopted as amended.

HOD ACTION: Resolution 216 adopted as amended.

RESOLVED, That our American Medical Association continue its efforts to fix the flawed Medicare payment system for physicians recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes that increase revenue streams, reduce waste and inefficiency, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians (Directive to Take Action); and be it further

RESOLVED, That our AMA address Medicare plans overpayments by urging the Department of Justice to prosecute those found complicit in fraudulent activity (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for change in CMS risk adjustment methods to guarantee a level playing field by using a competitive bidding process to replace the current benchmark system for determining Medicare Advantage bonus payments (Directive to Take Action); and be it further

RESOLVED, That our AMA support the “Save Medicare ACT” which proposes renaming Medicare “Advantage” plans as “Alternative Private Health Plans”. (New HOD Policy)

Your Reference Committee heard mixed testimony for resolution 216. Your Reference Committee heard testimony advocating for the merits of Medicare Advantage (MA) plans while also hearing testimony calling for significant reforms. However, testimony disagreed on how best to achieve improvements within MA. Your Reference Committee heard that our AMA has consistently advocated for improvements in both traditional Medicare and MA plans. Testimony stated that our AMA can readily adopt the first resolved as it aligns with our AMA's primary goal of fixing traditional Medicare. Your Reference Committee also heard that our AMA seeks to prohibit private plans from considering any physician as a participant without a specific signed contract and to work with Centers for Medicare & Medicaid Services (CMS) to stop all-products clauses from applying to MA plans. Your Reference Committee heard that in addressing issues of overpayments, marketing, network adequacy, and potentially fraudulent activities associated with MA, our AMA has actively implemented and advocated for policies emphasizing holistic education on MA's nuances, including

eliminating undue subsidies to private Medicare plans, and strengthening measures against fraud and abuse. Moreover, testimony noted that our AMA policy H-330.886 supports competitive bidding to determine payments to MA plans. This policy also notes the importance of network adequacy, standardized benefits, and appropriate geographic regions. Testimony stated that this policy aligns with the resolution's request for advocacy surrounding a change in CMS risk adjustment methods. Finally, your Reference Committee heard that the term “Medicare Advantage” is deeply embedded within AMA policy, will still be utilized by the government, and could cause confusion if it is changed within AMA policy. However, poignant testimony was heard concerning the misnomer of MA plans and the poor patient outcomes that result from uninformed patients choosing this plan based on its name alone. Therefore, your Reference Committee recommends that resolution 216 be adopted as amended.

Strengthening Medicare Through Competitive Bidding H-330.886

1. Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program:
a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries.
b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks.
c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses.
d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region.
e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area.
f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums.
g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans.
2. Our AMA supports using a competitive bidding process to determine federal payments to Medicare Advantage plans.

(10) RESOLUTION 218 - YOUTH RESIDENTIAL TREATMENT PROGRAM REGULATION

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 218 be amended by addition and deletion to read as follows:

~~**RESOLVED, that our American Medical Association advocate for the federal government to work with relevant parties to develop federal licensing standards for youth residential treatment programs (Directive to Take Action); and be it further**~~

RESOLVED, that our AMA recognizes the need for ~~federal~~ licensing standards for all youth residential treatment facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth; and be it further. (New HOD Policy)

RESOLVED, that our AMA support recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment programs. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 218 be adopted as amended.

HOD ACTION: Resolution 218 adopted as amended.

RESOLVED, that our American Medical Association advocate for the federal government to work with relevant parties to develop federal licensing standards for youth residential treatment programs (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize the need for federal licensing standards for all youth residential treatment facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth. (New HOD Policy)

Your Reference Committee heard mixed testimony for resolution 218. Your Reference Committee heard that the nation's mental health and substance use disorder crises would be greatly helped by greater use of evidence-based treatment modalities. Testimony highlighted that there are sham practices that take advantage of vulnerable individuals and families affected by mental illness or substance use disorders. However, additional testimony noted that there should not be federal licensing standards. Testimony noted that our AMA has opposed federal licensing efforts in multiple contexts with respect to physician

practices and the practice of medicine. Strong testimony stated that our AMA should not open the door to further government interference in the practice of medicine. Your Reference Committee heard that, instead of federal licensing standards, our AMA should focus on ensuring the use of evidence-based clinical practice guidelines developed by our partners in the Federation of Medicine. Your Reference Committee appreciates testimony highlighting our AMA's broad advocacy efforts to hold health plans accountable for mental health and substance use disorder parity failures. Additional testimony called attention to the partnerships between our AMA and multiple state and specialty societies. These partnerships support changes to state and federal laws and regulations that would require using medical society recommendations to determine the standard of care rather than false, financially derived standards used by health plans to delay and deny care. Therefore, your Reference Committee recommends that 218 be adopted as amended.

(11) RESOLUTION 219 - IMPROVING ACCESS TO POST-ACUTE MEDICAL CARE FOR PATIENTS WITH SUBSTANCE USE DISORDER (SUD)

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that our federal, state, and local governments remove barriers to evidence-based treatment for substance use disorders, including medications for opioid use disorder, ~~opioid agonist therapy (including methadone, suboxone or other appropriate treatments)~~ at skilled nursing facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that Medicare and Medicaid, including managed care organizations, remove barriers to ~~provide~~ coverage and treatment for substance use and opioid use disorder, including medications for opioid use disorder, ~~treatments~~ in skilled nursing facilities. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 219 be adopted as amended.

HOD ACTION: Resolution 219 adopted as amended.

RESOLVED, that our American Medical Association advocate to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that our federal, state, and local governments remove barriers to opioid agonist therapy (including methadone, buprenorphine or other appropriate treatments) at skilled nursing facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that Medicare and Medicaid provide coverage for substance use and opioid use disorder treatments in skilled nursing facilities. (Directive to Take Action)

Your Reference Committee heard supportive testimony for resolution 219. Your Reference Committee heard that individuals in a skilled nursing facility—or any other setting—should not suffer interruptions in care for an opioid use disorder (OUD) because of state or federal laws or regulations that interfere with continuity of care. Further testimony highlighted that individuals in a skilled nursing facility or other setting should not endure barriers to evidence-based substance use disorder (SUD) care regardless of the payer. Testimony noted that while Medicare and Medicaid may pose specific barriers to SUD care in a skilled nursing facility our AMA should still provide appropriate guidance to advocate to other payers to ensure patients receive the care they need. Your Reference Committee observes that nearly all proffered amendments were similar in wanting to broaden the scope of the resolution to protect patients who receive medications for OUD. Therefore, your Reference Committee recommends that resolution 219 be adopted as amended.

(12) RESOLUTION 223 - INITIAL CONSULTATION FOR CLINICAL TRIALS UNDER MEDICARE ADVANTAGE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 223 be amended by addition to read as follows:

RESOLVED, that our American Medical Association amend policy H-460.882, "Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations," by addition to read as follows:

4. Our AMA advocate that the Centers for Medicare and Medicaid Services allow ~~and pay for~~ out-of-network referral of patients with Medicare Advantage for the purpose of consultation for enrollment in a clinical trial, require covering plans to pay for such consultations, and that these consultations be considered administratively as participation in a clinical trial.
(Modify Current HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 223 be adopted as amended.

HOD ACTION: Resolution 223 adopted as amended.

RESOLVED, that our American Medical Association amend policy H-460.882, "Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations," by addition to read as follows:

4.Our AMA advocate that the Centers for Medicare and Medicaid Services allow out-of-network referral of patients with Medicare Advantage for the purpose of consultation for enrollment in a clinical trial, and that these consultations be considered administratively as participation in a clinical trial. (Modify Current HOD Policy)

Your Reference Committee heard testimony that was generally supportive of the intent of resolution 223. Your Reference Committee heard that our AMA supports the concerns raised in the resolution concerning the roles and responsibilities of Medicare Advantage Organizations (MAOs) in clinical trials. Your Reference Committee heard strong support for the proposal to amend policy H-460.882 to urge Centers for Medicare & Medicaid Services (CMS) to cover initial consultation costs for Medicare Advantage (MA) patients enrolling in clinical trials. Testimony emphasized the importance of addressing the financial burdens that are placed on patients necessitating payment reform and highlighted the broader disadvantages of MA plans. As such, your Reference Committee heard testimony noting the need to allow and pay for these services. There was a consensus heard on treating these initial consultations as routine costs to simplify processes. Your Reference Committee heard that the current review of Medicare guidelines and NCD 310.1 for MA members in clinical trials includes a recommendation to categorize consultation for enrollment as a covered expense. Your Reference Committee heard that this proposal is aimed at reducing financial barriers for MA patients seeking clinical trials, ensuring these consultations are not just allowed but also funded. Overall, your Reference Committee heard a unanimous agreement on the need to improve coverage for initial consultations in clinical trials for MA patients. Therefore, your Reference Committee recommends that resolution 223 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(13) RESOLUTION 203 - ANTI-DISCRIMINATION PROTECTIONS FOR HOUSING VOUCHERS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 203 be adopted in lieu of Resolution 203.

RESOLVED that our American Medical Association support preventing discrimination against individuals and families who utilize public assistance for housing, including housing vouchers. (New HOD Policy)

HOD ACTION: Alternate Resolution 203 adopted in lieu of Resolution 203.

RESOLVED, that our American Medical Association support local, state, and federal policies requiring landlords to accept Section 8 and related housing vouchers as valid sources of individual and family income (New HOD Policy); and be it further

RESOLVED, that our AMA support local, state, and federal policies preventing landlords from discriminating against individuals and families who utilize public assistance. (New HOD Policy)

Your Reference Committee heard mixed testimony on resolution 203. Your Reference Committee heard supportive testimony stating that adequate, safe, and affordable housing is an important social determinant of health and that individuals in need of federal housing assistance and subsidized housing may bear a greater burden of mental and physical illness, physical violence, and economic hardship than the general population. Your Reference Committee further heard that two out of three Housing Choice (formerly Section 8) voucher households are not protected by anti-discrimination laws at the local, state, or federal levels and this especially impacts minoritized and marginalized communities, exacerbating disparities in the health of individuals, families, and communities. However, your Reference Committee also heard that it is outside the purview of our AMA to dictate housing policy. Considering these opposing views your Reference Committee believes that the intent of the resolution and the views expressed in testimony would be better captured by an alternate resolution. Therefore, your Reference Committee recommends that alternate resolution 203 be adopted in lieu of resolution 203.

(14) RESOLUTION 222 - EXPANSION OF REMOTE DIGITAL LABORATORY ACCESS UNDER CLIA

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 222 be adopted in lieu of Resolution 222.

RESOLVED, that our AMA advocate to the Centers for Medicare and Medicaid Services that post-Public Health Emergency enforcement discretion of CLIA regulations 42 C.F.R. §§ 493.35(a), 493.43(a), and 493.55(a)(2) that requires laboratories to file a separate application for each laboratory location unless it meets a regulatory exception, be clarified to include all qualified physicians under CLIA, to review digital data, digital results, and digital images at a remote location under the primary location CLIA certificate. (Directive to Take Action)

RECOMMENDATION B:

The title of Resolution 222 be changed to read as follows:

OVERSIGHT MODERNIZATION OF CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

HOD ACTION: Alternate Resolution 203 adopted in lieu of Resolution 203 with a change of title.

OVERSIGHT MODERNIZATION OF CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

RESOLVED, that our American Medical Association advocate to the Centers for Medicare and Medicaid Services that post-Public Health Emergency enforcement discretion of Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations 42 C.F.R. §§ 493.35(a), 493.43(a), and 493.55(a)(2) that requires laboratories to file a separate application for each laboratory location unless it meets a regulatory exception, be clarified to include all qualified physicians under CLIA, to review digital data, digital results, and digital images at a remote location under the primary location CLIA certificate. (Directive to Take Action)

Your Reference Committee heard testimony supporting the intent of resolution 222, which focused primarily on modernizing language in CLIA following specific flexibilities that were granted during the public health emergency (PHE) and which will continue, pursuant to updated Centers for Medicare & Medicaid Services (CMS) guidance. Your Reference Committee heard testimony that highlighted how our AMA has long-standing policy on CLIA that has been used as the foundation for our advocacy positions up to now. Your Reference Committee also heard that it would be beneficial to amend our existing AMA policy in a manner that brings more clarity and consistency to our recent advocacy in this realm. The testimony also emphasized that a title change would potentially better represent our AMA activity and its stance on CLIA. Moreover, your Reference Committee heard from the author of the resolution that they supported the friendly amendment reflected in this report. Therefore, your Reference Committee recommends that Alternate Resolution 222 be adopted in lieu of resolution 222.

(15) RESOLUTION 224 - ERISA PREEMPTION OF STATE LAWS REGULATING PHARMACY BENEFIT MANAGERS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 224 be adopted in lieu of Resolution 224.

RESOLVED, that our American Medical Association study, and create resources for states, on the implication of *Rutledge, Attorney General Of Arkansas v. Pharmaceutical Care Management Association*, and any other relevant legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 (ERISA) when the quality of care or healthcare outcomes are questioned. (Directive to Take Action)

HOD ACTION: Alternate Resolution 224 adopted in lieu of Resolution 224.

RESOLVED, that our American Medical Association study enacted state pharmacy benefit management (PBM) legislation and create a model bill that would avoid the Employment Retirement Income Security Act of 1974 (ERISA) preemption. (Directive to Take Action)

Your Reference Committee heard testimony concerning the frustration caused by the limited reach of state managed care laws to only state-regulated plans and the desire for state laws to regulate self-funded Employment Retirement Income Security Act of 1974 (ERISA) plans. However, your Reference Committee also heard that our AMA's legal analysis of recent court cases, including the recent Supreme Court decision in *Rutledge*, involving the reach of state pharmacy benefit managers (PBM) laws is still ongoing, and moreover, some analyses offered in testimony may overestimate the reach and impact of these decisions. Further testimony highlighted that it is critical for efficiency, effectiveness, and reputational reasons, that our AMA further study the impact of such court decisions and produce an analysis and related resources to be used by medical societies and other interested parties to capitalize on any new state regulatory opportunities with regard to state regulation of health insurance, and specifically ERISA plans. Therefore, your Reference Committee recommends that alternate resolution 224 be adopted in lieu of resolution 224.

RECOMMENDED FOR REFERRAL

(16) RESOLUTION 206 - THE INFLUENCE OF LARGE LANGUAGE MODELS (LLMS) ON HEALTH POLICY FORMATION AND SCOPE OF PRACTICE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 206 be referred.

HOD ACTION: Resolution 206 referred.

RESOLVED, that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on healthcare issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers. (New HOD Policy)

Your Reference Committee heard mixed testimony for resolution 206, highlighting the importance of addressing the risks of misinformation resulting from the use of Large Language Models (LLMs) including Generative Pre-trained Transformers (GPTs). Your Reference Committee heard testimony about the importance of physicians understanding and weighing the benefits and the risks of the use of these tools as heightened excitement and eagerness to implement these tools in everyday practice to lessen the existing administrative clinical burden, begins to increase. Your Reference Committee also heard persuasive testimony recommending referral of resolution 206 to the Board for further deliberation. Testimony emphasized that our AMA is currently in the process of fulfilling a directive from A-23 that directs our AMA to study and develop recommendations on the benefits and unforeseen consequences to the medical profession of LLMs such as, GPTs, and other augmented intelligence-generated medical advice or content. Since resolution 206 covers some of the topics that are already planned to be discussed in this upcoming report, testimony noted that resolution 206 should be referred so that these issues can be further studied and aligned with our current research. Further testimony noted that scope of practice will continue to be a heightened point of contention as the use of augmented intelligence (AI) becomes more widely used and more sophisticated among AI developers and the end users. Therefore, your Reference Committee recommends that resolution 206 be referred.

(17) RESOLUTION 207 - ON-SITE PHYSICIAN REQUIREMENT FOR EMERGENCY DEPARTMENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 207 be referred.

HOD ACTION: Resolution 207 amended.

RESOLVED, that our American Medical Association develop model state legislation and support federal and state legislation or regulation, with appropriate consideration for limited rural exceptions, requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., physician assistants and advanced practice nurses) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department. (Directive to Take Action)

HOD ACTION: Amended Resolution 207 referred.

RESOLVED, that our American Medical Association develop model state legislation and support federal and state legislation or regulation requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., physician assistants and advanced practice nurses) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department. (Directive to Take Action)

Your Reference Committee heard extensive and mixed testimony regarding resolution 207. Your Reference Committee heard about the importance of the on-site presence of a physician in an emergency department when patients are seeking emergency medical care, and the importance of physicians supervising non-physicians in the emergency department. There was strong sentiment around the importance of our AMA taking a firm stance on this issue as part of our extensive campaign supporting physician-led care. Testimony also noted that patients expect care from a physician when seeking care in an emergency department and that a growing number of emergency departments are staffed by non-physicians. Your Reference Committee heard that Indiana recently passed legislation that requires all emergency departments to have a physician on-site who is responsible for the emergency department at all times the emergency department is open. However, your Reference Committee also heard strong concerns that requiring the on-site presence of a physician in the emergency department will have a negative and potentially devastating impact on rural hospitals, including the risk of closure. Your Reference Committee received multiple amendments that strived to address this and other concerns with the language, including amendments offered by the resolution's author. Your Reference Committee also heard that given the complexity of the issue it warrants further study, including a deeper dive into the impact on rural hospitals, and the differing staffing capacities and needs between rural and urban facilities. Therefore, your Reference Committee recommends that resolution 207 be referred.

(18) RESOLUTION 215 - A PUBLIC HEALTH-CENTERED CRIMINAL JUSTICE SYSTEM

RECOMMENDATION:

Your Reference Committee recommends that Resolution 215 be referred.

HOD ACTION: Resolution 215 referred.

RESOLVED, that our American Medical Association support legislation that reduces the negative health impacts of incarceration by:

a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution,
b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause, and
c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society (Directive to Take Action); and be it further

RESOLVED, that our AMA (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules. (New HOD Policy)

Your Reference Committee heard mixed testimony for resolution 215. Your Reference Committee heard that individuals within the United States are incarcerated at exceptionally high rates, especially when compared to other Western democracies, and disproportionately affects communities of color. Testimony also highlighted the benefits of diversion programs and the negative health outcomes experienced by individuals who are incarcerated. However, your Reference Committee also heard that our AMA already has strong existing policy that supports proper health care in all situations including within the criminal justice system. Testimony highlighted that our AMA has engaged in extensive advocacy work concerning health care for incarcerated individuals. Testimony also noted that the resolution, though well intentioned, might not be actionable. For example, it was noted that there is no real understanding of what “decreasing the magnitude” of penalties entails. In consideration of the conflicting testimony and complexities of this issue which could benefit from further study, your Reference Committee recommends that resolution 215 be referred.

(19) RESOLUTION 217 - ADDRESSING WORK REQUIREMENTS FOR J-1VISA WAIVER PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 217 be referred.

HOD ACTION: Resolution 217 referred.

RESOLVED, That our American Medical Association acknowledge that the requirement of 40 hours of direct patient care could impose a burden on IMG physicians and may hinder opportunities for professional growth (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for a revision in the J-1 waiver physician's requirement, proposing a transition to a comprehensive 40-hour work requirement that encompasses both direct clinical responsibilities and other professional activities. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning resolution 217. Your Reference Committee heard how important international medical graduates (IMGs) are to the medical community and the important role they play especially in underserved areas across the United States. Testimony highlighted how much work was expected of IMGs and how, due to patient load and administrative burdens, IMGs do not have much time for additional professional development. However, your Reference Committee also heard that though J-1 physicians do need to be in a fulltime program, there was significant confusion surrounding the accuracy of the 40 hours of direct patient care per week requirement. Therefore, due to a need for further clarification, your Reference Committee recommends that resolution 217 be referred.

(20) RESOLUTION 227 - REFORMING STARK LAW'S BLANKET SELF-REFERRAL BAN

RECOMMENDATION:

Your Reference Committee recommends that Resolution 227 be referred.

HOD ACTION: Resolution 227 referred.

Resolved, That our American Medical Association recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs (New HOD Policy); and be it further

Resolved, That our American Medical Association supports comprehensive Stark law reform aimed at rectifying the disparities by ending the blanket ban on self-referral practices, particularly in the context of capitated, risk-adjusted payment programs such as Medicare Advantage and Medicaid managed care (Directive to Take Action); and be it further

Resolved, That our American Medical Association is committed to advocating for equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care (New HOD Policy).

Your Reference Committee heard mixed testimony for resolution 227. Testimony noted that the Stark Law referral ban disadvantaged physicians while allowing health systems to flourish. Further testimony noted how this ban has harmed the coordination of care and how private physician practices are greatly disadvantaged. However, conflicting testimony noted that the Stark law does allow physicians to self-refer Medicare and Medicaid patients under a broad exception (the in-office ancillary services exception). Your Reference Committee also heard that the requirement to make referrals to a particular provider does not apply if the patient expresses a preference for a different provider or if the referral is not in the patient's best medical interests -- in the eyes of the physician. Finally, your Reference Committee heard that our AMA has many policies calling on our AMA to rectify problematic conditions created by consolidation in health care markets and that our AMA advocates vigorously to address these problematic conditions. Due to the factually conflicting testimony, your Reference Committee recommends that resolution 227 be referred.

(21) RESOLUTION 233 - CORPORATE PRACTICE OF MEDICINE PROHIBITION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 233 be referred.

HOD ACTION: Resolution 233 referred.

Resolved, That our American Medical Association amend policy H-215.981, Corporate Practice of Medicine, by deletion and substitution to read as follows:

1. Our AMA ~~vigorously opposes any effort to pass~~ will seek federal legislation to ~~preempting state laws~~ prohibit~~ing~~ the corporate practice of medicine by limiting ownership and corporate control of physician medical practices to physicians or physician-owned groups only and ensure private equity/non-medical groups do not have a controlling interest.

2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues. (Directive to Take Action).

Your Reference Committee heard testimony that sympathized with the underlying rationale of resolution 233. Nevertheless, testimony noted that the kinds of corporate ownership and corporate control issues addressed by the resolution are almost always addressed by state statutes and regulations. Federal law very rarely, if at all, concerns these kinds of garden-variety ownership and corporate control issues. Testimony also indicated that our AMA does provide assistance to state medical associations seeking help on corporate practice of medicine issues. However, additional testimony noted the desire for additional information on this topic so that physicians can better know how to navigate this issue in their state. Therefore, your Reference Committee recommends that resolution 233 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(22) RESOLUTION 226 - DELAY IMMINENT PROPOSED CHANGES TO U.S. CENSUS QUESTIONS REGARDING DISABILITY

RECOMMENDATION:

Your Reference Committee recommends Resolution 226 be referred for decision.

HOD ACTION: Resolution 226 referred for decision.

RESOLVED, that our American Medical Association urge that the National Advisory Committee of the U.S. Census Bureau, that is meeting on November 16-17, 2023, delay a decision on the change in the U.S. Census disability questions until comprehensive input has been obtained from the disability community and key stakeholders (Directive to Take Action); and be it further

RESOLVED, that our AMA submit comments before the December 19,2023 deadline to the U.S Census Bureau regarding the changes proposed in the Federal Register to the disability questions in the census (Directive to Take Action); and be it further

RESOLVED, that our AMA request that the U.S. Census Bureau develop an extensive plan to improve the inclusion of individuals with disabilities across the activities of the U.S. Census Bureau (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the formation of a U.S. Government task force to develop a plan for improving and expanding disability data collection across the federal government. (New HOD Policy)

Your Reference Committee heard mixed testimony on resolution 226. Your Reference Committee heard that the U.S. Census Bureau has proposed revisions to the questions regarding disability in the census. Testimony highlighted concerns about these proposed revisions and noted that there has not been adequate input about these changes from the disability community and key stakeholders, and that a delay should be requested by our AMA and that our AMA should submit comments on the proposed changes. However, your Reference Committee also heard concerns that this resolution may be based upon inaccurate assertions about the process followed by the Census Bureau in proposing changes to the disability questions used in the census, and that in fact, the Census Bureau followed a years-long process in proposing changes as a result of testing done to ensure the census gathers data that meets the needs of its stakeholders. Your Reference Committee further heard that the disability questions are being revised to capture information on functioning in order to reflect advances in the measurement of disability and is conceptually consistent with the World Health Organization's International Classification of Functioning, Disability, and Health (ICF) disability framework.

Your Reference Committee further heard that this is an issue that was only recently brought to our AMA's attention, and concern that our AMA does not have the staff expertise or policy to guide substantive comments to the Census Bureau in the short turnaround time required

under the regulatory comment period. Your Reference Committee believes that in light of the questions and concerns raised about the background provided in the resolution and the lack of AMA policy to guide the development of comments to the Census Bureau in a short turn-around time, that resolution 226 should be referred for decision to ensure attention is brought to this issue before the November and December deadlines. Therefore, your Reference Committee recommends that resolution 226 be referred for decision.

(23) RESOLUTION 229 - FACILITATING APPROPRIATE REIMBURSEMENT OF DIAGNOSTIC RADIOPHARMACEUTICALS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 229 be referred for decision.

HOD ACTION: Resolution 229 referred for decision.

Resolved, That our American Medical Association advocate with the congress and with Centers for Medicare and Medicaid Services to change the categorization of diagnostic radiopharmaceuticals by the Hospital Outpatient Prospective Payment System (OPPS) from "supplies" to correctly classify them as "drugs," as would be consistent with the Medicare Modernization Act (MMA) of 2003, and which will allow diagnostic radiopharmaceuticals, similar to other drugs, to similarly be paid separately for costs above the packaging threshold of $140 per-day (Directive to Take Action); and be it further

Resolved, That our AMA advocate for congressional efforts to urgently separate payment requirements for diagnostic radiopharmaceuticals under the Medicare prospective payment system for hospital outpatient department services to apply to diagnostic radiopharmaceuticals that are appropriate for the cost of radiopharmaceuticals and that carry a cost above that applied to them as supplies by Outpatient Prospective Payment System (Directive to Take Action).

Your Reference Committee heard mixed testimony on resolution 229. Your Reference Committee heard a range of testimonies, reflecting diverse opinions on the reimbursement of radiopharmaceuticals and related healthcare policies. Further testimony expressed support for equitable reimbursement by the Centers for Medicare & Medicaid Services (CMS), particularly focusing on the affordability challenges of radiopharmaceuticals. Your Reference Committee heard about the FIND Act being a significant step towards addressing high pharmaceutical costs. Additional testimony highlighted the need for direct engagement with CMS to align with the Medicare Modernization Act of 2003. Further concerns were expressed about oversimplifying these complex policy matters, raising the potential of unintended consequences of policy changes, such as increased costs in nuclear medicine ambulatory payment classifications (APCs). Your Reference Committee heard about the need for a nuanced understanding of the impact of the Hospital Outpatient Prospective Payment System (HOPPS) on access to care. Further testimony stressed the importance of differentiating radiopharmaceuticals from contrast agents, emphasizing their crucial role in diagnostics, especially in cancer therapy, impacting healthcare efficiency and patient access. Your Reference Committee heard non-supportive testimony urging a broader consideration of the overall high costs in healthcare, advocating for further study, and

congressional involvement. Your Reference Committee heard suggestions that immediate policy changes might offer short-term solutions, but a comprehensive, long-term approach is necessary for sustainable improvement. Your Reference Committee appreciates the urgency conveyed in the testimonies, reflecting a deep commitment to advancing healthcare outcomes and policies. Your Reference Committee heard a general inclination towards supporting policies for better reimbursement structures and recognizing radiopharmaceuticals as essential medical agents, balanced with a call for caution and deeper analysis. Due to the conflicting testimony and the potential need for immediate action, your Reference Committee recommends that resolution 229 be referred for decision.

RECOMMENDED FOR NOT ADOPTION

(24) RESOLUTION 220 - MERIT-BASED PROCESS FOR THE SELECTION OF ALL FEDERAL ADMINISTRATIVE LAW JUDGES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 220 not be adopted.

HOD ACTION: Resolution 220 not adopted.

RESOLVED, that our American Medical Association support the pre-2018, merit-based process for the selection of all federal administrative law judges (ALJs), including the requirements that:

1. All federal ALJ candidates must be licensed and authorized to practice law under the laws of a State, the District of Columbia, the Commonwealth of Puerto Rico, or any territorial court established under the United States Constitution throughout the ALJ selection process,

2. All federal ALJ candidates must have a full seven (7) years of experience as a licensed attorney preparing for, participating in, and/or reviewing formal hearings or trials involving litigation and/or administrative law at the Federal, State, or local level, and

3. All federal ALJ candidates must pass an examination, the purpose of which is to evaluate the competencies/knowledge, skills, and abilities essential to performing the work of an Administrative Law Judge. (New HOD Policy)

Your Reference Committee heard mixed testimony concerning the adoption of resolution 220. Opposing testimony pointed out that the resolution implicated many constitutional and other legal questions on which many experts on the issues raised by resolution 220 could not agree. Testimony also pointed out that our AMA has no prior familiarity with these constitutional and legal questions. Finally, testimony showed that the action called for by resolution 220 would require our AMA to support efforts to restore competitive service requirements with respect to approximately 2,000 Administrative Law Judges (ALJs) in all of the federal agencies, most of which have nothing to do with physician concerns, and which would require our AMA to engage in advocacy far outside of its expertise and scope of work. Therefore, your Reference Committee recommends that resolution 220 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(25) RESOLUTION 202 - PROTECTING THE HEALTH OF PATIENTS INCARCERATED IN FOR-PROFIT PRISONS

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-430.986 and H-430.997 be reaffirmed in lieu of Resolution 202.

HOD ACTION: Resolution 202 referred.

RESOLVED, that our American Medical Association advocate against the use of for-profit prisons (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for for-profit prisons, public prisons with privatized medical services, and detention centers to be held to the same standards as prisons with public medical services, especially with respect to oversight, reporting of health-related outcomes, and quality of healthcare. (Directive to Take Action)

Your Reference Committee heard mixed testimony on resolution 202. Your Reference Committee heard that it is important to ensure that proper health care is administered to those in prisons and detention centers. Testimony highlighted the increased vulnerability of individuals that are incarcerated, particularly in for-profit prisons, which are motivated more by maximizing profits than funding the health services that are needed. However, your Reference Committee also heard that advocacy specifically concerning for-profit prison policy is beyond the scope of our AMA's focus.

Your Reference Committee further heard that our AMA already has existing policy that allows our AMA to advocate for appropriate health care in all forms of correctional facilities and has done extensive advocacy work in this space. Testimony noted that our AMA already has policy that correctional and detention facilities should provide medical, including psychiatric and substance use disorder, care that meets prevailing community standards and additional policy that requires our AMA to advocate for a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release. Your Reference Committee heard that our AMA should not be limiting our policy to just prisons that are "for-profit" when all prisons should be meeting proper health standards and when we already have broad policy that allows us to advocate for proper health care in all correctional facilities not just "for-profit" prisons. Therefore, your Reference Committee recommends that existing AMA policies H-430.986 and H-430.997 be reaffirmed in lieu of resolution 202.

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and

behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.

7.Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.

8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.

9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.

10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs,

including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons: (a) MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting; (b) knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; (c) knowledge of the health disparities among individuals who are involved with the criminal justice system.
14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles.

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

(26) RESOLUTION 208 - NON-PHYSICIAN PRACTITIONERS OVERSIGHT AND TRAINING

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-35.965, H-35.989, H-360.987, and H-270.958 be reaffirmed in lieu of Resolution 208.

HOD ACTION: AMA policies H-35.965, H-35.989, H-360.987, and H-270.958 reaffirmed in lieu of Resolution 208.

RESOLVED, that our American Medical Association encourage oversight and regulation of non physician providers by regulatory bodies comprised of individuals with equivalent and higher levels of training, including state composite medical boards. (New HOD Policy)

Your Reference Committee heard mixed testimony on resolution 208, with significant testimony—including that of the resolution's author—recommending reaffirmation of existing policy. Your Reference Committee heard that our AMA already has extensive policy aligned with this resolution, establishing that state medical boards should regulate certain non-physician practitioners as appropriate. For example, testimony highlighted that H-35.965 requires the oversight of physician assistants by state medical licensing and

regulatory boards, while H-360.987 establishes that advanced practice registered nurses shall be licensed and regulated jointly by the state medical and nursing boards. Finally, H-270.958 applies to any non-physician, establishing policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state. Given the strength of existing AMA policy on this issue, your Reference Committee recommends that existing AMA policies H-35.965, H-35.989, H-360.987, and H-270.958 be reaffirmed in lieu of resolution 208.

Regulation of Physician Assistants H-35.965
Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by organizations to board certify physician assistants in a manner that misleads the public to believe such board certification is equivalent to medical specialty board certification.

Physician Assistants H-35.989
1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.

Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners H-270.958

1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.

2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.

4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly

responsible as the attending physician for the patient care services delegated to his physician assistant.
5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.
7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987
Our AMA endorses the following principles:
(1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.
(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.
(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.
(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.
(5) Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards.
(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

(27) RESOLUTION 210 - IMMIGRATION STATUS IN MEDICAID AND CHIP

RECOMMENDATION:

Your Reference Committee recommends that AMA policies D-440.927 and D-350.975, and D-440.985 be <u>reaffirmed in lieu</u> of Resolution 210.

HOD ACTION: Resolution 210 <u>adopted</u>.

RESOLVED, that our American Medical Association advocate for the removal of eligibility criteria based on immigration status from Medicaid and CHIP. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning resolution 210. Your Reference Committee heard that our AMA believes that all individuals should be able to receive access to health care and is actively working to improve access to healthcare and

minimize systemic health barriers for immigrant communities. Moreover, your Reference Committee heard how important access to programs such as CHIP and Medicaid are for individuals regardless of immigration status. However, your Reference Committee also heard that our AMA already has policy that specifically addresses allowing immigrants and their dependents to utilize non-cash public benefits including Medicaid and CHIP. Testimony stated that existing AMA policy has already been utilized numerous times to provide detailed comments concerning the Public Charge rule, eligibility requirements for Medicaid and CHIP for DACA recipients, and other legislation and regulations that concern allowing immigrants to access Medicaid and CHIP. Therefore, your Reference Committee recommends that existing AMA policies D-440.927, D-350.975, and D-440.985 be reaffirmed in lieu of resolution 210.

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

Immigration Status is a Public Health Issue D-350.975
1. Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

(28) RESOLUTION 213 - HEALTH TECHNOLOGY ACCESSIBILITY FOR AGING PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that AMA policy H-480.937 be <u>reaffirmed in lieu of</u> Resolution 213.

HOD ACTION: Resolution 213 <u>referred</u>.

RESOLVED, that our American Medical Association support the development of a standardized definition of "age-friendliness" in health information technology (HIT) advancements New HOD Policy); and be it further

RESOLVED, that our AMA encourage appropriate parties to identify current best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs (Directive to Take Action); and be it further

RESOLVED, that our AMA require EHR providers to provide standardized, easily accessible digital storage space for advance care paperwork. (New HOD Policy)

Your Reference Committee heard testimony largely in support of the spirit of resolution 213. Your Reference Committee also heard that the intent of this resolution was well represented in existing policy H-480.937. On closer review of policy, your Reference Committee agrees, and therefore, recommends reaffirmation.

Addressing Equity in Telehealth H-480.937

Our AMA:

(1) recognizes access to broadband internet as a social determinant of health;

(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;

(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;

(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;

(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;

(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;

(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;

(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize

care from a separate or preferred telehealth network over the patient's current physicians; and

(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Kenneth Certa, MD, Sarah Fessler, MD, Amar Kelkar, MD, Lisa Mattson, MD, Michael Medlock, MD, Helene Nepomuceno, MD, and all those who testified before the Committee.

Kenneth Certa, MD
American Psychiatric Association

Lisa Mattson, MD (Alternate)
Minnesota

Sarah Fessler, MD
Rhode Island

Michael Medlock, MD (Alternate)
Massachusetts

Amar Kelkar, MD
American Society of Hematology

Helene Nepomuceno, MD
Nevada

Peter Amadio, MD
American Association for Hand Surgery
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Interim 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 (I-23)

Report of Reference Committee C

Sarah Marsicek, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 04 – Recognizing Specialty Certifications for Physicians (Resolution 316-I-22)

2. Council on Medical Education Report 05 – Organizations to Represent the Interests of Resident and Fellow Trainees (Resolution 304-A-22)

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

3. Resolution 306 – Increasing Practice Viability for Female Physicians through Increased Employer and Employee Awareness of Protected Leave Policies

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

4. Council on Medical Education Report 01 – Leave Policies for Medical Students and Physicians

5. Council on Medical Education Report 03 – Ensuring Equity in Interview Processes for Entry to Undergraduate and Graduate Medical Education

6. Resolution 301 – Clarification of AMA Policy D-310-948, “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure”

7. Resolution 302 – Medical Student Reports of Disability-Related Mistreatment

8. Resolution 304 – Health Insurance Options for Medical Students

RECOMMENDED FOR REFERRAL

9. Resolution 307 - Re-evaluation of Scoring Criteria for Rural Communities in the National Health Service Corps Loan Repayment Program

RECOMMENDED FOR REFERRAL FOR DECISION

10. Resolution 305 – Addressing Burnout And Physician Shortages For Public Health

Amendments - If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL EDUCATION REPORT 4 – RECOGNIZING SPECIALTY CERTIFICATIONS FOR PHYSICIANS (RES 316-I-22)

RECOMMENDATION:

Your Reference Committee recommends the Recommendations in Council on Medical Education Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 4 be adopted and the remainder of the report be filed.

1. Encourage continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification. (Directive to Take Action)

2. Reaffirm the following policy: H-275.926, "Medical Specialty Board Certification Standards".

The recommendations in Council on Medical Education Report 4 received mostly supportive online and in-person testimony. The American Academy of Facial Plastic & Reconstructive Surgery suggested that the optional drafting note be preserved. The Reference Committee would note that drafting notes are advocacy tools and are not policy statements. Your Reference Committee recommends that Council on Medical Education Report 4 be adopted.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 5 – ORGANIZATIONS TO REPRESENT THE INTERESTS OF RESIDENT AND FELLOW TRAINEES (RESOLUTION 304-A-22)

RECOMMENDATION:

Your Reference Committee recommends the Recommendations in Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

1. That Our AMA will encourage the formation of peer-led resident/fellow organizations that can advocate for trainees' interests, as outlined by the AMA's Residents and Fellows' Bill of Rights, at sponsoring institutions. (New HOD Policy)

2. That Our AMA will encourage the development of a formal process for resident/fellow physicians to transfer to another graduate medical education program, without penalty, when an employment situation is not sustainable for a trainee and/or program. (New HOD Policy)

3. That Our AMA will investigate promoting the current capacity of FREIDA™ to post open positions and adding the ability for FREIDA™ to facilitate the process of residents and fellows who wish to transfer programs. (Directive to Take Action)

4. That AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition, to read as follows (Modify Current HOD Policy):

"12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.

"13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights."

The recommendations in Council on Medical Education Report 5 received limited but unanimously supportive online and in-person testimony. Your Reference Committee recommends adoption of this report and thanks the Council for its efforts.

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

(3) RESOLUTION 306 – INCREASING PRACTICE VIABILITY FOR FEMALE PHYSICIANS THROUGH INCREASED EMPLOYER AND EMPLOYEE AWARENESS OF PROTECTED LEAVE POLICIES

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 306 be adopted.

RECOMMENDATION B:

Your Reference Committee recommends the title of Resolution 306 be changed to read as follows:

INCREASING PRACTICE VIABILITY FOR ~~FEMALE~~ PHYSICIANS THROUGH INCREASED EMPLOYER AND EMPLOYEE AWARENESS OF PROTECTED LEAVE POLICIES.

HOD ACTION: Resolution 306 adopted with a change in title.

RESOLVED, that our American Medical Association oppose any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons; and be it further.

RESOLVED, that our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends.

Resolution 306 received online and in-person testimony that largely supported this item. Testimony was received for a more inclusive title by deleting gender-specific language. Your Reference Committee agrees with changing the title and recommends Resolution 306 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

(4) COUNCIL ON MEDICAL EDUCATION REPORT 1 – LEAVE POLICIES FOR MEDICAL STUDENTS AND PHYSICIANS

RECOMMENDATION A:

Your Reference Committee recommends the third Recommendation of the Council on Medical Education Report 1 be amended by a deletion in the fifth clause of AMA Policy H-405-947 "Compassionate Leave for Medical Students and Physicians", as follows:

5. Our AMA ~~will study~~ supports the concept of equal compassionate leave for ~~bereavement due to~~ death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students, ~~and physicians~~, medical trainees, and physician residents and fellows, regardless of gender or gender identity. (Modify Current HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends the Recommendations of the Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

1. That the fifth and fifteenth clauses of AMA Policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave," be amended by addition and deletion, to read as follows:

5. Our AMA recommends that medical practices, departments, and training programs strive to provide 12 weeks of paid parental, family, and medical necessity leave in a 12-month period for their attending and trainee physicians as needed~~.~~, with the understanding that no parent be required to take a minimum leave.

15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training ~~up to 12 weeks~~ after the traditional residency completion date while still maintaining board eligibility, ~~in that year~~ in the event of leave beyond six weeks. Our AMA encourages specialty

boards to develop flexible policies for board certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.

2. That AMA Policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave," be amended by addition to read as follows:

19. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.

3. That the first and fifth clauses of AMA Policy H-405.947, "Compassionate Leave for Medical Students and Physicians," be amended by addition and deletion with a change in title to read as follows:

Compassionate Leave for Physicians, Medical Students, Medical Trainees, and Physician Residents and Fellows ~~and Physicians~~

1. Our AMA urges:

(a) medical schools, and the ~~residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices~~ Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation to incorporate and/or encourage development of compassionate leave policies ~~as part of the physician's standard benefit agreement~~. Such compassionate leave policies should consider inclusion of extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to complete a medical degree;

(b) residency and fellowship training programs, their sponsoring institutions, and Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid, outline what obligations and absences must be made up, and determine how compassionate leave may be incorporated with alternative, timely means of achieving curricular goals when absent from curricular components and to meet competency requirements necessary to achieve independent practice and board eligibility for their specialty;

(c) medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit

agreement. Such compassionate leave policies should consider appropriateness of coverage during extensive travel and events impacting family planning, pregnancy, or fertility (including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, or a failed surrogacy arrangement). These policies should also include whether the leave is paid or unpaid and what obligations and absences must be made up.

5. Our AMA ~~will study~~ supports the concept of equal compassionate leave for bereavement due to death or loss (e.g., pregnancy loss and other such events impacting fertility in a physician or their partner) as a benefit for physicians, medical students ~~and physicians~~, medical trainees, and physician residents and fellows, regardless of gender or gender identity.

4. That the fourth clause of AMA Policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave," be rescinded, as having been fulfilled by this report.

~~4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.~~

5. That the second clause of AMA Policy H-405.947, "Compassionate Leave for Medical Students and Physicians," be rescinded, as having been fulfilled by this report.

~~2. Our AMA will study components of compassionate leave policies for medical students and physicians to include: a. whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; c. whether leave is paid or unpaid; d. whether obligations and time must be made up; and e. whether make-up time will be paid.~~

Council on Medical Education Report 1 received online and in-person testimony largely in support of this report. An amendment was offered to align with current Support Through Loss legislation. Another amendment was submitted to exclude vacation, sick time, research, and electives to be used as part of leave, but there was no other supportive testimony for this amendment. Your Reference Committee noted the broad agreement with the report which strikes a balance between providing leave for students, residents, and fellows, and ensuring they achieve competency upon completion of their training program. Your Reference Committee notes concerns that the second amendment offered would make significant changes to the report with potential unintended consequences. Therefore, your Reference Committee has included the first amendment and recommends the report be adopted as amended.

(5) COUNCIL ON MEDICAL EDUCATION REPORT 3 – ENSURING EQUITY IN INTERVIEW PROCESSES FOR ENTRY TO UNDERGRADUATE AND GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

Your Reference Committee recommends the third Recommendation in Council on Medical Education Report 3 be amended by addition, to read as follows:

That our AMA recommend that individual medical schools use the same interview format for all applicants to the same class at their institution to promote equity and fairness while allowing for accommodations for individuals with disabilities. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends the fourth Recommendation in Council on Medical Education Report 3 be amended by addition to read as follows:

That our AMA recommend that individual graduate medical education programs use the same interview format for all applicants to the same program to promote equity and fairness while allowing for accommodations for individuals with disabilities. (New HOD Policy)

RECOMMENDATION C:

Recommendations in Council on Medical Education Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 3 adopted as amended and the remainder of the report be filed.

1. That our AMA encourage interested parties to study the impact of different interview formats on applicants, programs, and institutions. (Directive to Take Action)

2. That our AMA continue to monitor the impact of different interview formats for medical school and graduate medical education programs and their effect upon equity, access, monetary cost, and time burden along with the potential downstream effects upon on applicants, programs, and institutions. (New HOD Policy)

3. That our AMA recommend that medical schools use the same interview format for all applicants to the same class to promote equity and fairness. (New HOD Policy)

4. That our AMA recommend that graduate medical education programs use the same interview format for all applicants to the same program to promote equity and fairness. (New HOD Policy)
5. That AMA Policy D-295.303, "Support Hybrid Interview Techniques for Entry to Graduate Medical Education," be rescinded, as having been addressed through this report. (Rescind HOD Policy)

The recommendations in Council on Medical Education Report 3 received mostly supportive online and in-person testimony. Testimony suggested the third recommendation in the report be amended by addition of the adjective "individual" before "medical school", and the fourth recommendation be amended by addition of the adjective "individual" before "medical education programs" to clarify the intent that each medical school and graduate medical education program can chose which interview format they will use for their applicant class. In-person testimony also raised equity concerns for rural applicants and applicants who require disability accommodations. Your Reference Committee recognizes the multitude of equity issues that are impacted by decisions to have in-person or virtual interview techniques and recommends adoption by amendment.

(6) RESOLUTION 301 – CLARIFICATION OF AMA POLICY D-310-948 "PROTECTION OF RESIDENT AND FELLOW TRAINING IN THE CASE OF HOSPITAL OR TRAINING PROGRAM CLOSURE"

RECOMMENDATION A:

Your Reference Committee recommends the Resolution 301 be amended by addition and deletion to read as follows:

Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by ~~corporate and~~ nonprofit and for-profit entities and their effect on medical education. (Modify Current HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 301 be adopted as amended.

HOD ACTION: Resolution 301 adopted as amended.

RESOLVED, that our American Medical Association amend Policy D-310.948 "Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure" by addition and deletion to read as follows:

Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training

programs run by corporate and ~~nonprofit~~ for-profit entities and their effect on medical education. (Modify HOD Policy).

Resolution 301 received supportive online and in-person testimony on this item. While the author offered an amendment to strike “nonprofit” and add “for-profit”, testimony explained the merits of monitoring issues, collecting data, and sharing information related to training programs run by both nonprofit and for-profit entities. Testimony also noted that the word “corporate” was limiting and could be removed. Your Reference Committee concurs with the testimony and therefore recommends that Resolution 301 be adopted as amended.

(7) RESOLUTION 302 – MEDICAL STUDENT REPORTS OF DISABILITY-RELATED MISTREATMENT

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 302 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~will work with~~ encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM) and other relevant bodies to ~~encourage data collection of medical student~~ include questions on mistreatment based on disability, as defined by United States Americans with Disabilities Act, ~~as a protected category in internal and external mistreatment~~ in their surveys~~,~~ including the AAMC Medical School Graduation Questionnaire. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 302 be amended by addition of a second resolve to read as follows:

RESOLVED, that our AMA encourages medical schools to cultivate learning environments that foster belonging for students with disabilities. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 302 be adopted as amended.

HOD ACTION: Resolution 302 be adopted as amended.

RESOLVED, that our American Medical Association will work with the Association of American Medical Colleges (AAMC) and other relevant bodies to encourage data

collection of medical student mistreatment based on disability as a protected category in internal and external mistreatment surveys, including the AAMC Medical School Graduation Questionnaire.

Resolution 302 received supportive online and in-person testimony. While testimony called for the inclusion of residents, the Council on Medical Education noted the residents are employees and are thus covered by employment law. The Council offered amendments to clarify the original resolve and added a new resolve, which were supported by the author. Additional amendments were offered to include asking questions on mistreatment based on disabilities in surveys, and further testimony offered a new resolve encouraging the National Board of Medical Examiners (NBME) to evaluate medical student requests for testing accommodations in compliance with the Americans with Disabilities Act. However, your Reference Committee noted that AMA Policy D-90.990 already addresses the issue with NBME. Also, your Reference Committee wanted to include both allopathic and osteopathic medical students in addressing this issue. Your Reference Committee appreciates the language offered in testimony to improve this important resolution. Your Reference Committee recommends that Resolution 302 be adopted as amended.

(8) RESOLUTION 304 – HEALTH INSURANCE OPTIONS FOR MEDICAL STUDENTS

RECOMMENDATION A:

Your Reference Committee recommends the first resolve of Resolution 304 be amended by addition and deletion, to read as follows:

RESOLVED, that our American Medical Association encourage ~~work with relevant parties to urge~~ medical schools to allow students and their families who qualify for and enroll in ~~a other~~ health insurance plans other than the institutionally offered health insurance plans, ~~with equal or greater coverage, including Medicaid, the Children's Health Insurance Program (CHIP), or Affordable Care Act (ACA) Marketplace health insurance plans~~, to be exempt from an otherwise mandatory student health insurance plan~~s~~ requirement, provided that the alternative plan has comparable care coverage and is accepted at the primary geographic locations of training. (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends the second resolve of Resolution 304 be amended by addition to read as follows:

RESOLVED, that our AMA support the continuation of comprehensive medical insurance benefits

for inactive students taking ~~a~~ an approved leave of absence during their time of degree completion and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 304 be adopted as amended.

HOD ACTION: Resolution 304 adopted as amended.

RESOLVED, that our American Medical Association work with relevant parties to urge medical schools to allow students and their families who qualify for and enroll in other health insurance with equal or greater coverage, including Medicaid, the Children's Health Insurance Program (CHIP), or Affordable Care Act (ACA) Marketplace health insurance plans, to be exempt from otherwise mandatory student health insurance plans; and be it further

RESOLVED, that our AMA support the continuation of comprehensive medical insurance benefits for students taking a leave of absence and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence.

Resolution 304 received mostly supportive online and in-person testimony. It also received opposing testimony explaining that some health insurance coverage (such as Medicaid) does not travel from state to state. Some plans will not be in effect if a student has a rotation out of state or leaves for another reason - even if the student attends medical school in the same state as their own coverage. There was also concern about medical students applying for Medicaid in states other than where they attend medical school. Amendments were offered that addressed ensuring students have coverage in the primary locations where they are being trained. Your Reference Committee felt the phrase "comparable care coverage" better reflected the intent of the amendment proffered by the Council in the online forum. Your Reference Committee recommends Resolution 304 be adopted as amended.

RECOMMENDED FOR REFERRAL

(9) RESOLUTION 307 - RE-EVALUATION OF SCORING CRITERIA FOR RURAL COMMUNITIES IN THE NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM

RECOMMENDATION:

Your Reference Committee recommends that Resolution 307 be referred.

HOD ACTION: Resolution 307 referred.

RESOLVED, that our American Medical Association advocate, in partnership with other major medical associations at the federal level, for a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area (HPSA) scoring criteria employed by the National Health Service Corps (NHSC) Loan Repayment Program with appropriate revisions to meet the physician workforce needs for the neediest rural communities and underserved areas. (Directive to Take Action)

In-person testimony was supportive of this item and cited concerns about bias in scoring. Testimony supported the need for a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area (HPSA) scoring criteria. Testimony noted there is a Shortage Designation Modernization Project underway by the federal government and recommended referral. The Council on Medical Education agreed with referral. Your Reference Committee concurs and recommends that Resolution 307 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(10) RESOLUTION 305 - ADDRESSING BURNOUT AND PHYSICIAN SHORTAGES FOR PUBLIC HEALTH

RECOMMENDATION:

Your Reference Committee recommends that Resolution 305 be referred for decision.

HOD ACTION: Resolution 305 referred for decision.

RESOLVED, that our American Medical Association (AMA) vigorously advocates for expanded training opportunities within residency programs, encompassing both preventive medicine residencies and public health physician training, in addition to advocating for increased funding and heightened federal support to address the repercussions of natural disasters; [New HOD Policy]; and be it further,

RESOLVED, that our AMA steadfastly supports the allocation of state and national funds aimed at fortifying the roles of public health physicians, including Public Health and General Preventive Medicine Residency programs in multiple federal Public Health agencies [New HOD Policy]; and be it further,

RESOLVED that our AMA unequivocally calls for the reinstatement of the CDC Preventive Medicine Residency program or Fellowship, as the CDC is the nation's premier public health agency.

Resolution 305 received significant supportive testimony online and in-person for public health and the need for more preventive medicine physicians. Your Reference Committee noted that the AMA has ample policy that addresses the topics in the first and second resolves, namely public health, preventive medicine and related residency programs to provide such training. Your Reference Committee noted that AMA policies D-295.327, D-305.974, D-305.964, H-440.982, D-440.922, H-440.965, and H-440.982 address the first and second resolves.

The author of the resolution provided impassioned testimony regarding the imperative nature of the third resolve given the CDC preventive medicine residency program is closing in July 2024. Testimony from the CDC indicated that this decision to close was driven by a decline in participants over the last several years as well as a shift in the landscape for accreditation for preventive medicine programs requiring more clinical training, which the CDC is unable to provide. The CDC noted plans to provide rotations for other residency programs. Your Reference Committee acknowledged that there is an underlying problem that would not be fixed by calling for reinstating the program. Additional testimony asked for referral. Recognizing the closure of a federal training program is a complex and urgent issue, your Reference Committee recommends that the resolution be referred for decision.

This concludes the report of Reference Committee C. I would like to thank my colleagues Kathleen Doo, MD, MHPE, Marygrace Elson, MD, MME, Saby Karuppiah, MD, MPH, Leif Knight, MD, Carlos Latorre, MD, MS, and David Whalen, MD, MPH. I would also like to thank AMA staff persons Amber Ryan, Tanya Lopez, Amanda Moutrage, and Richard Pan, MD, MPH, as well as all those who testified before this Committee.

Kathleen Doo, MD, MHPE
Society of Critical Care Medicine

Leif Knight, MD
Rhode Island

Marygrace Elson, MD, MME
American College of Obstetricians and Gynecologists

Carlos Latorre, MD, MS
Mississippi

Saby Karuppiah, MD, MPH
American Academy of Family Physicians

David Whalen, MD, MPH
Michigan

Sarah Marsicek, MD
American Academy of Pediatrics
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Interim 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 (I-23)

Report of Reference Committee on Amendments to Constitution and Bylaws

Po-Yin Samuel Huang, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT Report 01 – Employed Physicians
2. BOT Report 10 - Medical Decision-Making Autonomy of the Attending Physician
3. BOT Report 17 - Specialty Society Representation in the House of Delegates—Five-Year Review
4. Resolution 006 - Inappropriate Use of Health Records in Criminal Proceedings

RECOMMENDED FOR ADOPTION AS AMENDED

5. Resolution 002 – Support for International Aid for Reproductive Health
6. Resolution 007- Improving Access to Forensic Medical Evaluations and Legal Representation for Asylum Seekers
7. Resolution 004 – Reconsideration of Medical Aid in Dying (MAID)

RECOMMENDED FOR REFERRAL

8. CEJA Report 01 - Physicians' Use of Social Media for Product Promotion and Compensation
9. CEJA Report 02 - Research Handling of De-Identified Patient Data
10. Resolution 009 - Physicians Arrested for Non-Violent Crimes While Engaged in Public Protests

RECOMMENDED FOR NOT ADOPTION

11. Resolution 005 – Adopting a Neutral Stance on Medical Aid in Dying

Amendments

If you wish to propose an amendment to an item of business, click here: SUBMIT NEW AMENDMENT

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 01 – EMPLOYED PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that recommendations in Board of Trustees Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees report 01 adopted and the remainder of the Report be filed.

The Board of Trustees recommends that the following recommendation be adopted in lieu of the recommendations of BOT Report 09-I-22 and that the remainder of this report be filed:

That our AMA re-examine the representation of employed physicians within the organization and report back at the 2024 Annual Meeting.

Testimony was heard in unanimous support. Online testimony was also in unanimous support. Your Reference Committee recommends that BOT Report 01 be adopted.

(2) BOARD OF TRUSTEES REPORT 10 – MEDICAL DECISION-MAKING AUTONOMY OF THE ATTENDING PHYSICIAN

RECOMMENDATION:

Your Reference Committee recommends that recommendations in Board of Trustees Report 10 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 10 adopted and remainder of the Report filed.

In light of the foregoing, your Board of Trustees recommends that the:
1. First, second, and third resolve clauses of Resolution 009-I-22, “Medical Decision-Making Autonomy of the Attending Physician” not be adopted; and
2. Fourth resolve clause of Resolution 009-I-22 be adopted with amendment as follows:

That our AMA ~~aggressively pursue~~ continue to strongly oppose any encroachment of administrators upon the medical decision making of attending physicians that is not in the best interest of patients ~~as strongly as possible, for there is no more sacred relationship than that of a doctor and his/her patient, and as listed above, first, we do no harm~~. (Directive to Take Action)

Testimony was heard in unanimous support. Online testimony was also in unanimous support. Your Reference Committee recommends that BOT Report 10 be adopted.

(3) BOARD OF TRUSTEES REPORT 17 – SPECIALITY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES-FIVE YEAR REVIEW

RECOMMENDATION:

Your Reference Committee recommends that recommendations in the Board of Trustees Report 17 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in the Board of Trustees Report 17 adopted and the remainder of the Report be filed.

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

1. The American Academy of Ophthalmology, Inc., American Academy of Orthopaedic Surgeons, American Academy of Otolaryngology—Head and Neck Surgery, American Academy of Pain Medicine, American Academy of Pediatrics, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, and Society of Nuclear Medicine and Molecular Imaging retain representation in the American Medical Association House of Delegates. (Directive to Take Action)

2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 the American Academy of Allergy, Asthma & Immunology be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)

Testimony was heard in unanimous support. Your Reference Committee recommends that BOT Report 17 be adopted.

(4) RESOLUTION 006 – INAPPROPRIATE USE OF HEALTH RECORDS IN CRIMINAL PROCEEDINGS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 006 be <u>adopted.</u>

HOD ACTION: Resolution 006 <u>adopted</u>

RESOLVED, that our American Medical Association encourage collaboration with relevant parties, including state and county medical societies, the American College of Correctional Physicians, and the American Bar Association, on efforts to preserve patients' rights to privacy regarding medical care while incarcerated while ensuring appropriate use of medical records in parole and other legal proceedings to protect incarcerated individuals from punitive actions related to their medical care. (New HOD Policy)

Testimony was heard in unanimous support. Your Reference Committee recommends that Resolution 006 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(5) RESOLUTION 002 – SUPPORT FOR INTERNATIONAL AID FOR REPRODUCTIVE HEALTH

RECOMMENDATION A:

That the first resolve of Resolution 002 be amended by addition and deletion as follows:

RESOLVED, that our American Medical Association oppose restrictions on U.S. funding to non-governmental organizations ~~which~~ solely because they provide reproductive health care internationally, including but not limited to contraception and abortion care (New HOD Policy); and it be further

RECOMMENDATION B:

That the second resolve of Resolution 002 be amended by addition and deletion as follows:

RESOLVED, that our AMA supports funding for global humanitarian and non-governmental organizations ~~assistance~~ for maternal healthcare comprehensive reproductive health services, including but not limited to contraception and abortion care. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 002 be adopted as amended.

HOD ACTION: Resolution 002 adopted as amended.

RESOLVED, that our American Medical Association oppose restrictions on U.S. funding to non-governmental organizations which provide reproductive health care internationally, including but not limited to contraception and abortion care (New HOD Policy); and it be further

RESOLVED, that our AMA supports global humanitarian assistance for maternal healthcare and comprehensive reproductive health services, including but not limited to contraception and abortion care. (New HOD Policy)

Testimony was generally supportive including for a proffered amendment. Testimony cited the need to support our physicians who practice globally and

that the recommendation aligns with existing policy. Your Reference Committee recommends that Resolution 002 be adopted as amended.

(6) RESOLUTION 007 – IMPROVING ACCESS TO FORENSIC MEDICAL EVALUATIONS AND LEGAL REPRESENTATION FOR ASYLUM SEEKERS

RECOMMENDATION A:

That Resolution 007 be amended by deletion as follows:

~~**RESOLVED, that our American Medical Association support public funding of legal representation for people seeking legal asylum (New HOD Policy); and be it further**~~

RESOLVED, that our AMA support efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources~~, including, but not limited to, the Asylum Medicine Training Initiative**~~**. (New HOD Policy)**

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 007 be adopted as amended.

HOD ACTION: Resolution 007 referred.

RESOLVED, that our American Medical Association support public funding of legal representation for people seeking legal asylum (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources, including, but not limited to, the Asylum Medicine Training Initiative. (New HOD Policy)

Testimony was mixed. There were concerns raised about the first resolve clause because it was outside the purview of the AMA. Online testimony suggested amendment by deletion of specific reference to “Asylum Medicine Training Initiative” to avoid specific program references. Your Reference Committee recommends that Resolution 007 be adopted as amended.

(7) RESOLUTION 004 – RECONSIDERATION OF MEDICAL AID IN DYING (MAID)

RECOMMENDATION A:

That Resolution 004 be amended by deletion.

RESOLVED, that our American Medical Association oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying (New HOD Policy); and be it further

~~**RESOLVED, that our AMA use the term "medical aid in dying" instead of the term "physician-assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions**~~ **(New HOD Policy)**

~~**RESOLVED, that our AMA rescind our HOD policies on physician-assisted suicide, H-270.965 "Physician-Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue**~~ **(Rescind HOD Policy)**

RECOMENDATION B:

Your Reference Committee recommends that alternative Resolve 4 be adopted in lieu of current Resolve 4:

RESOLVED, that our AMA amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:
Decisions Near the End of Life, H-140.966
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
(4) Physicians must not perform euthanasia ~~or participate in assisted suicide~~. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia ~~and assisted suicide.~~ In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia ~~or physician-assisted suicide~~ at this time.
(5) Our AMA supports continued research into and education concerning pain management. (Modify Current HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that the fifth Resolve of 004 be referred.

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 004 be adopted as amended.

RECOMMENDATION E:

Your Reference Committee recommends a title change to Resolution 004 to read as follows:

STUDY OF PHYSICIAN ASSISTED SUICIDE AND MEDICAL AID IN DYING

HOD ACTION: First Resolve of Resolution 004 amended by addition and deletion as follows:

~~RESOLVED, that our American Medical Association oppose criminalization of~~

~~**physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying (New HOD Policy); and be it further**~~

RESOLVED, that our AMA oppose criminal or civil legal action against physicians and health professionals who engage, or attempt to engage in providing a lethal dose of medication for terminally ill patients to use at such time as the patient sees fit, and oppose civil or criminal legal action against patients for using medications prescribed with this intent; and be it further

RESOLVED, that our AMA study alternative terminology such as "End of Life Expanded Treatment Options" rather than either the term "Physician Assisted Suicide" or "Medical Aid in Dying", both of which have historically been considered objectionable by various groups of physicians and are therefore divisive.

HOD Action: Amended Resolution 004 referred.

RESOLVED, that our American Medical Association oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying (New HOD Policy); and be it further

RESOLVED, that our AMA use the term "medical aid in dying" instead of the term "physician-assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions (New HOD Policy)

RESOLVED, that our AMA rescind our HOD policies on physician-assisted suicide, H-270.965 "Physician-Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue (Rescind HOD Policy)

RESOLVED, that our AMA amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:
Decisions Near the End of Life, H-140.966
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves

to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
~~(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.~~
(5) Our AMA supports continued research into and education concerning pain management. (Modify Current HOD Policy)

RESOLVED, that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal. (Directive to Take Action)

Mixed testimony was heard, with a significant amount of testimony both in support and in opposition.

Your Reference Committee heard mixed but supportive testimony for resolve 1 to protect physicians from criminalization and did not hear any direct opposition to this resolve. Therefore, your Reference Committee recommends adoption of resolve 1.
Your Reference Committee heard impassioned but mixed testimony regarding resolves 2 through 5. Therefore, your Reference Committee thinks further study is warranted and is recommending referral of resolve 5 so that this may be accomplished. Until this study can be concluded, your Reference Committee recommends resolves 2 and 3 not be adopted and alternative resolve 4 be adopted until evidence-based information can be evaluated. Therefore, your Reference Committee recommends Resolution 004 be adopted as amended with a title change.

RECOMMENDATION FOR REFERAL

(8) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
REPORT 01 – PHYSICIANS' USE OF SOCIAL MEDIA
FOR PRODUCT PROMOTION AND COMPENSATION

RECOMMENDATION:

Your Reference Committee recommends that the recommendations in Council on Ethical and Judicial Affairs Report 01 be referred back to CEJA.

HOD ACTION: Recommendations in Council on Ethical and Judicial Affairs Report 01 referred back to CEJA.

In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that:
Opinion 9.6.4, "Sale of Health-Related Products," and Opinion 9.6.5, "Sale of Non-Health-Related Products" be consolidated and amended by substitution to read as follows:
The sale or promotion of products or services by physicians may offer benefit to patients or the public but may also conflict with their professional ethical responsibilities. Whether intended or not, they may be perceived to use their professional knowledge and stature as inducements to consumers. There are four key scenarios of sales or promotion: (1) health-related products or services marketed to patients, (2) health-related products or services marketed to the general public, (3) non-health-related product or services marketed to patients, and (4) non-health-related products or services marketed to the general public.
Of greatest concern are commercial practices in which physicians sell or promote goods or services to patients. In these circumstances patients may feel pressured to purchase the product or service, which may compromise the physician's fiduciary obligation to put patients' interests above their own financial interests and undermine the trust that grounds patient-physician relationships. Similarly, if physicians lend their credibility as medical professionals to products or services that are not supported by peer-reviewed evidence or are of questionable value they may put patient well-being and the integrity of the profession in jeopardy.
Physicians and medical students therefore should:
Refrain from leveraging their professional role to promote unrelated business ventures.
Fully disclose the nature of their financial interest in the product or service.
Avoid exclusive distributorship arrangements that make products or services available only through the individual's commercial venue.
Limit the sale or promotion of health-related goods or services only to those that serve the immediate needs of patients and strive to make the product or service available at a reasonable cost.
Refrain from the sale or promotion of non-health-related goods or services as a regular part of their professional activities. (Modify HOD/CEJA Policy); and

2. Opinion 2.3.2, “Professionalism in the Use of Social Media” be amended by substitution to read as follows: Social media—internet-enabled communication technologies—enable individual medical students and physicians to have both a personal and a professional presence online.
Social media can foster collegiality and camaraderie within the profession as well as provide opportunities to disseminate public health messages and other health communication widely. However, use of social media by medical professionals can also undermine trust and damage the integrity of patient-physician relationships and the profession as a whole, especially when medical students and physicians use their social media presence to promote personal interests.
Physicians and medical students should be aware that they cannot realistically separate their personal and professional personas entirely online and should curate their social media presence accordingly. Physicians and medical students therefore should:
Use caution when publishing any content that could damage their individual professional reputation or impugn the integrity of the profession.
(b) Respect professional standards of patient privacy and confidentiality and refrain from publishing identifiable patient information online. When they use social media for educational purposes or to exchange information professionally with other physicians or medical students they should follow ethics guidance regarding confidentiality, privacy, and informed consent.
(c) Maintain appropriate boundaries of the patient-physician relationship in accordance with ethics guidance if they interact with patients through social media, just as they would in any other context.
(d) Use privacy settings to safeguard personal information and content, but be aware that once on the Internet, content is likely there permanently. They should routinely monitor their social media presence to ensure that their personal and professional information and content published about them by others is accurate and appropriate.
Disclose any financial interests related to their social media content, including, but not limited to, paid partnerships and corporate sponsorships.
(f) When using social media platforms to disseminate medical health care information, ensure that such information is useful and accurate. They should likewise ensure to the best of their ability that non-health-related information is not deceptive. (Modify HOD/CEJA Policy); and
3. The remainder of this report be filed.

Testimony was mixed, but the majority supported referral. Testimony in support suggested that these were appropriate recommendations that do not actually prohibit physicians from offering products for sale but instead offer suitable guidelines concerning how to do so in an ethical manner. Testimony in opposition asked CEJA to reconsider recommendations concerning exclusive distributorship since these might negatively affect innovation. It was suggested that the language requiring that products meet the "immediate” needs of patients should be changed to include long-term healthcare needs as well. Some testimony pointed out that there are practice models in place that would be restricted by these recommendations, and that since reimbursement is declining, it is a benefit to practices to be able to sell products to offset costs. It was also noted that the recommendations concerning the use of social media for educational purposes

seem to imply that informed consent is required in that context even when it is not possible to obtain it. Your Reference Committee recommends that CEJA Report 01 be referred.

(9) COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS REPORT 02 – RESEARCH HANDLING OF DE-IDENTIFIED PATIENT DATA

RECOMMENDATION:

Your Reference Committee recommends that recommendations in Council on Ethical and Judicial Affairs Report 02 be referred back to CEJA.

HOD ACTION: Recommendations in Council on Ethical and Judicial and Ethical and Judicial Affairs Report 02 referred back to CEJA.

In light of the challenges considered with regard to constructing a framework for holding stakeholders accountable within digital health information ecosystems, the Council on Ethical and Judicial Affairs recommends:

1. That the following be adopted:

Within health care systems, identifiable private health information, initially derived from and used in the care and treatment of individual patients, has led to the creation of massive de-identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a means for quality improvement and innovation that can be used for the benefit of future patients and patient populations. While de-identification of data is meant to protect the privacy of patients, there remains a risk of re-identification, so while patient anonymity can be safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive to balance supporting and respecting patient privacy while also upholding ethical obligations to the betterment of public health. When clinical data are de-identified and aggregated, their potential use for societal benefits through research and development is an emergent, secondary use of electronic health records that goes beyond individual benefit. Such data, due to their potential to benefit public health, should thus be treated as a form of public good, and the ethical standards and values of health care should follow the data and be upheld and maintained even if the data are sold to entities outside of health care. The medical profession's responsibility to protect patient privacy as well as to society to improve future health care should be recognized as inherently tied to these datasets, such that all entities granted access to the data become data stewards with a duty to uphold the ethical values of health care in which the data were produced.

As members of health care institutions, physicians should:

(a) Follow existing and emerging regulatory safety measures to protect patient privacy;
(b) Practice good data intake, including collecting patient data equitably to reduce bias in datasets;
(c) Answer any patient questions about data use in an honest and transparent manner to the best of their ability in accordance with HIPAA (or current legal standards).

Health care systems, in interacting with patients, should adopt policies and practices that provide patients with transparent information regarding:
(d)The high value that health care institutions place on protecting patient data;
(e)The reality that no data can be guaranteed to be permanently anonymized, and that risk of re-identification does exist;
(f)How patient data may be used and by whom;
(g) The importance of de-identified aggregated data for improving the care of future patients.

Health care systems, as health data stewards, should:

(h) Establish appropriate data collection methods and practices that meet industry standards to ensure the creation of high-quality datasets;
(i) Ensure proper oversight of patient data is in place, including provisions for the use of de-identified datasets that may be shared, sold, or resold;
(j) Develop models for the ethical use of de-identified datasets when such provisions do not exist, such as establishing and contractually requiring independent data ethics review boards free of conflicts of interest to evaluate the sale and potential resale of clinically-derived datasets;
(k) Take appropriate cyber security measures to ensure the highest level of protection is provided to patients and patient data;
(l) Develop proactive post-compromise planning strategies for use in the event of a data breach to minimize additional harm to patients;
(m) Advocate that health- and non-health entities using any health data adopt the strongest protections and uphold the ethical values of the medical profession.

There is an inherent tension between the potential benefits and burdens of de-identified datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-identification of data may be permissible, or even obligatory, in rare circumstances when done in the interest of the health of individual patients. Re-identification of aggregated patient data for other purposes without obtaining patients' express consent, by anyone outside or inside of health care, is impermissible. (New HOD/CEJA Policy); and

2. That Opinion 2.1.1, "Informed Consent"; Opinion 3.1.1, "Privacy in Health Care"; Opinion 3.2.4, "Access to Medical Records by Data Collection Companies"; and Opinion 3.3.2, "Confidentiality and Electronic Medical Records" be amended by addition as follows:

a. Opinion 2.1.1, Informed Consent
Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. Transparency with patients regarding all options of treatment is critical to establishing trust and should extend to discussions regarding who has access to patients' health data and how data may be used.
The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the

patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines. (Modify HOD/CEJA Policy)

b. Opinion 3.1.1, Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.
Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).
Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:
(a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.
(b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
(c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.
(d) Be transparent that privacy safeguards for patient data are in place but acknowledge that anonymity cannot be guaranteed and that breaches can occur notwithstanding best data safety practices. (Modify HOD/CEJA Policy)

c. Opinion 3.2.4, Access to Medical Records by Data Collection Companies

Information contained in patients' medical records about physicians' prescribing practices or other treatment decisions can serve many valuable purposes, such as improving quality of care. However, ethical concerns arise when access to such information is sought for marketing purposes on behalf of commercial entities that have financial interests in physicians' treatment recommendations, such as pharmaceutical or medical device companies.
Information gathered and recorded in association with the care of a patient is confidential. Patients are entitled to expect that the sensitive personal information they divulge will be used solely to enable their physician to most effectively provide needed services. Disclosing information to third parties for commercial purposes without consent undermines trust, violates principles of informed consent and confidentiality, and may harm the integrity of the patient-physician relationship.

Physicians who propose to permit third-party access to specific patient information for commercial purposes should:
(a) Only provide data that has been de-identified.
(b) Fully inform each patient whose record would be involved (or the patient's authorized surrogate when the individual lacks decision-making capacity) about the purpose(s) for which access would be granted.
Physicians who propose to permit third parties to access the patient's full medical record should:
(c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's medical record.
(d) Prohibit access to or decline to provide information from individual medical records for which consent has not been given.
(e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics guidance.
Because de-identified datasets are derived from patient data as a secondary source of data for the public good, health care professionals and/or institutions who propose to permit third-party access to such information have a responsibility to ensure that any use of data derived from health care adhere to the ethical standards of the medical profession. (Modify HOD/CEJA Policy)
d. Opinion 3.3.2, Confidentiality and Electronic Medical Records
Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.
Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:
(a) Choose a system that conforms to acceptable industry practices and standards with respect to:
(i) restriction of data entry and access to authorized personnel;
(ii) capacity to routinely monitor/audit access to records;
(iii) measures to ensure data security and integrity; and
(iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.
(b) Describe how the confidentiality and integrity of information is protected if the patient requests.
(c) Release patient information only in keeping with ethics guidance for confidentiality and privacy. (Modify HOD/CEJA Policy); and
3. That the remainder of this report be filed.

Testimony was overwhelmingly in support of referral. Testimony cited that the topic was important but that issues related to informed consent, language regarding "all options" as opposed to "medically appropriate" options, and language regarding the use of "ensure" need to be reassessed. It was also noted that physicians cannot "ensure" that data is used only in certain ways, since they are not in control of what happens to it at the systems level. Some testimony opposed the claim that patients have a responsibility or duty to provide their data for the purposes of public health, instead maintaining that this was not obligatory but they could freely volunteer if they wished. Some testimony also indicated that guidelines for the sale of patient data implied that such sales are permissible when in reality they are a violation of confidentiality. It was asked that the recommendations be revised to include some discussion of exclusive contracts for data sharing that may inhibit innovation across whole areas of specialty. Your Reference Committee recommends that CEJA Report 02 be referred.

(10) RESOLUTION 009 – PHYSICIANS ARRESTED FOR NON-VIOLENT CRIMES WHILE ENGAGED IN PUBLIC PROTESTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 009 be referred.

HOD ACTION: Resolution 009 referred.

RESOLVED, that our American Medical Association advocate to appropriate credentialing organizations and payers—including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of health care goods and services—that misdemeanor or felony arrests of physicians as a result of exercising their First Amendment rights of protest through nonviolent civil disobedience should not be deemed germane to the ability to safely and effectively practice medicine. (Directive to Take Action)

Testimony was mixed. Testimony suggested that advocating for patients requires the ability to participate in nonviolent protests, and those who do so may find themselves arrested and so face negative implications for their careers. Further, testimony pointed out that the resolution only discusses arrests and not convictions, and this distinction should be recognized. Testimony highlighted the inconsistency in the severity of charges for the same activities in different jurisdictions. Opposing testimony recommended referral because the recommendation is overly broad and could allow those who spread medical disinformation or falsely pose as reproductive health providers to be protected from professional consequences. It was further noted that felonies maybe different from misdemeanors and so the recommendations should be omitted that suggest they are to be treated in an equivalent manner. Online testimony proffered an amendment to add “employers” to the list entities. Your Reference Committee recommends that Resolution 009 be referred.

RECOMMENDED FOR NOT ADOPTION

(11) RESOLUTION 005 – ADOPTING A NEUTRAL STANCE ON MEDIAL AID IN DYING

RECOMMENDATION:

Your Reference Committee recommends that Resolution 005 be <u>not adopted.</u>

HOD ACTION: Resolution 005 <u>not adopted.</u>

RESOLVED, that our American Medical Association adopt a neutral stance on medical aid in dying and respect the autonomy and right of self-determination of patients and physicians in this matter. (New HOD Policy)

Resolution 005 was considered at the same time as Resolution 004. As stated previously, your Reference Committee heard extensive but mixed testimony on this topic. Therefore, Your Reference Committee has recommended in Resolution 004 that this issue be further studied. Your Reference Committee recommends that Resolution 005 be not adopted.

Madam Speaker, this concludes the report of Reference Committee on Amendments to Constitution and Bylaws. I would like to thank Dr. Joseph Adashek, Dr. Kenneth Andreoni, Dr. Cee Davis, Dr. Lisa Hatcher, Dr. Tate Hinkle, and Dr. Elana Sitnik and all those who testified before the committee.

Joseph Adashek, MD
Nevada State Medical Association

Kenneth Andreoni, MD
American Society of Transplant Surgery

Cee Davis, MD, MPH
American College of OB/GYNs

Lisa Hatcher, MD
Indiana Medical Association

Tate Hinkle, MD, MPH
American Academy of Family Physicians

Elana Sitnik
Medical Student Section

Po-Yin Samuel Huang, MD
California Medical Association
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Interim 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 (I-23)

Supplemental Report of Reference Committee on Amendments to Constitution and Bylaws:
Speakers Report 03 – Report of the Election Task Force 2

Po-Yin Samuel Huang, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Recommendation 2
2. Recommendation 3
3. Recommendation 5
4. Recommendation 7
5. Recommendation 9
6. Recommendation 10
7. Recommendation 13
8. Recommendation 16
9. Recommendation 17
10. Recommendation 18
11. Recommendation 19
12. Recommendation 20
13. Recommendation 21
14. Recommendation 22
15. Recommendation 23
16. Recommendation 25
17. Recommendation 28
18. Recommendation 29

RECOMMENDED FOR ADOPTION AS AMENDED

19. Recommendation 11
20. Recommendation 15
21. Recommendation 26

RECOMMENDED FOR REFERRAL

22. Recommendation 1
23. Recommendation 4
24. Recommendation 6
25. Recommendation 8
26. Recommendation 12

27. Recommendation 14
28. Recommendation 24

RECOMMENDED FOR NOT ADOPTION

29. Recommendation 27

Amendments

If you wish to propose an amendment to an item of business, click here: SUBMIT NEW AMENDMENT

RECOMMENDED FOR ADOPTION

(1) RECOMMENDATION 2

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 2 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 2 of the Speakers Report 03 adopted.

Recommendation 2: Policy D-610.998, Election Task Force, paragraph 1 be amended by addition and deletion to read as follows:
1. Our AMA will ~~investigate the feasibility of a two- (2) year trial of~~ sponsor~~ing a welcome~~ the AMA Candidate R~~r~~eception which will be open to all candidates and all meeting attendees. Any candidate may elect to be "featured" at the AMA Candidate R~~r~~eception. There will not be a receiving line at the AMA Candidate R~~r~~eception. ~~Other receptions sponsored by societies or coalitions, whether featuring a candidate or not, would not be prohibited, but the current~~ The rules regarding cash bars only at campaign receptions and limiting each candidate to be featured at a single reception ~~(the AMA reception or another)~~ will apply to the AMA Candidate Reception. ~~would remain. The Speakers will report back to the House after the two-year trial with a recommendation for possible continuation of the AMA reception.~~ (Modify Current HOD Policy)

Testimony was heard from the Election Task Force. Online testimony was limited. Your Reference Committee recommends that Recommendation 2 of Speakers Report 03 be adopted.

(2) RECOMMENDATION 3

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 3 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 3 of the Speakers Report 03 referred.

Recommendation 3: An announced candidate in a currently contested election may not be "featured" at any gathering of delegates outside of the single campaign reception they have chosen. For the purpose of AMA elections, the definition of "featured" includes being mentioned in the invitation, whether written or verbal, or publicly acknowledging or discussing a candidacy with attendees at a function. (New HOD Policy)

Testimony for recommendations 3-6 was heard simultaneously. Testimony was heard in general support for Recommendations 3 and 5. Testimony in support noted that the point of these reforms is to improve objectivity and, if adopted, these processes can be refined and improved over time. Your Reference Committee notes that these proposed changes will level the playing field for those who do not have a large number of contacts

and resources. Your Reference Committee heard mixed testimony on Recommendations 4 and 6, with a request for referral, citing these recommendations are too vague and potentially restrictive. Online testimony was also in favor of referral of Recommendations 4 and 6. Your Reference Committee recommends that Recommendation 3 of Speakers Report 03 be adopted.

(3) RECOMMENDATION 5

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 5 of the Speakers Report 03 be <u>adopted.</u>

HOD ACTION: Recommendation 5 of the Speakers Report 03 <u>referred.</u>

Recommendation 5: Policy G-610.020, Rules for AMA Elections, paragraph 21 be amended by deletion to read as follows:
21) Group dinners, if attended by an announced candidate in a currently contested election, must be "Dutch treat" - each participant pays their own share of the expenses, with the exception that societies and delegations may cover the expense for their own members. This rule would not disallow societies from paying for their own members or delegations gathering together with each individual or delegation paying their own expense. ~~Gatherings of 4 or fewer delegates or alternates are exempt from this rule.~~ (Modify Current HOD Policy)

Testimony for recommendations 3-6 was heard simultaneously. Testimony was heard in general support for Recommendations 3 and 5. Testimony in support noted that the point of these reforms is to improve objectivity and, if adopted, these processes can be refined and improved over time. Your Reference Committee notes that these proposed changes will level the playing field for those who do not have a large number of contacts and resources. Your Reference Committee heard mixed testimony on Recommendations 4 and 6, with a request for referral, citing these recommendations are too vague and potentially restrictive. Online testimony was also in favor of referral of Recommendations 4 and 6. Your Reference Committee recommends that Recommendation 5 of Speakers Report 03 be adopted.

(4) RECOMMENDATION 7

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 7 of the Speakers Report 03 be <u>adopted.</u>

HOD ACTION: Recommendation 7 of the Speakers Report 03 <u>referred.</u>

Recommendation 7: Policy G-610.020, Rules for AMA Elections, paragraph 15 be amended by addition and deletion to read as follows:

15) Printed and digital ~~C~~campaign materials may not be distributed to members of the House other than by the HOD office candidate email and on the Candidate Web Pages. ~~by postal mail or its equivalent~~. The AMA Office of House of Delegates Affairs will not ~~longer~~ furnish a file containing the names and mailing addresses of members of the AMA-HOD. ~~Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials~~. (Modify Current HOD Policy)

Testimony for recommendations 7-8 was heard simultaneously. Testimony was generally in favor of adoption of Recommendation 7. Your Reference Committee recommends that Recommendation 7 of Speakers Report 03 be adopted.

(5) RECOMMENDATION 9

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 9 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 9 of the Speakers Report 03 adopted.

Recommendation 9: Policy G-610.020, Rules for AMA Elections, paragraph 11 be amended by addition and deletion to read as follows:
(11) ~~The Speaker's Office will coordinate the scheduling of candidate interviews for general officer positions (Trustees, President-Elect, Speaker and Vice Speaker).~~ Groups wishing to conduct interviews must designate their interviewing coordinator and provide the individual's contact information to the Office of House of Delegates Affairs. The Speaker's Office will collect contact information for groups wishing to conduct interviews as well as for candidates and their campaign teams and will provide the information to both groups ~~as requested~~. Groups must indicate whether they wish to interview in-person or virtually and for which contest by the deadlines designated by the speaker. (Modify Current HOD Policy)

Testimony for recommendations 9-12 was heard simultaneously. Testimony was heard in general support for Recommendations 9 and 10. Testimony for Recommendations 11 and 12 were mixed with multiple delegations citing the need for clarification. Your Reference Committee recommends that Recommendation 9 be adopted.

(6) RECOMMENDATION 10

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 10 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 10 of the Speakers Report 03 adopted.

Recommendation 10: Policy G-610.020, Rules for AMA Elections, paragraph 12 be amended by addition and renumbered to read as follows:

f. Recording of interviews is allowed only with the knowledge and consent of the candidate.
g. Interviews are recommended to be recorded with consent of all participating individuals and disseminated to the interviewing group members when all are not able to be present for the interview.
~~g~~h. Recordings of interviews may be shared only among members of the group conducting the interview.
(Modify Current HOD Policy)

Testimony for recommendations 9-12 was heard simultaneously. Testimony was heard in general support for Recommendations 9 and 10. Testimony for Recommendations 11 and 12 were mixed with multiple delegations citing the need for clarification. Your Reference Committee recommends that Recommendation 10 be adopted.

(7) RECOMMENDATION 13

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 13 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 13 of the Speakers Report 03 referred.

Recommendation 13: That Bylaws 3.4.2.1.3, 3.4.2.2, and 6.8.1.4 be amended to change the rules for elections of officers and councils with multiple candidates so that the lowest vote getter on each ballot is dropped on the subsequent ballot, with the exception of a tie for lowest vote getter in which case both would be dropped. (Directive to take Action)

Testimony for recommendations 13-14 was heard simultaneously. There was general support for Recommendation 13 with some concerns for potential unintended consequences that were clarified by the Council on Constitution and Bylaws. Therefore your Reference Committee recommends adoption of Recommendation 13 of Speakers Report 03.

(8) RECOMMENDATION 16

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 16 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 16 of the Speakers Report 03 amended by addition as follows:
Candidates may not produce a personal campaign website or direct to personal or professional websites that contain campaign

materials other than the AMA Candidates' Page. (New HOD Policy)

HOD ACTION: Amended Recommendation 16 of the Speakers Report 03 referred.

Recommendation 16: Candidates may not produce a personal campaign website or direct to personal or professional websites other than the AMA Candidates' Page. (New HOD Policy)

Testimony for recommendations 15-21 was heard simultaneously. Testimony was generally supportive of the recommendations with concerns about a few words in Recommendation 15 which were recommended for deletion, and the remainder recommended for adoption. Therefore, your Reference Committee recommends that Recommendation 16 be adopted.

(9) RECOMMENDATION 17

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 17 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 17 of the Speakers Report 03 adopted.

Recommendation 17: Policy G-610.020, Rules for AMA Elections, paragraph 3, be amended by addition and deletion to read as follows:
(3) Announcement cards of all known candidates will be projected on the last day of the Annual and Interim Meetings of our House of Delegates and posted on the AMA website as per Policy G-610.020, paragraph 2. Following each meeting, an "Official Candidate Notification" will be sent electronically to the House. It will include a list of all announced candidates and all potential newly opened positions which may open as a result of the election of any announced candidate. Additional notices will also be sent out with regular Speaker communications to the HOD and with the Speaker's notice of the opening of active campaigning which generally follows~~ing~~ the April Board meeting~~ and on "Official Announcement Dates" to be established by the Speaker~~. (Modify Current HOD Policy)

Testimony for recommendations 15-21 was heard simultaneously. Testimony was generally supportive of the recommendations with concerns about a few words in Recommendation 15 which were recommended for deletion, and the remainder recommended for adoption. Therefore, your Reference Committee recommends that Recommendation 17 be adopted.

(10) RECOMMENDATION 18

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 18 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 18 of the Speakers Report 03 referred.

Recommendation 18: Policy G-610.020, Rules for AMA Elections, paragraph 10, be amended by addition and deletion to read as follows:
(10) Active campaigning for AMA elective office may not begin until the Speaker so notifies the House, which is generally after the April Board of Trustees~~, after its April~~ meeting.~~, announce the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.~~ (Modify Current HOD Policy)

Testimony for recommendations 15-21 was heard simultaneously. Testimony was generally supportive of the recommendations with concerns about a few words in Recommendation 15 which were recommended for deletion, and the remainder recommended for adoption. Therefore, your Reference Committee recommends that Recommendation 18 of Speakers Report 03 be adopted.

(11) RECOMMENDATION 19

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 19 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 19 of the Speakers Report 03 adopted.

Recommendation 19: Policy G-610.020, Rules for AMA Elections, paragraph 25, be amended by addition and deletion to read as follows:
(25) Our AMA ~~(a)~~ requires completion of conflict of interest forms by all candidates for election to our AMA Board of Trustees and councils prior to their election.~~; and~~ Conflict of interest forms must be submitted after an individual has announced their candidacy and before the active campaign window begins or, if not previously announced, within 24 hours of the conclusion of the HOD Opening Session. ~~(b) will expand accessibility to completed conflict of interest information~~ The HOD Office will ~~by~~ post~~ing~~ such information on the "Members Only" section of our AMA website before election by the House of Delegates, with links to the disclosure statements from relevant electronic documents. (Modify Current HOD Policy)

Testimony for recommendations 15-21 was heard simultaneously. Testimony was generally supportive of the recommendations with concerns about a few words in Recommendation 15 which were recommended for deletion, and the remainder recommended for adoption. Therefore, your Reference Committee recommends that Recommendation 19 be adopted.

(12) RECOMMENDATION 20

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 20 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 20 of the Speakers Report 03 adopted.

Recommendation 20: Policy G-610.010, Rules for AMA Elections, paragraphs 3 and 4, be rescinded:
(3) the date for submission of applications for consideration by the Board of Trustees at its April meeting for the Council on Legislation, Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, Council on Science and Public Health, Council on Long Range Planning and Development, and Council on Ethical and Judicial Affairs is made uniform to March 15th of each year;
(4) the announcement of the Council nominations and the official ballot should list candidates in alphabetical order by name only; and

Testimony for recommendations 15-21 was heard simultaneously. Testimony was generally supportive of the recommendations with concerns about a few words in Recommendation 15 which were recommended for deletion, and the remainder recommended for adoption. Therefore, your Reference Committee recommends that Recommendation 20 be adopted.

(13) RECOMMENDATION 21

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 21 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 21 of the Speakers Report 03 adopted.

Recommendation 21: That the language in Bylaw 6.8.1, "Nomination and Election" be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place. (Directive to Take Action)

Testimony for recommendations 15-21 was heard simultaneously. Testimony was generally supportive of the recommendations with concerns about a few words in Recommendation 15 which were recommended for deletion, and the remainder recommended for adoption. Therefore, your Reference Committee recommends that Recommendation 21 be adopted.

(14) RECOMMENDATION 22

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 22 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 22 of the Speakers Report 03 adopted.

Recommendation 22: Policy D-610.998, "Directives from the Election Task Force," paragraph 7 be amended by addition to read as follows:
7. Campaign violation complaints will be investigated by the Election Committee or a subcommittee thereof with the option of including the Office of General Counsel or the Director of the House of Delegates.
a. The Committee will collectively determine whether a campaign violation has occurred. As part of the investigation process the Election Committee or its subcommittee shall inform the candidate of the complaint filed and give the candidate the opportunity to respond to the allegation.
b. If the complaint implicates a delegation or caucus, the Election Committee or its subcommittee shall inform the chair of the implicated delegation or caucus of the complaint filed and give the implicated delegation or caucus chair(s) the opportunity to answer to the allegation as a part of the investigative process.
c. For validated complaints, the Committee will determine appropriate penalties, which may include an announcement of the violation by the Speaker to the House.
d. Committee members with a conflict of interest may participate in discussions but must recuse themselves from decisions regarding the merits of the complaint or penalties.
e. Deliberations of the Election Committee shall be confidential.

f. The Speaker shall include a summary of the Election Committee's activities in "Official Candidate Notifications" sent to the House, following each meeting at which an election was held. Details may be provided at the discretion of the Election Committee and must be provided when the penalty includes an announcement about the violator to the House.
(Modify Current HOD Policy)

Testimony for recommendations 22-26 was heard simultaneously. Testimony was generally in support of these recommendations. There were no concerns with recommendations 22, 23, and 25. There was an amendment recommended for 26 by the Election Task Force that was also generally accepted. Therefore, your Reference Committee recommends that Recommendation 22 of Speakers Report 03 be adopted.

(15) RECOMMENDATION 23

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 23 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 23 of the Speakers Report 03 referred.

Recommendation 23: Candidates and their identified members of campaign teams will be provided a copy of the current election rules and will be required to attest to abiding by them. (New HOD Policy)

Testimony for recommendations 22-26 was heard simultaneously. Testimony was generally in support of these recommendations. There were no concerns with recommendations 22, 23, and 25. There was an amendment recommended for 26 by the Election Task Force that was also generally accepted. Therefore, your Reference Committee recommends that Recommendation 23 of Speakers Report 03 be adopted.

(16) RECOMMENDATION 25

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 25 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 25 of the Speakers Report 03 adopted.

Recommendation 25: Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," be amended by addition and deletion to read as follows:
Definition
Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of ~~his/her~~ race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or otherwise, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual's participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual's participation in such meetings or proceedings or, in the case of AMA staff, such individual's employment opportunities or tangible job benefits.
Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA's premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.
Harassing conduct also includes intimidation of participating individuals by a threat of consequences in order to compel actions by individuals or a group of individuals such as casting a particular vote. (Modify Current HOD Policy)

Testimony for recommendations 22-26 was heard simultaneously. Testimony was generally in support of these recommendations. There were no concerns with recommendations 22, 23, and 25. There was an amendment recommended for 26 by the Election Task Force that was also generally accepted. Therefore, your Reference Committee recommends that Recommendation 25 of Speakers Report 03 be adopted.

(17) RECOMMENDATION 28

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 28 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 28 of the Speakers Report 03 adopted.

Recommendation 28: Policy D-610.998, "Directives from the Election Task Force," paragraph 10 & 11 be rescinded.
10. After an interval of 2 years a review of our election process, including the adopted Recommendations from this report, be conducted by the Speaker and, at the Speaker's discretion the appointment of another election task force, with a report back to the House.
11. Amended Policy D-610.998 will be widely communicated, including being published in the Election Manual.

Testimony for recommendations 27-29 was heard simultaneously. Only supportive testimony was heard for recommendations 28 and 29. Therefore, your Reference Committee recommends that Recommendation 28 of Speakers Report 03 be adopted.

(18) RECOMMENDATION 29

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 29 of the Speakers Report 03 be adopted.

HOD ACTION: Recommendation 29 of the Speakers Report 03 adopted.

Recommendation 29: That policies G-610.010, Nominations; G-610.020, Rules for AMA Elections; G-610.021, Guiding Principles for House Elections; G-610.030, Election Process; and D-610.998, Election Task Force as amended, be combined into one policy entitled, "AMA Election Rules and Guiding Principles," and that this newly formed policy be widely distributed to the House and included in the Election Manual. (Directive to Take Action)

Testimony for recommendations 27-29 was heard simultaneously. Only supportive testimony was heard for recommendations 28 and 29. Therefore, your Reference Committee recommends that Recommendation 29 of Speakers Report 03 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(19) RECOMMENDATION 11

RECOMMENDATION A:

That Recommendation 11 be amended by addition and deletion as follows:

Recommendation 11: Any formal questioning of an announced candidate, ~~including~~ excluding a written questionnaire, is an interview and subject to the rules for ~~virtual~~ interviews. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Recommendation 11 be adopted as amended.

HOD ACTION: Recommendation 11 adopted as amended.

Recommendation 11: Any formal questioning of an announced candidate, including a written questionnaire, is an interview and subject to the rules for virtual interviews. (New HOD Policy)

Testimony for recommendations 9-12 was heard simultaneously. Testimony was heard in general support for Recommendations 9 and 10. Testimony for Recommendations 11 and 12 were mixed with multiple delegations citing the need for clarification. Your Reference Committee recommends that Recommendation 11 be adopted as amended.

(20) RECOMMENDATION 15

RECOMMENDATION A:

That Recommendation 15 be amended by deletion as follows:

Recommendation 15: Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition and deletion to read as follows:
2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, ~~URL,~~ the office sought and a list of ~~up to four (4)~~ endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume)

will not be posted to the website. Printed announcements may not be distributed ~~in the venue where the House of Delegates meets. Announcements sent by candidates~~ to members of the House by any method. ~~are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election.~~ (Modify Current HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Recommendation 15 be adopted as amended.

HOD ACTION: Recommendation 15 of the Speakers Report 03 adopted as amended.

Recommendation 15: Policy G-610.020, Rules for AMA Elections, paragraph 2 be amended by addition and deletion to read as follows:
2) Individuals intending to seek election at the next Annual Meeting should make their intentions known to the Speakers, generally by providing the Speaker's office with an electronic announcement "card" that includes any or all of the following elements and no more: the candidate's name, photograph, email address, ~~URL,~~ the office sought and a list of up to four (4) endorsing societies. The Speakers will ensure that the information is posted on our AMA website in a timely fashion, generally on the morning of the last day of a House of Delegates meeting or upon adjournment of the meeting. Announcements that include additional information (e.g., a brief resume) will not be posted to the website. Printed announcements may not be distributed ~~in the venue where the House of Delegates meets. Announcements sent by candidates~~ to members of the House by any method. ~~are considered campaigning and are specifically prohibited prior to the start of active campaigning. The Speakers may use additional means to make delegates aware of those members intending to seek election.~~ (Modify Current HOD Policy)

Testimony for recommendations 15-21 was heard simultaneously. Testimony was generally supportive of the recommendations with concerns about a few words in Recommendation 15 which were recommended for deletion, and the remainder recommended for adoption. Therefore, your Reference Committee recommends that Recommendation 15 be adopted as amended.

(21) RECOMMENDATION 26

RECOMMENDATION A:

That Recommendation 26 be amended by addition as follows:

Recommendation 26: That our AMA consider developing bylaw language regarding removal of elected individuals or candidates and the criteria by which this would be accomplished and to report back at A-24. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Recommendation 26 be <u>adopted as amended.</u>

Recommendation 26: That our AMA consider developing bylaw language regarding removal of elected individuals and the criteria by which this would be accomplished and to report back at A-24. (New HOD Policy)

Testimony for recommendations 22-26 was heard simultaneously. Testimony was generally in support of these recommendations. There were no concerns with recommendations 22, 23, and 25. There was an amendment recommended for 26 by the Election Task Force that was also generally accepted. Therefore, your Reference Committee recommends that Recommendation 26 of Speakers Report 03 be adopted as amended.

RECOMMENDED FOR REFERAL

(22) RECOMMENDATION 1

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 1 of the Speakers Report 03 be referred.

HOD ACTION: Recommendation 1 of the Speakers Report 03 referred.

Recommendation 1: Policy G-610.020, Rules for AMA Elections, paragraph 18 be amended by addition and deletion to read as follows:
(18) Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMA, AMPAC, the AMA Foundation, and health related causes as approved by the Speaker no less than 30 days prior the Opening Session of the House of Delegates. ~~s~~Specialty society~~ies~~, state and regional delegation~~s and health related causes~~ pins that do not include any candidate identifier may only be worn by members of the designated group. ~~These~~ All pins should be small, and may not be worn on the badge~~ and distributed only to members of the designated group~~. ~~General distribution~~ No other ~~of any~~ pin, button or sticker is ~~dis~~allowed. (Modify Current HOD Policy)

Mixed testimony was heard. One amendment was proffered by the author to remove the thirty-day stipulation. An author addressed concerns regarding the distribution of pins, noting that pins can be distributed but the Speaker should be asked before doing so. Confusion was expressed about the difference between candidate and non-candidate pins. Online testimony was limited. Your Reference Committee recommends that Recommendation 1 of Speakers Report 03 be referred.

(23) RECOMMENDATION 4

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 4 of the Speakers Report 03 be referred.

HOD ACTION: Recommendation 4 of the Speakers Report 03 referred.

Recommendation 4: Policy G-610.020, Rules for AMA Elections, paragraph 19 be amended by addition and deletion to read as follows:
19) At any AMA meeting convened prior to the time period for active campaigning, campaign-related expenditures and activities shall be discouraged. Large campaign receptions, luncheons, and other formal campaign activities~~ and the distribution of campaign literature and gifts~~ are prohibited. ~~It is permissible for candidates seeking election to engage in individual outreach meant to familiarize others with a candidate's opinions and positions on issues.~~ Candidates may participate in meals provided by groups of which they are a member, such as a delegation or caucus breakfast/lunch,

when the meal has other purposes and does not include campaigning by the candidate or campaign team. (Modify Current HOD Policy)

Testimony for recommendations 3-6 was heard simultaneously. Testimony was heard in general support for Recommendations 3 and 5. Testimony in support noted that the point of these reforms is to improve objectivity and, if adopted, these processes can be refined and improved over time. Your Reference Committee notes that these proposed changes will level the playing field for those who do not have a large number of contacts and resources. Your Reference Committee heard mixed testimony on Recommendations 4 and 6, with a request for referral, citing these recommendations are too vague and potentially restrictive. Online testimony was also in favor of referral of Recommendations 4 and 6. Your Reference Committee recommends that Recommendation 4 of Speakers Report 03 be referred.

(24) RECOMMENDATION 6

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 6 of the Speakers Report 03 be referred.

HOD ACTION: Recommendation 6 of the Speakers Report 03 referred.

Recommendation 6: Only an announced candidate in a currently contested election may discuss their candidacy on an individual basis in private conversations from announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy including members of campaign teams, delegations or caucuses, and “friends.” (New HOD Policy)

Testimony for recommendations 3-6 was heard simultaneously. Testimony was heard in general support for Recommendations 3 and 5. Testimony in support noted that the point of these reforms is to improve objectivity and, if adopted, these processes can be refined and improved over time. Your Reference Committee notes that these proposed changes will level the playing field for those who do not have a large number of contacts and resources. Your Reference Committee heard mixed testimony on Recommendations 4 and 6, with a request for referral, citing these recommendations are too vague and potentially restrictive. Online testimony was also in favor of referral of Recommendations 4 and 6. Your Reference Committee recommends that Recommendation 6 of Speakers Report 03 be referred.

(25) RECOMMENDATION 8

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 8 of the Speakers Report 03 be referred.

HOD ACTION: Recommendation 8 of the Speakers Report 03 referred.

Recommendation 8: Policy G-610.020, Rules for AMA Elections, paragraph 16 be amended by addition and deletion to read as follows:

16) Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited. ~~A reduction in the volume of telephone calls and~~ Personal electronic communication and telephone calls from candidates and on behalf of candidates is discouraged~~encouraged~~. ~~The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of e~~Electronic messages ~~to contact electors should be minimized, and if used~~ must include a simple mechanism to allow recipients to opt out of receiving future messages. (Modify Current HOD Policy)

Testimony for recommendations 7-8 was heard simultaneously. Testimony in support noted that the recommendations would create a more equitable playing field. ETF testified that a survey indicated the majority of delegates thought advance electronic communications did not affect their vote. Opposing testimony noted that Recommendation 8 is self-contradictory, since it requires that there should be no mass outreach except if there is an option to opt-out, which suggests that mass outreach is acceptable. Other opposing testimony noted that democracy is best supported by candidates speaking directly to constituents and the current wording of the recommendations might prevent a candidate from speaking directly to members and prevent the candidate from becoming familiar with their concerns. Referral of Recommendation 8 was suggested to clarify how candidates are permitted to communicate with their colleagues. Your Reference Committee recommends that Recommendation 8 of Speakers Report 03 be referred.

(26) RECOMMENDATION 12

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 12 of the Speakers Report 03 be referred.

HOD ACTION: Recommendation 12 of the Speakers Report 03 referred.

Recommendation 12: Any “presentation” to an assembly, with or without being followed by a discussion, question and answer session, or a vote of the assembly, is an interview and subject to the rules on in-person interviews. (New HOD Policy)

Testimony for recommendations 9-12 was heard simultaneously. Testimony was heard in general support for Recommendations 9 and 10. Testimony for Recommendations 11 and 12 were mixed with multiple delegations citing the need for clarification. Your Reference Committee recommends that Recommendation 12 be referred.

(27) RECOMMENDATION 14

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 14 of the Speakers Report 03 be referred.

HOD ACTION: Recommendation 14 of the Speakers Report 03 referred.

Recommendation 14: Policy D-610.998, "Directives from the Election Task Force," paragraph 4 be amended by addition and deletion to read as follows:
4. The Speaker is encouraged to consider means to reduce the time spent during the HOD meeting on personal points by candidates after election results are announced. If adequate time remains on the agenda when the business session reconvenes after lunch on the day that the Election Session was held, the Speaker is encouraged to allow candidate personal points from the floor confined to the current time limit for testimony. ~~including collecting w~~Written personal points from candidates should be sent to the HOD office within 10 days following the close of the meeting to be shared electronically with the House~~ after the meeting or imposing time limits on such comments~~. (Modify Current HOD Policy)

Testimony for recommendations 13-14 was heard simultaneously. Testimony was generally in favor of Recommendation 14, however, there were some concerns about timing of points of personal privilege and concerns about this recommendation being too proscriptive. Therefore, your Reference Committee recommends that Recommendation 14 of Speakers Report 03 be referred.

(28) RECOMMENDATION 24

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 24 of the Speakers Report 03 be referred.

HOD ACTION: Recommendation 24 of the Speakers Report 03 referred.

Recommendation 24: Candidates, members of their campaign teams, including Federation staff, and HOD members will agree to be interviewed by the Speakers or members of the Election Committee who will identify themselves and the reason for the request. (New HOD Policy)

Testimony for recommendations 22-26 was heard simultaneously. Testimony was generally in support of these recommendations. There were no concerns with recommendations 22, 23, and 25. There was an amendment recommended for 26 by the Election Task Force that was also generally accepted. Concerns were raised regarding the definition of "campaign teams" in Recommendation 24. Testimony pointed out that the term "campaign teams" was vague and so further clarification concerning who should be considered part of such a team was requested. Therefore, your Reference Committee recommends that Recommendation 24 of Speakers Report 03 be referred.

RECOMMENDED FOR NOT ADOPTION

(29) RECOMMENDATION 27

RECOMMENDATION:

Your Reference Committee recommends that Recommendation 27 of the Speakers Report 03 <u>not be adopted.</u>

HOD ACTION: Recommendation 27 of the Speakers Report 03 <u>not adopted.</u>

Recommendation 27: A maximum of four endorsements may be obtained by each candidate. These endorsements must be from organizations in which the candidate is an active and dues paying member, where applicable. Endorsements may only be obtained from a candidate's state and one specialty organization and from caucuses in which the endorsing state or specialty society is a current member. Endorsements may not be obtained from the AMA Sections, Advisory Committees, or the Specialty and Service Society. (New HOD Policy)

Testimony for recommendations 27-29 was heard simultaneously. Your Reference Committee noted that the authors presented this recommendation identifying that the will of the House asked that this recommendation be reviewed, and they agreed. In addition, subsequent overwhelming testimony was in opposition to significant parts of the recommendation. Therefore, your Reference Committee recommends that Recommendation 27 of Speakers Report 03 not be adopted.

Joseph Adashek, MD
Nevada State Medical Association

Kenneth Andreoni, MD
American Society of Transplant Surgery

Cee Davis, MD, MPH
American College of OB/GYNs

Lisa Hatcher, MD
Indiana Medical Association

Tate Hinkle, MD, MPH
American Academy of Family Physicians

Elana Sitnik
Medical Student Section

Po-Yin Samuel Huang, MD
California Medical Association
Chair

DISCLAIMER

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-23)

Report of Reference Committee F

Rebecca L. Johnson, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Report of the House of Delegates Committee on the Compensation of the Officers

2. Council on Long Range Planning and Development Report 1 - Women Physicians Section Five-Year Review

3. Board of Trustees Report 13 - House of Delegates (HOD) Modernization

4. Speakers Report 2 - Extending Online Forum Trial Through A-24

5. Resolution 606 - Prevention of Healthcare-Related Scams

RECOMMENDED FOR REFERRAL

6. Board of Trustees Report 12 - American Medical Association Meeting Venues and Accessibility

7. Resolution 601 - Carbon Pricing to Address Climate Change

Amendments
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE COMPENSATION OF THE OFFICERS

RECOMMENDATION:

Your Reference Committee recommends that the recommendation in the Report of the House of Delegates Committee on the Compensation of the Officers be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in the Report of the House of Delegates Committee on the Compensation of the Officers adopted and the remainder of the Report filed.

The Committee on Compensation of the Officers recommends the following recommendation be adopted and the remainder of this report be filed:

That the President honorarium be increased by 3% and that the President-Elect, Immediate Past-President, Chair and Chair-Elect honoraria be increased by 2% effective July 1, 2024. These increases result in the following Honoraria:

POSITION	GOVERNANCE HONORARIUM
President	$298,865
Immediate Past President	$290,659
President-Elect	$290,659
Chair	$285,886
Chair-Elect	$211,630

Beyond an introduction of the report by the Committee on Compensation of the Officers, your Reference Committee received no further testimony; therefore, your Reference Committee recommends adoption of the report.

(2) COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT REPORT 1 - WOMEN PHYSICIANS SECTION FIVE-YEAR REVIEW

RECOMMENDATION:

Your Reference Committee recommends that the recommendation in Council on Long Range Planning and Development Report 1 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Council on Long Range Planning and Development Report 1 adopted and the remainder of the Report filed.

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Women Physicians Section through 2028 with the next review no later than the 2028 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

There was only supportive testimony of this item, which included comments encouraging the Council on Long Range Planning and Development (CLRPD) to consider amending our AMA Bylaws to provide for permanent section status after two successful five-year reviews of a delineated section. This concept garnered opposition that cited the benefits of having Sections continue to reflect on their structure, objectives, and accomplishments with a regular cadence.

Based on the CLRPD's positive review and the favorable testimony regarding the benefits of our AMA having a Women Physicians Section, your Reference Committee recommends adoption of the report.

(3) BOARD OF TRUSTEES REPORT 13 - HOUSE OF DELEGATES (HOD) MODERNIZATION

RECOMMENDATION:

Your Reference Committee recommends that the recommendation in Board of Trustees Report 13 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendation in Board of Trustees Report 13 adopted and the remainder of the Report filed.

In light of these considerations, your Board of Trustees recommends that:

1. Resolution 622-A-22 not be adopted.
2. Board of Trustees Report 20-A-23 be reaffirmed.

Board of Trustees Report 13 responds to referral of Resolution 622-A-22, HOD Modernization, which called on the AMA to convene a task force to determine how future House of Delegates (HOD) meetings may be updated to improve efficiency and effectiveness.

The Board of Trustees noted that there are ongoing task forces and planned activities to advance the modernization of the HOD, including:

- The Resolution Modernization Task Force Open Forum that is being hosted during the 2023 Interim Meeting;

- Speakers Report 2 - Extending Online Forum Trial Through A-24 calls for an extension of the Online Forum trial that began at the 2022 Annual Meeting. The outcome of the trial, and the success of subsequent adjustments that have been made, have yet to be determined; and

- Board of Trustees Report 20-A-23, Surveillance Management System for Organized Medicine Policies and Reports, reflects the AMA's commitment to invest in technology and other infrastructure changes to support tracking of HOD business.

Beyond the statement from the Board of Trustees, there was no testimony on this report; therefore, your Reference Committee recommends that Board of Trustees Report 13 be adopted.

(4) SPEAKERS REPORT 2 - EXTENDING ONLINE FORUM TRIAL THROUGH A-24

RECOMMENDATION:

Your Reference Committee recommends that the recommendation in Speakers Report 2 be <u>adopted</u> and the remainder of the Report be <u>filed</u>.

HOD ACTION: Recommendation in Speakers Report 2 <u>adopted</u> and the remainder of the Report <u>filed.</u>

That the trial established by Policy D-600.956 be continued through Annual 2024.

Speakers Report 2 calls for a continuation of the Online Forum trial through the 2024 Annual Meeting. The trial was established by Policy D-600.956, "Increasing the Effectiveness of Online Reference Committee Testimony."

Testimony was limited. The Chair of Resolution Modernization Task Force noted that the Online Forums were currently under discussion as a part of their work. A suggestion was offered in response that educational opportunities for resolution writing be made available.

Your Reference Committee noted that Online Forum testimony was generally supportive of extending the trial; therefore, your Reference Committee favors adoption of Speakers Report 2.

(5) RESOLUTION 606 - PREVENTION OF HEALTHCARE-RELATED SCAMS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 606 be adopted.

HOD ACTION: Resolution 606 adopted.

RESOLVED, that our American Medical Association encourage relevant parties to educate patients and physicians on healthcare-related scams, including how to avoid and report them. (New HOD Policy)

The author of Resolution 606 noted that healthcare related fraud has increased in recent years. Although individuals from various backgrounds have been affected, it was noted that the elderly population has been particularly vulnerable to fraudulent healthcare-related events. Testimony also highlighted that marginalized and minoritized populations were disproportionately impacted due to factors such as language barriers.

Your Reference Committees noted that Online Forum testimony supported patient and physician education on recognizing and avoiding healthcare related scams.

Therefore, your Reference Committee recommends that Resolution 606, Prevention of Healthcare-Related Scams, be adopted.

RECOMMENDED FOR REFERRAL

(6) BOARD OF TRUSTEES REPORT 12 - AMERICAN MEDICAL ASSOCIATION MEETING VENUES AND ACCESSIBILITY

RECOMMENDATION:

Your Reference Committee recommends that the recommendation in Board of Trustees Report 12 be referred with report back at the 2024 Annual Meeting.

HOD ACTION: Recommendation in Board of Trustees Report 12 referred with report back at the 2024 Annual Meeting.

The Board of Trustees therefore recommends that Policy G-630.140, "Lodging, Meeting Venues, and Social Functions," be amended by addition and deletion as follows in lieu of Resolution 610-A-22, Resolve 2, and Resolution 602-I-22, and the remainder of this report be filed:

AMA policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.

2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.

3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted ~~comprehensive~~ regulation or legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.

4. It is the policy of our AMA not to ~~hold meetings and/or primarily sponsored by our AMA, in cities, counties, or states, or~~ pay member officer or employee dues in any club, restaurant, or other institution that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.

5. Our AMA will not hold meetings organized by or primarily sponsored by our AMA at venues that have exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual

orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.

6. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.

7. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.

8. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.

9. Our AMA will utilize security experts to assess the safety risk for our attendees and guests at all venues. (Modify Current HOD Policy)

Board of Trustees Report 12 outlines issues with our AMA's current venue policies that have presented challenges in accommodating House of Delegates meetings. The report indicates that few venues currently meet AMA's policy requirements and can handle the size of an AMA meeting without requiring multiple hotels and a convention center. The Board of Trustees recommend amending AMA policy to allow for the selection of venues that comport with AMA policy independent of local and state legislation or policies.

The response to the report was mixed as the matter is complex. The majority of the testimony was in opposition and many supported referral. Most testimony was heard regarding Recommendations 4, 5, and 9.

Supportive testimony recognized the difficulty given the restrictions current policy places upon choice of meeting venues. There was also concern raised that boycotting a locale may not be an effective way to advocate for change.

Opposition to the report noted concerns, including but not limited to, personal safety and professional legal protections for provision of medical care. An amendment was proffered, which reads:

> It is the policy of our AMA to not hold meetings in cities, counties, or states that have laws in which 1) physicians travelling from other states could be placed at-risk of prosecution for providing evidence-based medical care; or 2) access to the full spectrum of urgent evidence-based medical care for AMA meeting attendees is restricted.

Your Reference Committee believes the additional language would address some of the concerns expressed by those who are opposed to changing current AMA policy, but the language is neither fully inclusive of minority or LGBTQ communities, nor does the language fully resolve the conundrum our Board of Trustees have outlined.

Your Reference Committee believes that referral of Board of Trustees Report 12 with a report back at the 2024 Annual Meeting would give our AMA an opportunity to address concerns that were raised in the testimony.

(7) RESOLUTION 601 - CARBON PRICING TO ADDRESS CLIMATE CHANGE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 601 be referred.

HOD ACTION: Resolution 601 referred.

RESOLVED, that our American Medical Association amend D-135.966 by addition and deletion to read as follows:

Declaring Climate Change a Public Health Crisis D-135.966

Our AMA:

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.

2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.

3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.

4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.

5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

6. Our AMA will advocate for federal and state carbon pricing systems and for US support of international carbon pricing.

7. Our AMA will work with the World Medical Association and interested countries' medical associations on international carbon pricing and other ways to address climate change. (Modify Current HOD Policy)

As was stated in Reference Committee F's Preliminary Document, testimony was mixed regarding AMA's role in addressing climate change by advocating for carbon pricing.

Those in support proffered that the United States healthcare sector is responsible for 8.5 percent of the country's greenhouse emissions, which is why our AMA already has policy declaring climate change to be a public health crisis. It is believed that advocating for carbon pricing would set the stage for AMA advocacy in this area and would serve to protect patients worldwide. Those opposed proffered that carbon pricing increases costs for those who can least afford it, and our AMA does not have the expertise to advise or contribute effectively to national or global policy on environmental legislation. There are many climate institutions that are much more experienced in helping to direct effective policy.

Given the cogent but divided testimony that emerged in the Online Forum and that continued during the on-site hearing, your Reference Committee recognizes this to be a complex issue. Your Reference Committee therefore recommends referral of Resolution 601 so our House of Delegates can be fully informed, by way of a report back, on the benefits and pitfalls of carbon pricing, including the possible consequences of our AMA endorsing a specific climate-saving alternative.

This concludes the report of Reference Committee F. I would like to thank Brooks F. Bock, MD, Robyn F. Chatman, MD, MPH, Robert A. Gilchick, MD, MPH, Richard F. Labasky, MD, MBA, Brandi N. Ring, MD, MBA, Michael B. Simon, MD, MBA, and all those who testified before the Committee.

Brooks F. Bock, MD
American College of Emergency Physicians

Richard F. Labasky, MD, MBA
Utah

Robyn F. Chatman, MD, MPH
Ohio

Brandi N. Ring, MD, MBA
American College of Obstetricians and Gynecologists

Robert A. Gilchick, MD, MPH
American College of Preventive Medicine

Michael B. Simon, MD, MBA
American Society of Anesthesiologists

Rebecca L. Johnson, MD
Florida
Chair

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-23)

Report of Reference Committee J

Man-Kit Leung, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 1 – ACO REACH
2. Resolution 801 – Improving Pharmaceutical Access and Affordability
3. Resolution 816 – Reducing Barriers to Gender-Affirming Care though Improved Payment and Reimbursement

RECOMMENDED FOR ADOPTION AS AMENDED

4. Council on Medical Service Report 2 – Health Insurers and Collection of Patient Cost-Sharing
5. Council on Medical Service Report 3 – Strengthening Network Adequacy
6. Council on Medical Service Report 5 – Medicaid Unwinding Update
7. Council on Medical Service Report 6 – Rural Hospital Payment Models
8. Resolution 804 – Required Clinical Qualifications in Determining Medical Diagnoses and Medical Necessity
9. Resolution 805 - Medication Reconciliation Education
10. Resolution 811 – Expanding Use of Medical Interpreters
11. Resolution 812 – Indian Health Service Improvements
12. Resolution 813 – Strengthening Efforts Against Horizontal & Vertical Consolidation
13. Resolution 817 – Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations
14. Resolution 819 – Amend Virtual Credit Card Policy

RECOMMENDED FOR ADOPTION IN LIEU OF

15. Resolution 803 – Improving Medicaid and CHIP Access and Affordability
16. Resolution 806 – Evidence-Based Anti-Obesity Medication as a Covered Benefit
    Resolution 820 – Affordability and Accessibility of Treatment of Overweight and Obesity
17. Resolution 807 – Any Willing Provider
18. Resolution 808 – Prosthodontic Coverage after Oncologic Reconstruction

19. Resolution 814 – Providing Parity for Medicare Facility Fees
20. Resolution 815 – Long-Term Care and Support Services for Seniors

RECOMMENDED FOR REFERRAL

21. Council on Medical Service Report 7 – Sustainable Payment for Community Practices
22. Resolution 802 – Improving Nonprofit Hospital Charity Care Policies
23. Resolution 818 – Amendment to AMA Policy on Health Care System Reform Proposals
24. Resolution 821 – Modernizing the AMA/Specialty Society RVS Update Committee (RUC) Processes

RECOMMENDED FOR REFERRAL FOR DECISION

25. Resolution 809 – Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion

Amendments

If you wish to propose an amendment to an item of business, click here: SUBMIT NEW AMENDMENT

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL SERVICE REPORT 1 -- ACO REACH

RECOMMENDATION A:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendation in the Report of the Council on Medical Service adopted and the remainder of the Report filed.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 822-I-22, and the remainder of the report be filed:

1. That our American Medical Association reaffirm the following policies:
    a. Policy H-160.915, “Accountable Care Organization Principles”
    b. Policy H-373.998, “Patient Information and Choice”
    c. Policy H-160.892, “Effects of Hospital Integrated System Accountable Care Organizations”
    d. Policy D-385.963, “Health Care Reform Physician Payment Models”
    e. Policy H-180.944, “Plan for Continued Progress Toward Health Equity”
    f. Policy H-160.912, “The Structure and Function of Interprofessional Health Care Teams”
    g. Policy D-385.952, “Alternative Payment Models and Vulnerable Populations” (Reaffirm HOD Policy)

Your Reference Committee heard testimony in support of Council on Medical Service Report 1. Testimony from the authors of the resolution prompting this report thanked the Council for its work and stated that they believe the report adequately addressed the concerns of their resolution. Additional testimony online and in-person was supportive of the report. There was testimony provided to refer the report back and that asked for the Council to do more on this topic, but your Reference Committee feels that the Council explicitly stated in the report that it will continue to monitor this issue and update the House as necessary. We feel that is sufficient, especially considering that the ACO REACH model began at the beginning of 2023 and data is not yet available on the outcomes of the model. Therefore, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted, and the remainder of the report be filed.

(2) RESOLUTION 801 -- IMPROVING PHARMACEUTICAL ACCESS AND AFFORDABILITY

RECOMMENDATION A:

Your Reference Committee recommends that Policy H-110.987 be reaffirmed in lieu of the first Resolve of Resolution 801.

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 801 be adopted.

HOD ACTION: Resolution 801 adopted.

RESOLVED, that our American Medical Association supports lowering out-of-pocket maximums in insurance plans including but not limited to ERISA plans, other forms of employer-sponsored insurance, plans offered on the ACA marketplace, TRICARE, and any other public or private payers (New HOD Policy); and be it further

RESOLVED, that our AMA oppose Direct Member Reimbursement plans, where patients pay the full retail costs of a prescription drug that they may then be reimbursed for, due to their potential to expose patients to significant out-of-pocket costs. (New HOD Policy)

Testimony on Resolution 801 was mixed. Your Reference Committee heard testimony in support of the spirit of the resolution, indicating the importance of ensuring that prescription medications are affordable and accessible to patients. Testimony was largely supportive of the second resolved clause and split on the first resolved clause. Specifically, testimony indicated concern that the adoption of the first resolved clause could unintentionally cause costs to be shifted to increased patient deductibles, premiums, or copays. Additionally, testimony reflected that your AMA has extensive policy indicating support and efforts to lower the cost of prescription drugs to patients. Therefore, your Reference Committee recommends that Policy H-110.987 be reaffirmed in lieu of the first resolved clause and the second resolved clause be adopted.

PHARMACEUTICAL COSTS H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and

efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

7. Our AMA supports legislation to shorten the exclusivity period for biologics.

8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.

9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.

10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.

14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation. (CMS Rep. 2, I-15; Reaffirmation in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17)

(3) RESOLUTION 816 -- REDUCING BARRIERS TO GENDER-AFFIRMING CARE THROUGH IMPROVED PAYMENT AND REIMBURSEMENT

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 816 be <u>adopted</u>.

HOD ACTION: Resolution 816 <u>adopted</u>.

RESOLVED, that our American Medical Association appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care. (Directive to Take Action)

Testimony on Resolution 816 was unanimously supportive. Your Reference Committee heard testimony regarding the importance of ensuring that gender-affirming care is accessible to patients. Additionally, testimony made it clear that the ask of this resolution was specifically centered on the issues of payment for providing gender-affirming care. Due to the unanimous supportive testimony, your Reference Committee recommends the adoption of Resolution 816.

RECOMMENDED FOR ADOPTION AS AMENDED

(4) COUNCIL ON MEDICAL SERVICE REPORT 2 -- HEALTH INSURERS AND COLLECTION OF PATIENT COST-SHARING

RECOMMENDATION A:

Your Reference Committee recommends that the first Recommendation of Council on Medical Service Report 2 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) support requiring health insurers to collect patient cost-sharing and pay physicians their full ~~contracted~~ allowable amount for the health care services provided, unless the physicians opt-out to collect such cost-sharing on their own. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Council on Medical Service Report 2 be amended by addition of a new third Recommendation to read as follows:

3. That our AMA work with interested state medical associations and national medical specialty societies to support the adoption of policies requiring insurers to collect patient cost-sharing and pay physicians their full allowable amount for the health care services provided, unless the physician should opt out. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Council on Medical Service Report 2 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support requiring health insurers to collect patient cost-sharing and pay physicians their full contracted amount for the

health care services provided, unless the physicians opt-out to collect such cost-sharing on their own. (New HOD Policy)

2. That our AMA reaffirm Policy H-165.838, which details the AMA's ongoing support for affordable and accessible insurance coverage. (Reaffirm HOD Policy)

Your Reference Committee heard supportive testimony in favor of the adoption of CMS Report 2. Testimony noted that the current system of physician cost-sharing collection is unfair to physicians. Additionally, testimony indicated support for ensuring that the burden of collecting cost-sharing is shifted to insurers. Testimony explained the importance of ensuring that the adoption of policies encouraging this shift in cost-sharing collection be supported by our AMA's work with state and specialty societies. Therefore, your Reference Committee recommends that CMS Report 2 be adopted as amended and the remainder of the report be filed.

(5) COUNCIL ON MEDICAL SERVICE REPORT 3 -- STRENGTHENING NETWORK ADEQUACY

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

1. That our American Medical Association (AMA) support establishment and enforcement of a minimum ~~federal~~ network adequacy standard requiring all health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorder, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Recommendation 2 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

2. That our AMA encourage the use of multiple criteria to evaluate the sufficiency of health plan ~~provider~~ physician networks, including but not limited to:
a. Minimum physician-to-enrollee ratios across specialties and subspecialties, including mental health and substance use disorder providers who are accepting new patients;
b. Minimum percentages of non-emergency ~~providers~~ physicians available on nights and weekends;
c. Maximum time and distance standards, including for enrollees who rely on public transportation;
d. Clear standard for network appointment wait times across specialties and subspecialties, developed in consultation with appropriate specialty societies, for both new patients and continuing care, that are appropriate to a patient's urgent and non-urgent health care needs; and
e. Sufficient ~~providers~~ physicians to meet the care needs of people experiencing economic or social marginalization, chronic or complex health conditions, disability, or limited English proficiency. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Recommendation 4 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

4. That our AMA support requiring health plans to report to regulators annually and prominently display network adequacy information so that it is available to enrollees and consumers shopping for plans, including:
a. The breadth of a plan's provider network, by county and geographic region or Metropolitan Statistical Area (MSA);
b. Average wait times for primary and behavioral health care appointments as well as common specialty and subspecialty referrals;
c. The number of in-network physicians treating substance use disorder who are ~~actively~~ accepting new patients in a timely manner, and the type of ~~opioid~~ substance use disorder medications offered;
d. The number of in-network ~~mental health physicians~~ psychiatrists and other mental health providers ~~actively~~ accepting new patients in a timely manner; ~~and~~
e. Instructions for consumers and physicians to easily contact regulators to report complaints about inadequate provider networks and other access problems~~.~~;
f. The number of physicians versus non-physician providers in the network overall and by specialty/practice focus; and
g. The number, geographic location, and medical specialty of any physician contracts terminated or added during the prior calendar year. (Modify HOD Policy)

RECOMMENDATION D:

Your Reference Committee recommends that Recommendation 6 in Council on Medical Service Report 3 be amended by addition and deletion to read as follows:

6. That our AMA affirm that in-network physicians who provide both in-person and telehealth services may count towards health plan network adequacy requirements on a ~~very~~ limited basis when their physical practice does not meet time and distance standards, based on regulator discretion, such as when there is a shortage of physicians in the needed specialty or subspecialty within the community served by the health plan. The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements. (New HOD Policy)

RECOMMENDATION E:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 3 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support establishment and enforcement of a minimum federal network adequacy standard requiring health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorder, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. (New HOD Policy)

2. That our AMA encourage the use of multiple criteria to evaluate the sufficiency of health plan provider networks, including but not limited to:
   a. Minimum physician-to-enrollee ratios across specialties, including mental health and substance use disorder providers who are accepting new patients;
   b. Minimum percentages of non-emergency providers available on nights and weekends;
   c. Maximum time and distance standards, including for enrollees who rely on public transportation;

d. Clear standard for network appointment wait times across specialties, for both new patients and continuing care, that are appropriate to a patient's urgent and non-urgent health care needs; and
e. Sufficient providers to meet the care needs of people experiencing economic or social marginalization, chronic or complex health conditions, disability, or limited English proficiency. (New HOD Policy)

3. That our AMA encourage the development and promulgation of network adequacy assessment tools that allow patients and employers to compare insurance plans and make informed decisions when enrolling in a plan. (New HOD Policy)

4. That our AMA support requiring health plans to report to regulators annually and prominently display network adequacy information so that it is available to enrollees and consumers shopping for plans, including:
    a. The breadth of a plan's provider network, by county and geographic region;
    b. Average wait times for primary and behavioral health care appointments as well as common specialty referrals;
    c. The number of in-network physicians treating substance use disorder who are actively accepting new patients, and the type of opioid use disorder medications offered;
    d. The number of in-network mental health physicians actively accepting new patients; and
    e. Instructions for consumers and physicians to easily contact regulators to report complaints about inadequate provider networks and other access problems. (New HOD Policy)

5. That our AMA encourage the use of claims data, audits, secret shopper programs, complaints, and enrollee surveys or interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy, and to identify other access or quality problems. (New HOD Policy)

6. That our AMA affirm that in-network physicians who provide both in-person and telehealth services may count towards health plan network adequacy requirements on a very limited basis when their physical practice does not meet time and distance standards, based on regulator discretion, such as when there is a shortage of physicians in the needed specialty within the community served by the health plan. The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements. (New HOD Policy)

7. That our AMA support regulation to hold health plans accountable for network inadequacies, including through use of corrective action plans and substantial financial penalties. (New HOD Policy)

8. That our AMA reaffirm Policy H-285.908, which supports state regulators as the primary enforcer of network adequacy requirements, sets parameters for out-of-network care and insurer termination of in-network providers, and advocates that plans be required to document to regulators that they have met requisite network adequacy standards including hospital-based physician specialties. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-285.904, which supports principles related to unanticipated out-of-network care and advocates that state regulators should enforce network adequacy standards through active regulation of health plans. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-285.902, which urges the Centers for Medicare & Medicaid Services to take several steps to ensure network adequacy, enhance provider directory accuracy, measure network stability, and effectively communicate provider network information to patients. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-285.911, which advocates that health insurance provider networks be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (Reaffirm HOD Policy)

Although several amendments were proffered, testimony was generally supportive of Council on Medical Service Report 3 and its approach to strengthening health plan network adequacy. The Council on Medical Service stated that the report recommendations support a multipronged approach by regulators that includes meaningful standards, transparency of network breadth, parameters for out-of-network care and effective monitoring and enforcement of existing standards. The Council on Medical Service also responded to several proffered amendments. The Council clarified that Recommendation 1 is intended to apply to *all* health plans and proposed the addition of "all" prior to "health plans" in this recommendation. Your Reference Committee concurs that, with this addition, a proposed amendment to add "including Medicaid managed care" to Recommendation 1 is not needed. Your Reference Committee also heard considerable testimony supportive of deleting "federal" before "network adequacy" in this recommendation. With this deletion, your Reference Committee believes proffered amendments to add "federally regulated" before health plans as well as the clause "and these standards be a guidance to state medical associations for state regulated plans" are no longer needed.

After reviewing proffered amendments to Recommendation 2, the Council proposed changing "provider" to "physician" in the stem clause and subparts 2(b) and 2(e) to address scope of practice concerns raised in Online Member Forum testimony. However, an amendment to delete Recommendation 2(b) was opposed by the Council which stressed that night and weekend availability is an important aspect of network adequacy that is already being fulfilled by many physician practices.

On Recommendation 4, testimony was mixed regarding use of the word "actively" before "accepting new patients" in subparts 4(c) and 4(d). A delegation suggested deletion of "actively," while the Council on Medical Service asked that it be retained to address the problem of provider directories including physicians who may be open to taking patients but do not have any openings for patients. Your Reference Committee heard both sides and recommends adding "in a timely manner" to Recommendations 4(c) and 4(d) which addresses the Council's concerns regarding the deletion of "actively." Your Reference Committee also heard testimony requesting additional health plan reporting requirements in Recommendation 4(f) and (g).

Your Reference Committee heard mixed testimony regarding deletion of “very limited basis” in Recommendation 6 with the Council on Medical Service arguing against deletion. As a compromise, your Reference Committee recommends deleting “very” before “limited basis.” Although one delegation testified against Recommendation 7, the Council testified that enforcement is the heart of this report and there are various ways these standards could be enforced when there are violations of network adequacy. Your Reference Committee agrees, and also incorporated a few minor amendments, including the addition of “metropolitan statistical area” to Recommendation 4(a), the addition of “and subspecialty/subspecialties” in Recommendations 2(a), 2(d), 4(b), and 6, and the use of “psychiatrists and other mental health providers” in Recommendation 4(d) instead of “mental health physicians.” Your Reference Committee recommends that Council on Medical Service Report 3 be adopted as amended.

(6) COUNCIL ON MEDICAL SERVICE REPORT 5 -- MEDICAID UNWINDING UPDATE

RECOMMENDATION A:

Your Reference Committee recommends that Recommendation 1 in Council on Medical Service Report 5 be amended by addition to read as follows:

1. That our American Medical Association (AMA) amend Policy H-290.955 by addition to read:

4. Our AMA encourages state Medicaid agencies to implement strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons, including automating renewal processes and following up with enrollees who have not responded to a renewal request, using multiple modalities, before terminating coverage.
5. Our AMA encourages states to provide continuity of care protections to patients transitioning from Medicaid or CHIP to a new health plan that does not include their treating physicians and other providers in network, and to recognize prior authorizations completed under the prior Medicaid/CHIP plan.
6. Our AMA encourages state Medicaid agencies to make Medicaid coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals through the state's portal or by other readily accessible means.
7. Our AMA supports additional strategies that respond to improper Medicaid disenrollments, such as requiring states to reinstate Medicaid coverage for individuals improperly terminated and encouraging states to pause disenrollments until the cause of the improper terminations has been mitigated.
8. Our AMA supports the establishment of special enrollment periods that allow those disenrolled from Medicaid to enroll in Affordable Care Act marketplace plans outside of annual open enrollment dates, and increased funding for health insurance navigators, when significant Medicaid/CHIP disenrollments occur.
9. Our AMA supports strategies to prevent states from improperly disenrolling physicians from Medicaid/CHIP. (Modify HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 5 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 5 adopted as amended and the remainder of the report filed.

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-290.955 by addition to read:
   4. Our AMA encourages state Medicaid agencies to implement strategies to reduce inappropriate terminations from Medicaid/CHIP for procedural reasons, including automating renewal processes and following up with enrollees who have not responded to a renewal request, using multiple modalities, before terminating coverage.
   5. Our AMA encourages states to provide continuity of care protections to patients transitioning from Medicaid or CHIP to a new health plan that does not include their treating physicians and other providers in network, and to recognize prior authorizations completed under the prior Medicaid/CHIP plan.
   6. Our AMA encourages state Medicaid agencies to make Medicaid coverage status, including expiration of current coverage and information on pending renewals, accessible to physicians, clinics, and hospitals through the state's portal or by other readily accessible means. (Modify HOD Policy)

2. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans and supports allowing for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy)

Testimony was very supportive of Council on Medical Service Report 5 as timely and appropriately focused on keeping patients covered during Medicaid unwinding. The Council on Medical Service introduced the report, noting that disenrollment rates in some states have been far too high and almost three out of every four disenrollments have been for procedural reasons. The Council also explained that little to no data on coverage transitions has been reported for individuals disenrolled from Medicaid and CHIP and the impact of the unwinding on coverage and uninsurance rates may not be fully understood until well after the unwinding period ends next summer.

To address the addition of two new clauses to Recommendation 1 proffered in the Online Member Forum, the Council proposed language capturing the intent of these amendments without calling on states and the Centers for Medicare & Medicaid Services (CMS) to take actions that have already been taken. The Council affirmed that any new policy established at this meeting will be cited in AMA advocacy with CMS. The Council said that a proffered amendment to Recommendation 1, subpart 4, which would encourage CMS and state medical associations to work with state Medicaid agencies, was unnecessary since this is already occurring and asked that Recommendation 1, subpart 4 be adopted as written. Your Reference Committee recommends adoption of the Council's proffered language as well as a third clause reflective of testimony heard regarding physicians in one state being improperly disenrolled from Medicaid during the unwinding period. Your Reference Committee recommends that Council on Medical Service Report 5 be adopted as amended.

(7) COUNCIL ON MEDICAL SERVICE REPORT 6 -- RURAL HOSPITAL PAYMENT MODELS

RECOMMENDATION A:

Your Reference Committee recommends that Council on Medical Service Report 6 be amended by addition of a fifth Recommendation to read as follows:

5. That our AMA support data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM). (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Recommendations in Council on Medical Service Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: That Resolve 5 of CMS Report 6 adopted as amended to read as follows and the remainder of the report filed:

5. That our AMA ~~support~~ report back no later than A-26 on data analysis and appropriate recommendations for improved rural hospital payments based on innovative payment models such as the Pennsylvania Rural Health Model (PARHM). (~~New HOD~~ Policy Directive for action)

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support and encourage efforts to develop and implement proposals for improving payment models to rural hospitals. (New HOD Policy)

2. That our AMA reaffirm Policy H-465.978, which recognizes the payment bias toward rural hospitals as a factor in rural health disparities and encourages solutions to help solve this bias. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-465.998, which advocates for improvements to the payment and health care service delivery in rural hospitals. (Reaffirm HOD Policy)

4. That our AMA rescind Policy D-465.996 as having been accomplished with this report. (Rescind HOD Policy)

Your Reference Committee heard supportive testimony regarding Council on Medical Service Report 6. One amendment suggested the addition of a fifth recommendation. The testimony indicated the importance of ensuring that rural hospitals are able to remain viable and provide care to the vulnerable communities they serve. Testimony indicated that future studies and reports should include discussions on maternal health in rural settings. Finally, testimony indicated a desire for ongoing support of both data collection and innovative payment models by your AMA. Therefore, your Reference Committee recommends that CMS Report 6 be adopted as amended and the remainder of the report be filed.

(8) RESOLUTION 804 -- REQUIRED CLINICAL QUALIFICATIONS IN DETERMINING MEDICAL DIAGNOSES AND MEDICAL NECESSITY

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 804 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association (AMA) advocate for change to existing public and private processes including Utilization Management, Prior Authorization, Medicare and Medicaid audits, Medicare and State Public Health surveys of clinical care settings, to only allow physicians ~~clinicians~~ with adequate and commensurate training, scope of practice, and licensure to determine accuracy of medical diagnoses and assess medical necessity. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 804 be amended by addition of a new Resolve to read as follows:

RESOLVED, that to prevent a delay in care, our AMA support favoring the treating physician's judgment if the reviewing physician is not available. (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 804 be adopted as amended.

HOD ACTION: Resolution 804 adopted as amended.

RESOLVED, that our American Medical Association advocate for a change to existing public and private processes including Utilization Management, Prior Authorization, Medicare and Medicaid audits, Medicare and State Public Health surveys of clinical care settings, to only allow clinicians with adequate and commensurate training, scope of practice, and licensure to determine accuracy of medical diagnoses and assess medical necessity. (Directive to Take Action)

Your Reference Committee heard supportive testimony for Resolution 804, which pointed out that prior authorization was created to reduce the use of low-value treatments, but has instead become a tool to prevent patients in need from getting treatments recommended by qualified and dedicated physicians. The authors testified that the intent of the resolution

was not necessarily prior authorization but, rather, reducing or even eliminating situations where nurses in facilities make determinations regarding physicians' medical diagnoses and assessment of medical necessity. The Council on Medical Service agreed that physicians should only be audited or surveyed by peers with adequate and commensurate training, scope of practice, and licensure to determine accuracy of medical diagnoses and assess medical necessity, and offered amendments equivalent to the language outlined in Section V of our AMA *Ensuring Transparency in Prior Authorization Act* model bill. Another amendment was proffered to require that if the reviewing party with equivalent expertise is not available, the decision should favor the treating physician. Therefore, your Reference Committee recommends that Resolution 804 be adopted as amended.

(9) RESOLUTION 805 -- MEDICATION RECONCILIATION EDUCATION

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 805 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~work with Centers for Medicare and Medicaid Services and other appropriate organizations to~~ encourage the study of current medication reconciliation practices across transitions of care ~~with dissimilar electronic health records~~ to evaluate the impact on patient safety and quality of care, including when there are dissimilar electronic health records, and to develop strategies, including ~~determine~~ the potential need for additional training, to reduce medical errors and ensure patient safety and quality of care (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 805 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~work with other appropriate organizations to determine whether~~ support education for relevant health care providers ~~physicians-in-training is sufficient~~ to attain the medication reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care ~~and provide recommendations for action as applicable~~. (Directive to Take Action)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 805 be <u>adopted as amended</u>.

HOD ACTION: Resolve two of Resolution 805 <u>referred</u> and the remainder of the resolution <u>adopted as amended</u>.

RESOLVED, that our American Medical Association work with Centers for Medicare & Medicaid Services and other appropriate organizations to study current medication-reconciliation practices across transitions of care with dissimilar electronic health records to evaluate the impact on patient safety and quality of care, and to determine the potential need for additional training to reduce medical errors and ensure patient safety and quality of care (Directive to Take Action); and be it further

RESOLVED, that our American Medical Association work with other appropriate organizations to determine whether education for physicians-in-training is sufficient to attain the medication reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care and provide recommendations for action as applicable. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 805. Testimony indicated the importance of the spirit of the resolution and emphasized how vital appropriate medication reconciliation is to patient safety. Additionally, testimony indicated that this is not an issue around the education of physicians, but rather the challenges that can occur for physicians working toward medication reconciliation. Testimony indicated that these challenges are especially burdensome when electronic health records are dissimilar. Therefore, your Reference Committee recommends the adoption of Resolution 805 as amended.

(10) RESOLUTION 811 -- EXPANDING THE USE OF MEDICAL INTERPRETERS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 811 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association amend H-160.924, "Use of Language Interpreters in the Context of the Patient-Physician Relationship," by addition and deletion as follows:

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924 27
1. AMA policy is that:
(~~1~~a) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care;
(b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;
(c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care;
(d) patients ~~have expanded~~ should have access to documentation and communications ~~available~~ in their preferred language, when feasible and in a manner that requires all payers to directly pay for such services; ~~including appointment reminder calls/messages, post-appointment summaries, and electronic medical records, through access to trained interpreter and translator services;~~ and
(~~d~~e) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

3. Our AMA encourage hospital systems, clinics, residency programs, and medical schools to ~~promote and incentivize~~ pursue opportunities for physicians, staff, and trainees to voluntarily receive medical interpreter training and certification should they desire. (Modify Current HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 811 be adopted as amended.

HOD ACTION: Resolution 811 adopted as amended.

RESOLVED, that our American Medical Association amend H-160.924, "Use of Language Interpreters in the Context of the Patient-Physician Relationship," by addition as follows:

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924

1. AMA policy is that: (1) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care; (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care; d) patients have expanded access to documentation and communications available in their preferred language, including appointment reminder calls/messages, post-appointment summaries, and electronic medical records, through access to trained interpreter and translator services; and (~~d~~e) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

3. Our AMA encourage hospital systems, clinics, residency programs, and medical schools to promote and incentivize opportunities for physicians, staff, and trainees to receive medical interpreter training and certification. (Modify Current HOD Policy)

Testimony on Resolution 811 was largely supportive of the intent of the resolution to ensure that patients have access to communications and care in their preferred language. However, testimony did indicate concerns around the burden that these services may place on physicians and their practices and around the feasibility of accessing certified medical interpreters of uncommonly spoken languages. Testimony indicated particular concern around the financial burden that could result should practices be required to implement these translation changes. Additionally, testimony outlined the vital nature of quality interpreters in health care. Testimony indicated that patients who have access to quality interpreters have better outcomes. Finally, concern was voiced that relying upon physicians, staff, and trainees could amount to an increased burden. Therefore, your Reference Committee recommends Resolution 811 be adopted as amended.

(11) RESOLUTION 812 -- INDIAN HEALTH SERVICE IMPROVEMENTS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 812 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support ~~advocate to permanently~~ an increase to the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) and encourage state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 812 be deleted.

~~**RESOLVED, that our AMA encourage state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs; and be it further**~~

RECOMMENDATION C:

Your Reference Committee recommends that the third Resolve of Resolution 812 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support ~~advocate for~~ greater physician and federal oversight of the IHS National Core Formulary, ensuring that the pharmacy benefit for American Indian and Alaska Native patients represents the standard-of-care for prevalent diseases and medical conditions in this population and includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be available for use by physicians in deciding the best treatment options for their patients; and be it further

RECOMMENDATION D:

Your Reference Committee recommends that the fourth Resolve of Resolution 812 be deleted.

~~**RESOLVED, that our AMA work with IHS and appropriate agencies and organizations to ensure that their National Core Formulary includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients; and be it further**~~

RECOMMENDATION E:

Your Reference Committee recommends that the fifth Resolve of Resolution 812 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support permanent ~~re~~authorization of the Special Diabetes Program for Indians and the Special Diabetes Program for Type 1 Diabetes Research along with inflationary increases for public health and health profession grants for physicians sponsored by IHS.~~; and be it further~~

RECOMMENDATION F:

Your Reference Committee recommends that the sixth Resolve of Resolution 812 be deleted.

~~**RESOLVED, that our AMA support biannual inflationary increases for public health and health profession grants sponsored by IHS.**~~

RECOMMENDATION G:

Your Reference Committee recommends that Resolution 812 be adopted as amended.

HOD ACTION: Resolution 812 adopted as amended.

RESOLVED, that our American Medical Association advocate to permanently increase the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for greater physician and federal oversight of the IHS National Core Formulary, ensuring that the pharmacy benefit for American Indian and Alaska Native patients represents the standard-of-care for prevalent diseases and medical conditions in this population (Directive to Take Action); and be it further

RESOLVED, that our AMA work with IHS and appropriate agencies and organizations to ensure that their National Core Formulary includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients (Directive to Take Action); and be it further

RESOLVED, that our AMA support permanent reauthorization of the Special Diabetes Program for Indians (New HOD Policy); and be it further

RESOLVED, that our AMA support biannual inflationary increases for public health and health profession grants sponsored by IHS. (New HOD Policy)

Your Reference Committee heard unanimously supportive testimony on Resolution 812. Commenters noted that the COVID-19 pandemic has highlighted the disparities and shortcomings of the Indian Health Service (IHS), largely due to chronic underfunding of the agency. The three main tenets of the resolution (i.e., 100% of FMAP for IHS, oversight of the National Core Formulary, and permanent authorization of the Special Diabetes Program for Indians) will lead to enhanced and directed advocacy of priorities as identified by American Indian/Alaska Native-serving health organizations and other important stakeholders. The Council on Medical Service recognized the importance of the IHS, as it provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Alaska Natives who belong to 574 federally recognized Tribes. While the IHS was previously the only federal health program without advance appropriations, the Department of Health and Human Services successfully secured advance appropriations for IHS for Fiscal Year 2024. Therefore, starting in 2024, the majority of IHS-funded programs, including Tribal Health Programs and Urban Indian Organizations, will remain funded and operational in the event of a lapse of appropriation. The Council proffered amendments to streamline the resolution’s asks, which several commenters supported. Your Reference Committee recommends that Resolution 812 be adopted as amended.

(12) RESOLUTION 813 -- STRENGTHENING EFFORTS AGAINST HORIZONTAL & VERTICAL CONSOLIDATION

RECOMMENDATION A:

Your Reference Committee recommends that the second Resolve of Resolution 813 be amended by deletion to read as follows:

RESOLVED, that our AMA oppose not-for-profit firm immunity from FTC competition policy enforcement in the health care sector~~, which represent the majority of U.S. hospitals~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolve of Resolution 813 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support appropriate ~~lowering the~~ transaction value threshold~~s~~, including cumulative transaction values, for merger reporting in health care sectors to ensure that vertical acquisitions in health care do not evade antitrust scrutiny (New HOD Policy); and be it further

RECOMMENDATION C:

Your Reference Committee recommends that the fourth Resolve of Resolution 813 be amended by deletion to read as follows:

RESOLVED, that our AMA support health care-specific advocacy efforts that will strengthen antitrust enforcement in the health care sector through multiple mechanisms~~, including but not limited to a) simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) encouraging the FTC to leverage its authority to increase the frequency of challenges in consolidated health care markets~~. (New HOD Policy)

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 813 be adopted as amended.

HOD ACTION: Resolution 813 adopted as amended.

RESOLVED, that our American Medical Association advocate to adequately resource competition policy authorities such as the Federal Trade Commission (FTC) and Department of Justice Antitrust Division to perform oversight of health care markets (Directive to Take Action); and be it further

RESOLVED, that our AMA oppose not-for-profit firm immunity from FTC competition policy enforcement in the health care sector, which represent the majority of U.S. hospitals (New HOD Policy); and be it further

RESOLVED, that our AMA support lowering the transaction value threshold for merger reporting in health care sectors to ensure that vertical acquisitions in health care do not evade antitrust scrutiny (New HOD Policy); and be it further

RESOLVED, that our AMA support health care-specific advocacy efforts which will strengthen antitrust enforcement in the health care sector through multiple mechanisms, including but not limited to a) simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) encouraging the FTC to leverage its authority to increase the frequency of challenges in consolidated health care markets. (New HOD Policy)

Testimony was mixed on Resolution 813. Testimony in support of Resolution 813 stated that countless studies have documented the problems associated with health care consolidation, including increasing costs while limiting access to care.

There was concern that as written, resolved clauses 3 and 4 could lead to unintended consequences, specifically that lowering the threshold for merger review and reporting could increase the burden on small- and medium-sized physician practices that may wish to merge and remain small- or medium-sized practices. Lowering the threshold could lead to costs and administrative burdens that these practices would not be able to afford.

The Council on Medical Service shared the concerns raised in previous testimony and proposed several amendments to the resolved clauses to address these and prevent the unintended consequence of putting the burden on small- and medium-sized physician practices if the transaction value threshold is lowered. The Council recommended striking “which represent the majority of U.S. hospitals” from the second resolved clause, which was deemed unnecessary. The Council recommended amending the third resolved clause to support a continuous, cumulative lookback period to address the concern that if a hospital or a private equity firm acquires one physician practice, the value may fall below the threshold, but if it acquires many practices over time, eventually the value of all these transactions will reach the threshold set by the FTC. The Council amendment removed support for broadly lowering the threshold and put safeguards in place to protect small- and medium-sized private physician practices. Finally, the Council recommended striking “through multiple mechanisms, including but not limited to a) simplifying the evidentiary burden on plaintiffs and shifting the evidentiary burden to defendants and b) encouraging the FTC to leverage its authority to increase the frequency of challenges in consolidated health care markets.” This streamlines the fourth resolved clause by removing unnecessary language.

The original authors of the resolution did not support striking the text in the fourth resolved clause, stating that simplifying the evidentiary burden is an essential part of this resolution. However, your Reference Committee agreed with previous testimony that shifting the evidentiary burden to defendants still has the potential to harm physicians, especially those in small- and medium-sized practices.

Your Reference Committee agreed with the amendments proposed by the Council. Therefore, your Reference Committee recommends that Resolution 813 be adopted as amended.

(13) RESOLUTION 817 -- EXPANDING AMA PAYMENT REFORM WORK AND ADVOCACY TO MEDICAID AND OTHER NON-MEDICARE PAYMENT MODELS FOR PEDIATRIC HEALTH CARE AND SPECIALTY POPULATIONS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 817 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~examine and report back on~~ support demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolve of Resolution 817 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations, such as pediatric populations, ~~health care~~ and medical and surgical specialties and continue to advocate that the Center for Medicare and Medicaid Innovation implement physician-developed payment models; (New HOD Policy)

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 817 be adopted as amended.

HOD ACTION: Resolution 817 adopted as amended to read as follows:

RESOLVED, that our American Medical Association ~~examine and report back on~~ support appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena (Directive to Take Action); and be it further

RESOLVED, that our AMA extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts (Directive to Take Action); and be it further

RESOLVED, that our AMA support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations~~, such as~~ including pediatric populations, ~~health care~~ and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models (New HOD Policy); and be it further

RESOLVED, that our AMA consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care (New HOD Policy); and be it further

RESOLVED, that our AMA support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account. (New HOD Policy)

RESOLVED, That our American Medical Association examine and report back on demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena (Directive to Take Action); and be it further

RESOLVED, That our AMA extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts (Directive to Take Action); and be it further

RESOLVED, That our AMA support and work with medical specialty societies who are developing alternative payment models for pediatric health care (New HOD Policy); and be it further

RESOLVED, That our AMA consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care. (New HOD Policy)

Testimony strongly supported Resolution 817 and the need to prioritize increasing Medicaid payment rates, which will in turn improve Medicaid enrollees' access to care and help maintain the solvency of physicians who care for these patients. Testimony also noted that pediatric patients are often after-thoughts in discussions of alternative payment models (APMs) and that APMs designed for adults should not be applied to children. Speakers were adamant that our AMA should help with both Medicaid payment and APMs for populations served by the Medicaid program.

The Council on Medical Service suggested that the first resolved could be amended to "support" demonstration projects and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena and that "examination and report back" are not needed. The Council also noted that, at every opportunity and in every comment letter to CMS in response to proposed Medicaid/CHIP rulemaking, our AMA advocates for improved Medicaid payment rates that are at a minimum equal to Medicare rates.

The Council on Legislation offered amendments to the third and fourth resolved clauses, noting that, since Medicaid payment decisions are generally made at the state level, the best way for our AMA to help AAP achieve its payment reform goals is by supporting multi-payer models and specialty society-developed APMs. Testimony by the Council highlighted several examples of our AMA working with and providing support to medical specialty societies on APMs, including support for APM proposals developed by the American Academy of Family Physicians and the American College of Physicians on advanced primary care and medical neighborhoods and improving the Primary Care First model. According to the Council's testimony, our AMA has also worked closely with allergists on a payment model for patients with asthma, with the American Society of Addiction Medicine on a payment model for opioid use disorder treatment, and with the American College of Emergency Physicians to advocate for a model to support emergency physicians in preventing inpatient admissions and improving safe patient discharges back to their communities. The amendment to the third resolved clause proffered by the Council reflects this ongoing work. The Council suggested amending the fourth resolved clause to reflect AMA federal and state advocacy efforts that continually highlight access problems that stem from inadequate Medicaid payment rates while urging the establishment of a payment floor that is at a minimum 100% of Medicare rates.

Your Reference Committee supports the second and fourth resolved clauses as written and believes amendments to the first and third resolved clauses are consistent with the intent of Resolution 817. Your Reference Committee recommends that Resolution 817 be adopted as amended.

(14) RESOLUTION 819 -- AMEND VIRTUAL CREDIT CARD POLICY

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 819 be amended by deletion to read as follows:

~~**RESOLVED, that our American Medical Association make no further statements regarding the "legality" of Virtual Credit Cards (VCCs) (New HOD Policy); and be it further**~~

RECOMMENDATION B:

Your Reference Committee recommends that the third Resolve of Resolution 819 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA advocate on behalf of physicians and plainly state that ~~in no circumstance is~~ it is not advisable or beneficial for medical practices to get paid by VCCs; and be it further~~.~~

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 819 be amended by addition of a new Resolve to read as follows:

RESOLVED, that our AMA engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at: (1) the issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services, (2) CMS enforcement activities related to this issue, and (3) physician access to a timely no fee EFT option as an alternative to virtual credit cards (VCCs).

RECOMMENDATION D:

Your Reference Committee recommends that Resolution 819 be adopted as amended.

RECOMMENDATION E:

Your Reference Committee recommends that the title of Resolution 819 be changed to read as follows:

AMEND VIRTUAL CREDIT CARD AND ELECTRONIC FUNDS TRANSFER FEE POLICY

HOD ACTION: Resolution 819 adopted as amended with a change in title.

RESOLVED, that our American Medical Association (AMA) make no further statements regarding the "legality" of Virtual Credit Cards (VCCs) (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for legislation or regulation that would prohibit the use of VCCs for electronic health care payments (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate on behalf of physicians and plainly state that in no circumstance is it advisable or beneficial for medical practices to get paid by VCCs (Directive to Take Action).

Your Reference Committee heard robust testimony on Resolution 819, with several commenters recommending amendments. One concern was raised pertaining to the possible antitrust implications of the third resolved clause. Several commenters stated that physicians should have the freedom to accept these payments if they desire, but it should be voluntary (i.e., a requirement for a voluntary opt-in, not a need for an opt out). The author of the resolution and several additional commenters supported alternative language focused more directly on advocacy to the Department of Health & Human Services and the Centers for Medicare & Medicaid Services (CMS). Those in support of alternative language indicated that the only solution may be to sue CMS for violations of the Administrative Procedure Act, including the need to overturn illegal regulations that allow these practices, while another provided a 2016 example where Maryland was able to pass a law to make VCCs an opt-in for physicians. Yet another referenced a 2014 Interim Meeting adopted resolution (225-I-14), which has not resulted in any significant change in VCC payments in their practice. One commenter noted that VCCs are loopholes that insurance companies have used to exploit physicians in private practice and that many physicians are not even aware that they are being charged "credit card processing fees" to receive their payments.

The Council on Medical Service testified that it wholeheartedly agrees that virtual credit cards have a significant negative impact on physician practices, both in terms of finances and administrative burdens. Our AMA has strongly advocated for increased guidance and transparency, along with fair business practices, regarding virtual credit card payments

over the past 10 years. The Council clarified that virtual credit cards are not currently illegal. A 2012 Interim Final Rule on electronic funds transfer (EFT) issued by the Centers for Medicare & Medicaid Services (CMS) allows payment by virtual credit cards, and CMS reiterated in guidance released last year that "adopted HIPAA EFT and ERA standards permit health plans to pay claims by VCC." Therefore, the issue at hand is what would be the most impactful policy for our AMA to adopt to address this issue. Creating policy stating that our AMA shall refer to virtual credit cards as illegal will not change the current reality or protect practices from the financial harms imposed by this payment method. Accordingly, the Council supported the amendments proffered in the Online Member Forum, that would establish new policy calling on our AMA to advocate for legislation or regulation that would prohibit the use of VCCs for electronic health care payments. In addition, the proffered amendment addresses a separate but related issue of add-on service fees for standard EFT payments. By advocating for legislation or regulation to address fees with standard EFT payments, our AMA would be taking action to ensure that physicians have access to free and timely standard electronic payments – which was the initial intent of the HIPAA EFT standard. Therefore, your Reference Committee recommends that Resolution 819 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(15) RESOLUTION 803 -- IMPROVING MEDICAID AND CHIP ACCESS AND AFFORDABILITY

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 803 be adopted in lieu of Resolution 803.

RESOLVED, That our American Medical Association amend Policy H-290.982[10], "Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured," by addition and deletion to read as follows:

AMA policy is that our AMA … (10) supports ~~modest co-pays or income-adjusted premium shares for~~ continued state flexibility to waive copayments or impose minimal copayment amounts that are based on income and in limited circumstances including non-emergent, non-preventive services, excluding children, who should not be subject to cost-sharing in Medicaid ~~as a means of expanding access to coverage for currently uninsured individuals~~ (Modify Current HOD Policy)

HOD ACTION: Resolution 803 adopted as amended to read:

RESOLVED, that our American Medical Association oppose premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our American Medical Association amend Policy H-290.982[10], "Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured," by addition and deletion to read as follows:

AMA policy is that our AMA … ~~(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;~~ (Modify Current HOD Policy) and be it further

RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries. (New HOD Policy)

RESOLVED, that our American Medical Association oppose premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries (New HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-290.982 "Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured" by deletion as follows;

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions;

providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

~~(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals~~; (Modify Current HOD Policy) and be it further

RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums to Medicaid beneficiaries. (New HOD Policy)

Testimony on Resolution 803 was mixed, with some speakers expressing strong support for eliminating Medicaid copays and citing studies that have shown that even nominal cost-sharing can create barriers to care. Additional supportive testimony noted that cost-sharing requirements pose significant hardships for many Medicaid enrollees, increase emergency department utilization, and have no impact on appropriateness of care being sought.

Testimony in opposition to Resolution 803 was supportive of modest Medicaid copays in certain situations to discourage inappropriate utilization of services, which is consistent with Policy H-290.982[10]. Further testimony was heard on a state’s successful use of copay requirements for the Medicaid expansion population.

The Council on Medical Service offered alternate language to amend Policy H-290.982[10] as a potential compromise between those supportive and opposed to Resolution 803 and the elimination of all Medicaid cost-sharing. The Council noted that AMA policy (Policies D-165.942 and D-165.966) has for decades supported state flexibility to develop and test different Medicaid models, which allows our AMA to support or oppose waivers on a state-by-state basis. The Council also pointed out that state and federal Medicaid administrators will not be receptive to calls to eliminate all cost-sharing in Medicaid at this time, since everyone—including advocacy groups—are completely focused on and overwhelmed by the unwinding. The Council on Legislation testified in support of this alternate language and said that adoption of the resolution as written might eliminate opportunities for our AMA to meaningfully engage in Medicaid waiver design. The Council further stated that resolved clauses 1 and 3 likely exceed the statutory authority granted to the Centers for Medicare & Medicaid Services. Your Reference Committee believes the alternate language suggested by the Council on Medical Service reflects a reasonable middle

ground and recommends that Alternate Resolution 803 be adopted in lieu of Resolution 803.

(16) RESOLUTION 806 -- EVIDENCE-BASED ANTI-OBESITY MEDICATIONS AS A COVERED BENEFIT
RESOLUTION 820 -- AFFORDABILITY AND ACCESSIBILITY OF TREATMENT OF OVERWEIGHT AND OBESITY

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 806 be adopted in lieu of Resolution 806 and Resolution 820.

RESOLVED, that our American Medical Association amend Policy H-150.953, "Obesity as a Major Public Health Problem," by addition of a new clause to read as follows:

9. Urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

HOD ACTION: Alternate Resolution 806 adopted in lieu of Resolution 806 and Resolution 820.

Resolution 806

RESOLVED, that our American Medical Association amend Policy H-150.953, "Obesity as a Major Public Health Problem," by addition as follows:

9. Urge national payers to ensure coverage parity for FDA-approved anti-obesity medications without exclusions or additional carve-outs. (Modify Current HOD Policy)

Resolution 820

RESOLVED, that our American Medical Association join in efforts to convince Congress to address the affordability and accessibility of prevention and evidence-based treatment of obesity across the United States as well as, urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to: 1. Revise their policies to ensure that prevention and evidence-based treatment of obesity is covered for patients who meet the appropriate medical criteria; and 2. Ensure that insurance policies in their states do not discriminate against potential evidence-based treatment of obese patients based on age, gender, race, ethnicity, socioeconomic status. (Directive to Take Action)

Your Reference Committee heard overwhelming testimony in support of combining Resolutions 806 and 820, including support from both authors. There was strong support for amending AMA Policy H-150.953 to ensure coverage parity for evidence-based treatment of obesity, including medications. While concerns were raised regarding the cost

of covering anti-obesity medications, your Reference Committee believes existing policy adequately addresses these concerns. For these reasons, your Reference Committee recommends Alternate Resolution 806 be adopted in lieu of Resolution 820.

(17) RESOLUTION 807 – ANY WILLING PROVIDER

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 807 be adopted in lieu of Resolution 807.

RESOLVED, that our American Medical Association support improved physician access to provider networks by continuing to work with interested state medical associations to enact our AMA Physicians Fair Process Protections model act, which requires health insurers to provide physicians with due process prior to making changes to, terminating physicians from, or denying physicians participation in, a provider network. (New HOD Policy)

HOD ACTION: Original Resolution 807 adopted.

RESOLVED, that our American Medical Association shall develop and advocate for model "Any Willing Provider" legislation nationwide, enabling all physicians to build successful practices and deliver quality patient care (Directive to Take Action); and be it further

RESOLVED, that our AMA shall lobby for federal regulations or legislation mandating insurers to implement "Any Willing Provider" policies as a prerequisite for participating in federally-supported programs (Directive to Take Action); and be it further

RESOLVED, that our AMA will work with state and national organizations, including insurance companies, to promote and support the adoption of "Any Willing Provider" laws, and will monitor the implementation of these laws to ensure that they are having a positive impact on access to quality health care. (Directive to Take Action)

Testimony on Resolution 807 was mixed. Supportive testimony indicated that this resolution could have a positive effect on maintaining private practice viability, especially for early career physicians. Comments made in opposition to mandating “any willing provider” policies indicated that these policies could result in negative consequences such as acceptance of non-physicians or physicians who do not provide high quality care. Testimony indicated that these policies may also be problematic for physician-led groups and integrated health systems and that our AMA’s focus should be on competition in insurer markets and ensuring network adequacy. Testimony also pointed out that insurance companies will never adopt “any willing provider” policies, as requested in the third resolved clause.

The Council on Medical Service highlighted existing AMA model legislation, which is requested in the first resolved clause, and proposed alternate language supporting the

Physicians Fair Process Protections model act, which requires health insurers to provide physicians with due process prior to making changes to, terminating physicians from, or denying physicians participation in, a provider network. The Council also pointed to several strong policies (including Policies H-285.984, D-285.972 and H-285.908) intended to protect physicians from unfairly being excluded from provider networks.

The Council on Legislation testified in support of the alternate language and the existing model bill which was written to provide a high level of fair process to physicians. The Council noted that “any willing provider” policies are supported by physicians and medical societies in some states; however, other states may have competing views on the effectiveness and appropriateness of such laws. Amendments proffered online and in-person suggested replacing “any willing provider” with “any willing physician” or “any qualified physician;” however, additional testimony emphasized that “any willing provider” is the commonly recognized term used across states. Your Reference Committee agrees and favors alternate language supportive of our AMA’s model bill and reflective of testimony highlighting the need for improved physician access to provider networks. Accordingly, your Reference Committee recommends adoption of Alternate Resolution 807 in lieu of Resolution 807.

(18) RESOLUTION 808 -- PROSTHODONTIC COVERAGE AFTER ONCOLOGIC RECONSTRUCTION

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 808 be adopted in lieu of Resolution 808.

RESOLVED, that our American Medical Association amend Policy H-475.992, "Definitions of "Cosmetic" and "Reconstructive" Surgery," by addition and deletion:

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992

(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, including prosthodontic reconstruction (including dental implants) caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. ~~It is generally performed to improve function, but may also be done to approximate a normal appearance~~. (2) Our AMA supports that reconstructive surgery be covered by all insurers and encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.

HOD ACTION: Alternate Resolution 808 adopted in lieu of Resolution 808 to read as follows:

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992

(2) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, including prosthodontic reconstruction (including dental implants) caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA supports that reconstructive surgery be covered by all insurers and encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.

RESOLVED, that our American Medical Association with appropriate stakeholders to advocate: (a) that prosthodontic reconstruction (including dental implants) after orofacial reconstruction secondary to oncologic resection be covered by all insurers, (b) that such coverage, shall include treatment which, in the opinion of the treating physician is medically necessary to optimize the patient's appearance and function to their original form as much as possible, and (c) that such insurability be portable, i.e. not denied as a pre-existing condition if the patients insurance coverage changes before treatment has been initiated or completed. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 808. Opponents suggested that the scope is too narrow as patients lose dentition for a myriad of reasons besides cancer. Supporters indicated that dental care *is* health care and has a direct impact on an individual's nutritional intake and overall health. Further, dentition is a cornerstone of psychosocial well-being. An amendment and title change were proffered to include trauma as a covered indication. The Council on Medical Service testified that existing AMA policy addresses the medical necessity of prosthodontic reconstruction following oncologic procedures and recommended amending the resolution to reinforce AMA policy. Your Reference Committee identified amendments to existing policy that fulfill the intent of the resolution and, therefore, recommends that Alternate Resolution 808 be adopted in lieu of Resolution 808.

(19) RESOLUTION 814 -- PROVIDING PARITY FOR MEDICARE FACILITY FEES

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 814 be adopted in lieu of Resolution 814.

RESOLVED, that our American Medical Association continue advocating for an annual, inflation-based update to Medicare physician payment, which will increase payment parity across outpatient sites of service by allocating additional funds for the Medicare physician payment system. (New HOD Policy)

HOD ACTION: Resolution 814 referred for decision.

RESOLVED, that our American Medical Association promote awareness that the 'site of service' payment differential does not reflect quality of care (Directive to Take Action); and be it further

RESOLVED, that our AMA seek legislative action or relief for independent physician practices, including rural and underserved practices, to be paid equally for office-based procedures whether or not they practice in offices, facilities or hospitals (Directive to Take Action); and be it further

RESOLVED, that our AMA amend policy D-330.902, The Site-of-Service Differential, by addition to read as follows:

Our AMA will produce a graphic report yearly illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation. (Modify Current HOD Policy)

Testimony on Resolution 814 was mixed. Supportive testimony emphasized that, in order to preserve independent physician practices, services provided in hospitals and physician practices must be paid equally. Similar to testimony offered in the Online Member Forum, the Council on Medical Service maintained that this resolution is addressed by numerous AMA policies developed over the years to address payment differentials across outpatient sites of service. The Council proffered alternate language that is consistent with existing policy and our AMA's Medicare physician payment efforts. The Council spoke specifically against adoption of the third resolved clause, explaining that the graphic report called for in Policy D-330.902 was completed earlier this year but the data provided only limited information on the payment differential and was not useful to physicians or to our AMA's advocacy in support of payment parity.

The Council on Legislation testified in support of the alternate language proffered by the Council on Medical Service, stating that our AMA has addressed parity concerns for many years using robust AMA policy which supports site-neutral payments without lowering total Medicare payments (Policy D-330.902), calls for payment equity between hospital outpatient services and similar services in physician offices (Policy H-240.993), and urges

third party payers to implement coverage policies that do not unfairly discriminate between hospital-owned and independently-owned outpatient facilities with respect to payment of "facility" costs (Policy H-240.979). The Council explained that AMA's advocacy supports site neutrality and recognizes that achieving parity is best accomplished by increases in physician payment, underscoring that most policy proposals addressing problematic pay differentials would actually reduce payments for all sites to rates paid at the least costly setting, usually by lowering payments for all sites to Medicare physician fee schedule rates. The Council spoke against the second resolved clause because it could lower physician payments for everyone. Instead, the Council stated that our AMA strongly advocates for site-neutral payments that do not lower total Medicare payments and urges Congress to allocate additional funds into the payment system through legislation, including H.R. 2474, which provides an inflation-based payment update based on the Medicare Economic Index.

Your Reference Committee agrees that several AMA policies address the intent of Resolution 814 and recognizes that advocating for an annual, inflation-based update to Medicare physician payment will increase payment parity. Accordingly, your Reference Committee recommends that Alternate Resolution 814 be adopted in lieu of Resolution 814.

(20) RESOLUTION 815 -- LONG-TERM CARE AND SUPPORT SERVICES FOR SENIORS

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 815 be adopted in lieu of Resolution 815.

RESOLVED, that our American Medical Association amend Policy D-280.982, Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options, by addition to read as follows:

Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options D-280.982

1. Our AMA will advocate for business models in long term care for the elderly which incentivize and promote the ethical and equitable use of resources to maximize care quality, staff and resident safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit.

2. Our AMA will, in collaboration with other stakeholders, including major payers, advocate for further research into alternatives to current options for long term care to promote the highest quality and value long term care services and supports (LTSS) models as well as functions and structures which best support these models for care.

RESOLVED, that our AMA amend Policy H-280.945, Financing of Long-Term Services and Supports, by addition to read as follows:

Financing of Long-Term Services and Supports H-280.945
Our AMA supports:
(1) policies and incentives that standardize and simplify private Long Term Care Insurance (LTCI) to achieve increased coverage and improved affordability for all Americans; (2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees; (3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI; (4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities; (5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy; (6) Medicare Advantage plans offering LTSS in their benefit packages; (7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit; (8) a back-end public catastrophic long-term care insurance program; (9) incentivizing states to expand the availability of and access to home and community-based services; and (10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly. (Modify HOD Policy)

RESOLVED, that our American Medical Association amend Policy H-280.991, Policy Directions for the Financing of Long-Term Care, by addition to read as follows:

Policy Directions for the Financing of Long-Term Care H-280.991

1. Our AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) account for equity in order to assure affordability of long-term care for all Americans (45) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (56) coordinate benefits across different LTC financing program; (67) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (78) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (89) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (910) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (1011) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. (Modify HOD Policy)

The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms. 2. Our AMA will work with Centers for Medicare & Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance plans to provide long-term care coverage for patients with Alzheimer's and other forms of dementia. (Modify HOD Policy)

RESOLVED, that our AMA support increased awareness and education about long-term care insurance, including a mandate for public and private insurers to provide such information to potential enrollees during their annual health insurance election. (New HOD Policy)

HOD ACTION: Alternate Resolution 815 adopted in lieu of Resolution 815.

RESOLVED, that our American Medical Association advocate that private payers offer an affordable insurance product[s] to address long-term care needs (Directive to Take Action); and be it further

RESOLVED, that our AMA with other interested organizations, including the insurance industry, explore ways to ensure the viability of long-term care insurance by a mix of mandates and/or incentives that can be advocated for (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for equity in the financing of long-term care in order to assure affordable care of long-term care for all Americans (Directive To Take Action); and be it further

RESOLVED, that our AMA reaffirm Policy H-25.991, to continue to advocate for fiscal support for "aging in place" by promoting state and federal policy to expand home and community-based services (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA promote research regarding evidence-based interventions to assure the quality of long-term care for seniors both in the home and institutional settings. (Directive to Take Action)

Your Reference Committee heard unanimously supportive testimony of Resolution 815 with comments emphasizing the need to equitably prepare for the demands that will be placed on Long-Term Services and Supports (LTSS) as Baby Boomers age. Your Reference Committee recognizes that many individuals do not have access to quality, equitable, and affordable long-term care. The Council on Medical Service offered Alternate Resolution 815 that leveraged amendments to existing policy to promote quality, equitable, and affordable long-term care for all Americans. Accordingly, your Reference Committee recommends adopting Alternate Resolution in lieu of Resolution 815.

RECOMMENDED FOR REFERRAL

(21) COUNCIL ON MEDICAL SERVICE REPORT 7 -- SUSTAINABLE PAYMENT FOR COMMUNITY PRACTICES

RECOMMENDATION A:

Your Reference Committee recommends that Council on Medical Service Report 7 be referred.

HOD ACTION: Council on Medical Service Report 7 referred.

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-23, and the remainder of the report be filed:

1. That our American Medical Association (AMA) amend Policy H-290.976[2] by addition and deletion, and modify the title by deletion, as follows:

Enhanced ~~SCHIP~~ Enrollment, Outreach, and ~~Reimbursement~~ Payment H-290.976
1. It is the policy of our AMA that prior to or concomitant with states' expansion of State Children's Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.
2. Our AMA affirms its commitment to advocating for reasonable SCHIP, ~~and~~ Medicaid, and private insurance payment ~~reimbursement~~ for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable. (Modify Current HOD Policy)

2. That our AMA amend Policy H-385.921 by addition and deletion, and modify the title by deletion, as follows:

Health Care Access ~~for Medicaid Patients~~ H-385.921
It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, ~~and~~ any other publicly funded insurance plan, and private insurance must be at minimum 100 percent of the RBRVS Medicare allowable. (Modify Current HOD Policy)

3. That our AMA reaffirm Policy D-400.990, which seeks legislation and/or regulation to prevent insurance companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory fee schedule. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-200.949, which supports development of administrative mechanisms to assist primary care physicians in the logistics of

their practices to help ensure professional satisfaction and practice sustainability, support increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, and advocate for public and private payers to develop physician payment systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure adequate payment for services rendered by private practicing physicians, creating and maintaining a reference document establishing principles for entering into and sustaining a private practice, and issuing a report in collaboration with the Private Practice Physicians Section at least every two years to communicate efforts to support independent medical practices. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on CMS Report 7, with some strongly supporting the report as written and others recommending referral. Those supporting referral provided robust testimony, indicating that the report did not adequately address the impact of Medicaid rates on community practice payments as demonstrated by its narrow focus and recommendations that co-opted existing AMA Medicaid policies. Further, report recommendations were deemed deficient since they did not uncouple private payer rates from a Medicare benchmark, thus continuing to tether private payment to a dropping Medicare rate and possibly encouraging insurers currently paying more than 100 percent of the Medicare allowable to lower payment to that level. While your Reference Committee acknowledges that CMS opposed referral as the report responded to the specific referred resolution on Medicare versus private payment, testimony offered additional suggestions not addressed in the report. Accordingly, your Reference Committee recommends that CMS Report 7 be referred to allow reconsideration of a) non-Medicare benchmarks for private payers; b) a minimum government rate, including Medicaid; and c) the impact that rates below these benchmarks have on small community practices.

(22) RESOLUTION 802 -- IMPROVING NONPROFIT HOSPITAL CHARITY CARE POLICIES

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 802 be referred.

HOD ACTION: Resolution 802 referred.

RESOLVED, that our American Medical Association advocate for legislation and regulations that require nonprofit hospitals to notify and screen all patients for financial assistance according to their own eligibility criteria prior to billing (Directive to Take Action); and be it further

RESOLVED, that our AMA support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility (New HOD Policy); and be it further

RESOLVED, that our AMA encourages the Centers for Medicare & Medicaid Services (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities. (New HOD Policy)

Testimony on Resolution 802 was mixed. Opposition noted that the resolution did not accurately address specific benchmarks for charity to expense and charity to benefit ratios. Some supported only the third resolved clause, stating that nonprofit hospitals have significantly benefited from taxation relief without providing sufficient charity care. The Council on Medical Service offered interest in studying the issue. Given the mixed testimony, your Reference Committee recommends that Resolution 802 be referred.

(23) RESOLUTION 818 -- AMENDMENT TO AMA POLICY ON HEALTH CARE SYSTEM REFORM PROPOSALS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 818 <u>not be adopted</u>.

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 818 be <u>referred</u>.

HOD ACTION: The first Resolve of Resolution 818 <u>not adopted</u> and the second Resolve of Resolution 818 <u>referred</u>.

RESOLVED, that our American Medical Association remove opposition to single-payer health care delivery systems from its policy, and instead evaluate all health care system reform proposals based on our stated principles as in AMA policy (Directive to Take Action); and be it further

RESOLVED, that our AMA support a national unified financing health care system that meets the principles of freedom of choice, freedom and sustainability of practice, and universal access to quality care for patients. (New HOD Policy)

Testimony on Resolution 818 was mixed, with opinions ranging from strong support to strong opposition for removing AMA opposition to single-payer health care systems from AMA policy. Referral was also suggested given the complexity of the topic and its conflict with numerous AMA policies.

Testimony highlighted the benefits of single payer systems, stating that they save lives, reduce administrative burdens, unify health care financing in multi- or single payer systems by public and/or private payers, and expand freedom of choice/practice. Some suggested that only a single payer system or a model including a public option alongside private insurance could achieve universal coverage. Further, proponents of the resolution stated that a neutral stance on single payer systems would allow our AMA to evaluate all health reform proposals for consistency with AMA policy and principles.

Opposition affirmed support for a pluralistic system that ensures choice of coverage and cited problems with monopoly power in single payer systems and analogs such as Medicare, Medicaid, and Indian Health Service programs. Testimony stated that a single payer system would restrict patient access to care, limit physician autonomy, and erode physician practice sustainability. Concerns were expressed that adoption of this resolution would jeopardize our AMA's efforts to fix Medicare physician payment.

The Chair of the Board of Trustees testified on behalf of the Board in opposition to Resolution 818, stating that a uniform health care financing system would not necessarily guarantee access to timely, affordable, and high-quality care and could potentially cause harm to patients. Furthermore, the Board Chair emphasized that adoption of this resolution would severely compromise AMA Medicare physician payment reform advocacy efforts and undermine our AMA's relationships with key members of Congress across all parties.

The Council on Medical Service recommended that Resolution 818 not be adopted. The Council on Legislation indicated that current AMA policy does not preclude our AMA from evaluating all health reform proposals.

Your Reference Committee appreciates all of the testimony provided in the Online Member Forum and during the in-person hearing. Having heard substantial testimony opposing the first resolved clause, as well as apprehension about the second resolved clause, your Reference Committee recommends that the first resolved clause Resolution 818 not be adopted and the second resolved clause be referred.

(24) RESOLUTION 821 -- MODERNIZING THE AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE (RUC) PROCESSES

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 821 be referred.

HOD ACTION: Resolution 821 referred.

RESOLVED, that our American Medical Association encourage the AMA/Specialty Society RVS Update Committee (RUC) to modernize the RUC's processes and implement the following principles:
1. Data-Driven Decision Making: Enhance the data used in making recommendations by shifting from almost exclusive reliance on surveys of physicians and others who perform services to broader use of evidence-based data and metadata (e.g., procedure time from operating logs, hospital length of stay data, and other extant data sources) that permit assessment of resource use and the relative value of physician and other qualified healthcare professional services comprehensively. This can ensure that data is reliable, verifiable, and can be accurately compared to or integrated with other important databases.
2. Collaboration and Transparency: Seek collaboration with healthcare data experts, stakeholders, and relevant organizations to maintain transparent data collection and analysis methodologies.
3. Continuous Review and Adaptation: Expand and enhance its system for continuous review and adaptation of relative value determinations beyond its Relativity Assessment Workgroup and other current strategies (e.g., New Technology/New Services list) to stay aligned with evolving healthcare practices and technologies.
4. Equity and Access: Work with the Current Procedural Terminology Editorial Panel and others, as appropriate, to identify the impact that factors related to healthcare equity and access have on the resources used to provide the services of physicians and other qualified healthcare professionals and how to account for those resources in the description and subsequent valuation of those services.
5. Broader Engagement: Actively engage with other parties to gather input and ensure that relative value determinations align with the broader healthcare community's goals and values.
6. Education and Training: Invest in the education and training of its members, AMA and specialty society staff, and other participants (e.g., specialty society RUC advisors) to build expertise in evidence-based data analysis and metadata utilization.
7. Timely Implementation: Invest the necessary resources and establish a clear timeline for the implementation of these modernization efforts, with regular progress self-assessments and adjustments as needed (Directive to Take Action); and be it further

RESOLVED, that our AMA provide an informational report back to the House of Delegates at the 2025 annual meeting on the RUC process and modernizations efforts. (Directive to take Action)

Your Reference Committee heard vigorous testimony regarding Resolution 821. Supportive testimony stated that the current RUC process is dated and could benefit from modernization by leveraging additional data to supplement the RUC survey process.

Many supported referral, specifically because of the complexity of the RUC and necessity of defining what data was available to determine an accurate fiscal note. Opposition did not consider this resolution relevant for this meeting and found no urgency for its consideration. Some, including the Council on Medical Service, recommended reaffirmation of existing policy. It was noted that our AMA cannot “direct” the RUC to follow specific methodology and process as the RUC operates independently of our AMA and must follow federal law in submitting recommendations to the Centers for Medicare & Medicaid Services.

Our AMA is currently funding a multi-million dollar Physician Practice Information (PPI) Survey to collect practice cost data and improve the accuracy of the RBRVS in determining Medicare physician payment. Rather than micromanaging the RUC process, organized medicine must work with policymakers on immediate and long-term solutions to reform the Medicare Physician Fee Schedule.

Given disparate testimony, your Reference Committee recommends referring Resolution 821.

RECOMMENDED FOR REFERRAL FOR DECISION

(25) RESOLUTION 809 -- OUTSOURCING OF ADMINISTRATIVE AND CLINICAL WORK TO DIFFERENT TIME ZONES -- AN ISSUE OF EQUITY, DIVERSITY, AND INCLUSION

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 809 be referred for decision.

HOD ACTION: Resolution 809 referred for decision.

RESOLVED, that our American Medical Association advocate that health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US should implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones (Directive to Take Action); and be it further

RESOLVED, that our AMA support national legislation that calls on health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US to implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for fair treatment of outsourced employees in vastly different time zones by health plans. (Directive to Take Action)

Testimony was mixed on Resolution 809. Opposition stated that it was beyond the scope of our AMA. The Board of Trustees recommended that this item be referred for decision in order to be incorporated into an ongoing Board report. Your Reference Committee recommends that Resolution 809 be referred for decision.

This concludes the report of Reference Committee J. I would like to thank Shawn Baca, MD, Alëna Balasanova, MD, Anna Brown, MD, MPhil, F. Wilson Jackson, III, MD, Jana Montgomery, MD, Bing Pao, MD, and all those who testified before the Committee.

Shawn Baca, MD (Alternate)
Florida

Alëna Balasanova, MD
American Academy of Addiction Psychiatry

Anna Brown, MD, MPhil (Alternate)
Women Physicians Section

F. Wilson Jackson, III, MD
Pennsylvania

Jana Montgomery, MD (Alternate)
American College of Cardiology

Bing Pao, MD (Alternate)
California

Man-Kit Leung, MD
California
Chair

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Interim 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 (I-23)

Report of Reference Committee K

Elisa Choi, MD, Chair

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 2 - Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
2. Board of Trustees Report 5 - AMA Public Health Strategy: The Mental Health Crisis
3. Board of Trustees Report 14 - Funding for Physicians to Provide Safe Storage Devices to Patients with Unsecured Firearms in the Home
4. Council on Science and Public Health Report 5 - Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
5. Council on Science and Public Health Report 7 - Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities
6. Resolution 910 - Sickle Cell Disease Workforce
7. Resolution 921 - Addressing Disparities and Lack of Research for Endometriosis
8. Resolution 923 - Eliminating Eligibility Criteria for Sperm Donors Based on Sexual Orientation
9. Resolution 924 – Laboratory Developed Tests Proposed FDA Rule

RECOMMENDED FOR ADOPTION AS AMENDED

10. Council on Science and Public Health Report 1 - Drug Shortages: 2023 Update
11. Council on Science and Public Health Report 2 - Precision Medicine and Health Equity
12. Council on Science and Public Health Report 3 - HPV-Associated Cancer Prevention
13. Council on Science and Public Health Report 4 - Supporting and Funding Sobering Centers
14. Council on Science and Public Health Report 6 - Marketing Guardrails for the "Over-Medicalization" of Cannabis Use
15. Resolution 901 - Silicosis from Work with Engineered Stone
16. Resolution 902 - Post Market Research Trials
17. Resolution 906 - Online Content Promoting LGBTQ+ Inclusive Safe Sex Practices
18. Resolution 913 - Public Health Impacts of Industrialized Farms
19. Resolution 914 - Adverse Childhood Experiences

RECOMMENDED FOR ADOPTION IN LIEU OF

20. Resolution 903 - Supporting Emergency Anti-Seizure Interventions
21. Resolution 904 - Universal Return-to-Play Protocols
22. Resolution 916 - Elimination of Buprenorphine Dose Limits

RECOMMENDED FOR REFERRAL

23. Board of Trustees Report 3 - Update on Climate Change and Health – AMA Activities
24. Resolution 915 - Social Media Impact on Youth Mental Health
25. Resolution 922 - Prescription Drug Shortages and Pharmacy Inventories

RECOMMENDED FOR REFERRAL FOR DECISION

26. Resolution 909 - High Risk HPV Subtypes in Minoritized Populations

RECOMMENDED FOR NOT ADOPTION

27. Resolution 905 - Support for Research on the Relationship Between Estrogen and Migraine

For the purposes of clarity, items marked with double underline or ~~double strikethrough~~ are highlighted in yellow.

Amendments
If you wish to propose an amendment to an item of business, click here: SUBMIT NEW AMENDMENT

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 2 – OPPOSING THE USE OF VULNERABLE INCARCERATED PEOPLE IN RESPONSE TO PUBLIC HEALTH EMERGENCIES

RECOMMENDATION A:

Your Reference Committee recommends that Board of Trustees Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 2 adopted and the remainder of the report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 901-I-22, and the remainder of this report be filed.

1. Our AMA acknowledges that systemic racism is a root of incarcerated labor policies and practices.

2. Our AMA supports:

(a) Efforts to ensure that all work done by individuals who are incarcerated in correctional facilities is fully voluntary.

(b) Eliminating policies that require forced labor or impose adverse consequences on incarcerated workers who are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.

(c) Eliminating policies that negatively impact good time, other reductions of sentence, parole eligibility, or otherwise extend a person's incarceration for refusal to work when they are unable to carry out their assigned jobs due to illness, injury, disability, or other physical or mental limitations.

(d) The authority of correctional health care professionals to determine when an individual who is incarcerated is unable to carry out assigned work duties.

3. Our AMA encourages:

(a) Congress and state legislatures to clarify the meaning of "employee" to explicitly include incarcerated workers within that definition to ensure they are afforded the same workplace health and safety protections as other workers.

(b) Congress to enact protections for incarcerated workers considering their vulnerabilities as a captive labor force, including anti-retaliation protections for workers who are incarcerated who report unsafe working conditions to relevant authorities.

(c) Congress to amend the Occupational Safety and Health Act to include correctional institutions operated by state and local governments as employers under the law.

(d) The U.S. Department of Labor to issue a regulation granting the Occupational Safety and Health Administration jurisdiction over the labor conditions of all workers incarcerated in federal, state, and local correctional facilities.

4. Our AMA encourages:

(a) Comprehensive safety training that includes mandatory safety standards, injury and illness prevention, job-specific training on identified hazards, and proper use of personal protective equipment and safety equipment for incarcerated workers.

(b) That safety training is delivered by competent professionals who treat incarcerated workers with respect for their dignity and rights.
(c) That all incarcerated workers receive adequate personal protective equipment and safety equipment to minimize risks and exposure to hazards that cause workplace injuries and illnesses.
(d) Correctional facilities to ensure that complaints regarding unsafe conditions and abusive staff treatment are processed and addressed by correctional administrators in a timely fashion.
5. Our AMA acknowledges that investing in valuable work and education programs designed to enhance incarcerated individuals' prospects of securing employment and becoming self-sufficient upon release is essential for successful integration into society.
6. Our AMA strongly supports programs for individuals who are incarcerated that provides opportunities for advancement, certifications of completed training, certifications of work performance achievements, and employment-based recommendation letters from supervisors.

Your Reference Committee heard testimony in support of this report. It was noted the recommendations in this report ensure that work done by incarcerated individuals is voluntary, regardless of a pandemic. There was a proffered amendment to clarify that work is done only if the incarcerated individual is physically or mentally able to do so. Your Reference Committee notes that this amendment would change the intent of this report, which aims to address coercive working conditions for incarcerated individuals. Therefore, your Reference Committee recommends that Board of Trustees Report 2 be adopted.

(2) BOARD OF TRUSTEES REPORT 5 -- AMA PUBLIC HEALTH STRATEGY: THE MENTAL HEALTH CRISIS

RECOMMENDATION A:

Your Reference Committee recommends that Board of Trustees Report 5 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 5 adopted and the remainder of the report filed.

The Board of Trustees recommends that the second directive of BOT Report 17 be rescinded as having been accomplished by this report. (Rescind HOD Policy)

Limited, but supportive testimony was heard in support of the Board's report, which provides detailed information on our AMA's efforts to address the mental health crisis. The Board was thanked for the update and was encouraged to continue these efforts. Therefore, your Reference Committee recommends adoption.

(3) BOARD OF TRUSTEES REPORT 14 -- FUNDING FOR PHYSICIANS TO PROVIDE SAFE STORAGE DEVICES TO PATIENTS WITH UNSECURED FIREARMS IN THE HOME

RECOMMENDATION A:

Your Reference Committee recommends that Board of Trustees Report 14 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 14 adopted and the remainder of the report filed.

The Board of Trustees recommends that Alternate Resolution 923 be adopted in lieu of Resolution 923 and that the remainder of the report be filed:

RESOLVED, That our AMA egncourage health departments and local governments to partner with police departments, fire departments, and other public safety entities and organizations to make firearm safe storage devices accessible (available at low or no cost) in communities in collaboration with schools, hospitals, clinics, physician offices, and through other interested stakeholders. (New HOD Policy)

Testimony received on this Board of Trustees report was largely supportive. There is an urgent need to reduce firearm injuries and violence and the tragic toll it takes on patients, families, and communities. Providing injury prevention education and resources to patients improves patient utilization and it is critical to have physician offices involved in dissemination of firearm safe storage devices. While there was a call to broaden the recommendation to address firearm retailers and manufacturers, your Reference Committee thought these ideas were outside of the scope of the report and noted that existing AMA policy calls for mandatory inclusion of safety devices on all firearms. Therefore, your Reference Committee recommend the report be adopted.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 5 -- PROMOTING THE USE OF MULTI-USE DEVICES AND SUSTAINABLE PRACTICES IN THE OPERATING ROOM

RECOMMENDATION A:

Your Reference Committee recommends that Council on Science and Public Health 5 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health 5 adopted and the remainder of the report filed.

Your Council on Science and Public Health recommends that the following recommendations be adopted, and the remainder of this report be filed.

1. That Resolution 936-I-22, which asks for our AMA to advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for “single-use” with verified similar safety and efficacy profiles be adopted. (New HOD Policy)

2. That Policy H-480.959, “Reprocessing of Single-Use Medical Devices,” be reaffirmed. (Reaffirm Existing Policy)

3.That our AMA work with interested parties to establish best practices for safe reuse of equipment and improved surgical kits used in the operating room, and to disseminate best practices for reducing waste in the operating room as well as guides for implementing more sustainable purchasing processes in health care. (New HOD Policy)

Testimony on the Council’s report was limited, but supportive. The health care sector is a major contributor of both plastic waste and greenhouse gas emissions. The U.S. health sector is estimated to produce 6 billion tons of waste annually and to be responsible for 8.5 percent of U.S. greenhouse gas emissions. Operating rooms are generally one of the most resource intensive areas within hospitals. There was strong support for our AMA working with interested parties to develop best practices and guides for sustainable purchasing processes. Therefore, your Reference Committee recommends adoption.

(5) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 7 -- EFFICACY OF REQUIREMENTS FOR METAL DETECTION/WEAPONS INTERDICTION SYSTEMS IN HEALTH CARE FACILITIES

RECOMMENDATION A:

Your Reference Committee recommends that Council on Science and Public Health Report 7 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 7 adopted and the remainder of the report filed.

The Council on Science and Public Health recommends that the following recommendations be adopted, and the remainder of the report be filed.

1) That existing AMA policies on preventing violence against health care professionals be reaffirmed:

D-515.983, “Preventing Violent Acts Against Health Care Providers,” H-515.966, “Violence and Abuse Prevention in the Health Care Workplace,” H-515.957, “Preventing Violent Acts Against Health Care Providers,” H-215.977, “Guns in Hospitals,” and H-515.950, “Protecting Physicians and Other Healthcare Workers in Society.” (Reaffirm Existing Policy)

2) That our AMA encourages: (1) additional funding and research to evaluate effective interventions to prevent workplace violence against physicians and other health care professionals, including the effectiveness of magnetometers and other weapons interdiction systems in health care facilities; (2) health care facilities that have implemented magnetometers and other weapons interdiction systems to evaluate the impact on workplace violence and share best practices, including equity considerations; (3) the dissemination and awareness of guidance by OSHA and other organizations on the prevention of violence in health care facilities, including hospitals, ambulatory centers, and other clinical settings. (New HOD Policy)

Testimony on the Council's report was mostly supportive. Health care personnel represent a significant portion of the victims of workplace violence. The Council noted that most studies on workplace violence have been designed to quantify the problem, but few have described methods to prevent such violence and more research is needed. Therefore, your Reference Committee recommends the report be adopted.

(6) RESOLUTION 910 - SICKLE CELL DISEASE WORKFORCE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 910 be <u>adopted</u>.

HOD ACTION: Resolution 910 <u>adopted</u>.

RESOLVED, that our American Medical Association amend H-350.973, "Sickle Cell Disease," by addition to read as follows:

Sickle Cell Disease H-350.973

Our AMA:
(1) recognizes sickle cell disease (SCD) as a chronic illness;
(2) encourages educational efforts directed to health care providers and the public regarding the treatment and prevention of SCD;
(3) supports the inclusion of SCD in newborn screening programs and encourages genetic counseling for parents of SCD patients and for young adults who are affected, carriers, or at risk of being carriers;
(4) supports ongoing and new research designed to speed the clinical implementation of new SCD treatments;
(5) recommends that SCD research programs have input in the planning stage from the local African American community, SCD patient advocacy groups, and others affected by SCD;
(6) supports the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises;
(7) supports the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive

the best in-school care, and are not discriminated against, based on current federal and state protections; and
(8) encourages the development of model school policy for best in-school care for children with sickle cell disease;
(9) supports expanding the health care and research workforce taking care of patients with sickle cell disease; and
(10) collaborates with relevant parties to advocate for improving access to comprehensive, quality, and preventive care for individuals with sickle cell disease, to address crucial care gaps that patients with sickle cell disease face and improve both the quality of care and life for patients affected by sickle cell disease. (Modify Current HOD Policy)

Your Reference Committee heard limited, but unanimously supportive testimony on this resolution. Amendments were proffered that were editorial in nature. However, your Reference Committee felt the original language was appropriate and sufficient. Therefore, your Reference Committee recommends that Resolution 910 be adopted.

(7) RESOLUTION 921 - ADDRESSING DISPARITIES AND LACK OF RESEARCH FOR ENDOMETRIOSIS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 921 be adopted.

HOD ACTION: Resolution 921 adopted.

RESOLVED, that our American Medical Association collaborate with stakeholders to recognize endometriosis as an area for health disparities research that continues to remain critically underfunded, resulting in a lack of evidence-based guidelines for diagnosis and treatment of this condition amongst people of color (Directive to Take Action)

RESOLVED, that our AMA collaborate with stakeholders to promote awareness of the negative effects of a delayed diagnosis of endometriosis and the healthcare burden this places on patients, including health disparities among patients from communities of color who have been historically marginalized (Directive to Take Action)

RESOLVED, that our AMA advocate for increased endometriosis research addressing health disparities in the diagnosis, evaluation, and management of endometriosis (Directive to Take Action)

RESOLVED, that our AMA advocate for increased funding allocation to endometriosis-related research for patients of color, especially from federal organizations such as the National Institutes of Health. (Directive to Take Action)

Your Reference Committee heard supportive testimony for this resolution. Our AMA has broad and detailed policy on women's health issues, and the need for research to address health disparities in diseases. For example, in the Code of Medical Ethics 8.5 Disparities in Health Care it states that our AMA "support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups,

and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities." However, your Reference Committee recommends adoption due to the specificity of the disease, and because our AMA does not currently have policy specifically on endometriosis.

(8) RESOLUTION 923 - ELIMINATING ELIGIBILITY CRITERIA FOR SPERM DONORS BASED ON SEXUAL ORIENTATION

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 923 be <u>adopted</u>.

HOD ACTION: Resolution 923 <u>adopted</u>.

RESOLVED, that our American Medical Association work with other interested organizations to ask the US Food and Drug Administration (FDA) to eliminate its eligibility criteria for sperm donation based on sexual orientation, with a report back at I-24.

Testimony on Resolution 923 was unanimously supportive and is consistent with existing AMA policy. Therefore, your Reference Committee recommends adoption.

(9) RESOLUTION 924 - LABORATORY DEVELOPED TESTS PROPOSED FDA RULE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 924 be <u>adopted</u>.

HOD ACTION: Resolution 924 <u>adopted</u>.

RESOLVED, that our American Medical Association submit a comment to the FDA proposed rule entitled "Medical Devices; Laboratory Developed Tests" (Published October 3, 2023) requesting a 60-day extension period to the current comment period.

Your Reference Committee heard generally supportive testimony for this item, citing the breadth and complexity of regulations around laboratory developed tests. Members testified that under the current deadline, those who would be directly affected by the proposed rule may not have the ability to fully assess and communicate the impact it would have on their practice and patients. Your Reference Committee agrees that while the FDA has already indicated that they do not intend to extend the comment period beyond the original deadline, it is appropriate for our AMA to advocate for the rulemaking process to follow previous precedents and allow for all those who wish to comment to be heard. As such, your Reference Committee recommends that this item be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(10) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 1 -- DRUG SHORTAGES: 2023 UPDATE

RECOMMENDATION A:

Your Reference Committee recommends that Council on Science and Public Health Report 1 be amended by addition and deletion to read as follows:

22. Our AMA opposes the practice of preferring drugs ~~experiencing a~~ in shortage on approved pharmacy formularies when ~~other,~~ similarly effective drugs, in patient-appropriate formulations, are available in adequate supply yet ~~but~~ otherwise excluded from formularies or coverage plans.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 1 adopted as amended and the remainder of the report filed.

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution I-22-935, and that the remainder of the report be filed:

1. That Policy H-100.956, "National Drug Shortages," be amended by addition to read as follows:

2. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.

3. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.

4. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

5. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy

in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

6. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

7. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces.

8. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

9. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

10. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

11. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.

12. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages.

13. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.

14. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.

15. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.

16. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.

17. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.

18. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.

19. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

20. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.

20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines.

21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.

22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.

23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary. (Amend HOD Policy)

2. That the following policy be adopted:

Non-Profit or Public Manufacturing of Drugs to Address Generic Drug Shortages

Our AMA:

(1) supports activities which may lead to the stabilization of the generic drug market by non-profit or public entities. Stabilization of the market may include, but is not limited to, activities such as government-operated manufacturing of generic drugs, the manufacturing or purchasing of the required active pharmaceutical ingredients, or fill-finish. Non-profit or public entities should prioritize instances of generic drugs that are actively, at-risk of, or have a history of being, in shortage, and for which these activities would decrease reliance on a small number of manufacturers outside the United States.

(2) encourages government entities to stabilize the generic drug supply market by piloting innovative incentive models for private companies which do not create artificial shortages for the purposes of obtaining said incentives. (New HOD Policy)

Your Reference Committee heard testimony that was largely supportive of the recommendations in the Council on Science and Public Health's annual report on drug shortages. As drug shortages are growing and continue to impede patient care, the Council was commended for their recommendations that highlight the need for diversifying drug manufacturing and supply chains, as well as opposing practices such as pharmacy benefits manager formulary restrictions that worsen drug shortages. An amendment was offered to specify considerations of medication formulations for coverage during a shortage to not hinder treatment for certain populations, such as children who may need liquid formulations over tablets and capsules. Others cited concerns around emerging areas affecting drug shortages, specifically the impact of 340B pricing. The Council noted the study of 340B pricing would be included in their annual report as a potential contributor to ongoing and new drug shortages. Your Reference Committee was compelled by the supportive testimony and interest in continued study on this issue and thus, recommends CSAPH Report 1 be adopted as amended.

(11) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 2 -- PRECISION MEDICINE AND HEALTH EQUITY

RECOMMENDATION A:

Your Reference Committee recommends that the first recommendation of Council on Science and Public Health Report 2 be amended by addition and deletion in subsections C and G to read as follows:

c) strongly opposes the use of race, ethnicity, genetic ancestry, sexual orientation, or gender identity as the basis for genetic testing recommendations, or as exclusion criteria for the insurance coverage of genetic tests.

g) ~~strongly opposes research seeking to find genetic causes for protected traits, including gender identity, sexual orientation, and differences in ability, unless specifically requested by, or in direct collaboration with, the impacted community.~~ Strongly opposes pathologizing protected traits (including but not limited to race, ethnicity, gender identity, sexual orientation, and disability status), and strongly encourages that any clinical research into the genetic or other physiological origins of such traits be conducted in collaboration with the communities who bear such traits through an inclusive, community-based participatory research framework.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Science and Public Health Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 2 be referred.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed:

1. That our AMA:

a) recognizes past and ongoing practices in the field of genetics, including eugenics, have resulted in harm and decreased the quality of care available to minoritized and marginalized groups, and undermined their trust in the available care. Our AMA strongly supports efforts to counter the impact of these practices.

b) supports efforts to increase the diversity of genetics research participants and for research participants and impacted communities to be appropriately compensated.

c) strongly opposes the use of race, ethnicity, genetic ancestry, sexual orientation, or gender identity as the basis for genetic testing recommendations, or the insurance coverage of genetic tests.
d) supports policies which restrict access to genetic databases, including newborn screening samples or carrier screening results, by law enforcement without a warrant. States should clearly outline procedures for law enforcement to obtain access to genetic databases when there are compelling public safety concerns, consistent with AMA patient privacy policy.
e) supports an affirmative consent or "opt-in" approach to genetics research including samples stored within large databases and encourages those in stewardship of genetic data to regularly reaffirm consent when appropriate.
f) recognizes that an individual's decision to participate in genetics research can impact others with shared genetic backgrounds and encourages researchers and funding agencies to collaborate with impacted community members to develop guidelines for obtaining and maintaining group consent, in addition to individual informed consent. Our AMA supports widespread use of a robust consent process which informs individuals about what measures are being taken to keep their information private, the difficulties in keeping genetic information fully anonymous and private, and the potential harms and benefits that may come from sharing their data.
g) strongly opposes research seeking to find genetic causes for protected traits, including gender identity, sexual orientation, and differences in ability, unless specifically requested by, or in direct collaboration with, the impacted community. (New HOD Policy)

2. That current AMA policies H-315.983, "Patient Privacy and Confidentiality," H-65.953 "Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice," and D-350.981 "Racial Essentialism in Medicine" be reaffirmed. (Reaffirm HOD Policy)

Testimony for this report was mixed and contradictory, and primarily was concerned with the sub-recommendations 1(c) and 1(g). Those who testified in favor of the original recommendations cited the critical need for including the voices of marginalized groups, particularly those in the disability community, to avoid repeating historical mistakes in medical research that resulted in inequities and harm. Those who spoke against recommendations 1(c) and 1(g) cited the difficulty that patients already experience with obtaining insurance reimbursement, and in settings with limited resources, race, ethnicity, and ancestry may be appropriate criteria. Additionally, testimony was heard citing the importance of maintaining patient autonomy when seeking counseling regarding their genetic risks. Your Reference Committee appreciates the complexities of this issue and felt that both perspectives were valid, and that the goals of the report were laudable, but may require more specific wording to alleviate concerns in instances where there may be differences of opinion. As such, your Reference Committee recommends that the recommendations of Council on Science and Public Health Report 2 be adopted as amended.

(12) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 3 -- HPV-ASSOCIATED CANCER PREVENTION

RECOMMENDATION A:

Your Reference Committee recommends that the first recommendation of Council on Science and Public Health Report 3 be amended by addition of a ninth subclause to read as follows:

9. Our AMA supports that HPV vaccines recommended by the Advisory Committee on Immunization Practices be required for school attendance for all vaccine-eligible individuals.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Science and Public Health Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 3 referred.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1. That our AMA amend policy by addition and deletion to read as follows:

HPV-Associated Cancer Prevention, H-440.872
1. Our AMA (a) strongly urges physicians and other health care professionals to educate themselves, appropriate patients, and patients' parents when applicable, about HPV and associated diseases, the importance of initiating and completing HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will work with interested parties to intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.
4. Our AMA:
(a) encourages the integration of HPV vaccination and ~~routine cervical~~ appropriate HPV-related cancer screening into all appropriate health care settings and visits,

(b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups ~~that benefit most from preventive measures~~, including but not limited to low-income and pre-sexually active populations,
(c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
5. Our AMA encourages ~~will encourage~~ all efforts by interested parties ~~appropriate stakeholders to investigate means~~ to increase HPV vaccine availability, and HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings ~~including school settings~~ such as local health departments, schools, and organized childcare centers.
~~6. Our AMA will study requiring HPV vaccination for school attendance.~~
6~~7~~. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.
8. Our AMA will encourage continued research into (a) interventions that equitably increase initiation of HPV vaccination and completion of the HPV vaccine series; and (b) the impact of broad opt-out provisions on HPV vaccine uptake. (Amend Current HOD Policy)

2. That our AMA reaffirm Policy H-440.970, "Nonmedical Exemptions from Immunizations." (Reaffirm HOD Policy)

Your Reference Committee heard testimony largely in support of the intent of the recommendations of the Council on Science and Public Health report. An amendment was proffered to include support of HPV vaccination requirements for all vaccine-eligible individuals for school attendance as recommended by the Advisory Committee on Immunization Practices (ACIP). Testimony noted that ACIP makes recommendations regarding clinical use of vaccines in the U.S. population. ACIP does not make recommendations regarding vaccine requirements for school attendance. It was noted that a mandate may be counterproductive to increasing vaccination rates. Given that the majority of the testimony was in support of the proffered amendment, your Reference Committee proposes language to address the issue highlighted about the purview of ACIP-recommended vaccines and recommends that the Council on Science and Public Health Report 3 be adopted as amended.

(13) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 4 -- SUPPORTING AND FUNDING SOBERING CENTERS

RECOMMENDATION A:

Your Reference Committee recommends that the first Recommendation of Council on Science and Public Health Report 4 be amended by addition and deletion to read as follows:

1. That our AMA will:

B. Support state and local efforts to decriminalize public intoxication and enact alternatives to criminalization of public intoxication, including deflection, diversion, and criminal record expungement policies.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Science and Public Health Report 4 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 4 adopted as amended and the remainder of the report filed.

The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 913-I-22, and the remainder of the report be filed.

1. That our AMA will:

A. Monitor the scientific evidence and encourage further research of sobering centers and similar entities for best practices including:

a. Health outcomes from sobering center utilization; and

b. Partnerships with medical personnel and health care entities for policies, protocols and procedures that improve patient outcomes, such as transitions of care and safety measures; and

c. The appropriate level of medical collaboration, evaluation, support, and training of staff in sobering centers; and

d. Health economic analyses for sobering care models in comparison to existing health care, criminal-legal, and community-based systems.

e. Best practices for sobering centers based on location (e.g., urban, suburban, and rural) and community needs.

B. Support state and local efforts to decriminalize public intoxication.

C. Support federal and state-based regulation of sobering centers.

D. Encourage and support local, state, and federal efforts (e.g., funding, policy, regulations) to establish safe havens for sobering care, as an alternative to criminalization, with harm reduction services and linkage to evidence-based treatment in place of EDs or jails/prisons for medically uncomplicated intoxicated persons. (New HOD Policy)

2. That our AMA reaffirm the following policies HOD policies: H-345.995, "Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill," H-95.912, "Involuntary Civic Commitment for Substance Use Disorder," H-95.931, "AMA Support for Justice Reinvestment Initiatives," H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," and D-430.993, "Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections." (Reaffirm HOD Policies)

Your Reference Committee heard significant testimony in support of the spirit of Council on Science and Public Health Report 4. Multiple speakers noted that sobering centers as a harm reduction strategy are critical for reducing drug overdose deaths. Concern was noted in testimony regarding the policy of decriminalization of public intoxication. The Council on Legislation noted that a report on criminalization of substances is forthcoming. Alternate wording to remove reference to decriminalization was suggested. Therefore, your Reference Committee recommends that the Council on Science and Public Health Report 4 be adopted as amended.

(14) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT 6 -- CANNABIS MARKETING PRACTICES

RECOMMENDATION A:

Your Reference Committee recommends that Council on Science and Public Health Report 6 be amended by addition and deletion to read as follows:

1.Our AMA supports and encourages federal, state, and private sector research on the effects of cannabis marketing to identify best practices in protecting vulnerable populations, as well as the benefits of safety campaigns such as preventing impaired driving or dangerous use. (New HOD Policy)

2.Our AMA encourages state regulatory bodies to enforce cannabis-related marketing laws and to publicize and make publicly available the results of such enforcement activities.

3.Our AMA encourages social media platforms to set a threshold age of 21 years for exposure to cannabis advertising and marketing and improve age verification practices on social media platforms.

4.Our AMA encourages regulatory agencies to research how marketing best practices learned from tobacco and alcohol policies can be adopted or applied to cannabis marketing.

6. Our AMA support and encourage state regulation of therapeutic claims in cannabis advertising.

7. Our AMA support using existing AMA channels to educate physicians and the public on the health risks of cannabis to children and potential health risks of cannabis to people who are pregnant or breastfeeding.

RECOMMENDATION B:

Your Reference Committee recommends that Council on Science and Public Health Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Science and Public Health Report 6 adopted as amended, Recommendation 6 referred, and the remainder of the report filed.

The Council on Science and Public Health recommends that the following be adopted, and the remainder of the report be filed.

1.Our AMA supports and encourages federal, state, and private sector research on the effects of cannabis marketing to identify best practices in protecting vulnerable populations, as well as the benefits of safety campaigns such as preventing impaired driving or dangerous use. (New HOD Policy)

2.Our AMA encourages state regulatory bodies to enforce cannabis-related marketing laws and to publicize and make publicly available the results of such enforcement activities.

3.Our AMA encourages social media platforms to set a threshold age of 21 years for exposure to cannabis advertising and marketing and improve age verification practices on social media platforms.

4.Our AMA encourages regulatory agencies to research how marketing best practices learned from tobacco and alcohol policies can be adopted or applied to cannabis marketing.

5.That our AMA reaffirm policies H-95.952, “Cannabis and Cannabinoid Research,” and H-95.923, “Taxes on Cannabis Products.”

Your Reference Committee heard mostly supportive testimony regarding the report. An amendment was proffered to add several additional recommendations to the Council’s report. Your Reference Committee decided to recommend adoption of portions of that amendment. There were some areas for which our AMA already had policy, such as warning labels on cannabis products. Other recommendations, such as those for a public health campaign, where the fiscal note would be substantial, were replaced with strategies to allow dissemination of content through our AMA’s existing channels. Another amendment regarding model legislation was not included as it is within the scope of a resolution being considered by another Reference Committee at this meeting. Given this, your Reference Committee suggests that the Council on Science and Public Health Report 6 be adopted as amended and the remainder of the report be filed.

(15) RESOLUTION 901 - SILICOSIS FROM WORK WITH ENGINEERED STONE

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 901 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~should~~ encourage physicians, including occupational health physicians, pulmonologists, radiologists, and pathologists, and other health-care professionals, to work together to report all diagnosed or suspected cases of silicosis in accordance with National Institute for Occupational Safety and Health (NIOSH) guidance; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that the second Resolve of Resolution 901 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA should advocate for the establishment of preventive measures to reduce exposure of workers to silica levels above the ~~OSHA~~ evidence-based permissible exposure level (PEL) for respirable crystalline silica ~~which is a time-weighted average (TWA) of 50 micrograms per cubic meter (µg/m3) of air~~; and be it further

RECOMMENDATION C:

Your Reference Committee recommends that Resolution 901 be adopted as amended.

HOD ACTION: Resolution 901 adopted as amended.

RESOLVED, That our American Medical Association should encourage physicians, including occupational health physicians, pulmonologists, radiologists, pathologists, and other health-care professionals, to report all diagnosed or suspected cases of silicosis in accordance with National Institute for Occupational Safety and Health (NIOSH) guidance; and be it further

RESOLVED, That our AMA should advocate for the establishment of preventive measures to reduce exposure of workers to silica levels above the OSHA permissible exposure level (PEL) for respirable crystalline silica, which is a time-weighted average (TWA) of 50 micrograms per cubic meter (µg/m3) of air; and be it further

RESOLVED, That our AMA should advocate for the establishment of a registry of cases of silicosis to be maintained for workers diagnosed with silicosis resulting from engineered stonework or from other causes, either by state Departments of Public Health or their Division of Occupational Safety and Health; and be it further

RESOLVED, That our AMA should advocate for the establishment of state funds to compensate workers who have been diagnosed with silicosis resulting from their work with silica, to recognize the progression and the need for increasing levels of compensation over time; and be it further

RESOLVED, That our AMA recommends that State Medical Associations should take action with respect to the prevention of silicosis and to the recognition and compensation of affected workers in their states.

Your Reference Committee heard testimony that was primarily supportive of the resolution. Your Reference Committee heard testimony against the use of specific micrograms per cubic meter reference, since this amount may change over time with newer data. Your Reference Committee agrees. Your Reference Committee heard another amendment which was deemed outside the scope of the original resolution. As such, your Reference Committee recommends adoption as amended.

(16) RESOLUTION 902 - POST MARKET RESEARCH TRIALS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 902 be <u>amended by addition</u> to read as follows:

RESOLVED, That our AMA advocate that the Food and Drug Administration use its authority to require that pharmaceuticals that received approval using surrogate endpoints demonstrate direct clinical benefit in post-market trials<u>, of appropriate size and scope for its relevant patient population,</u> as a condition of continued approval (Directive to Take Action); and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 902 be <u>adopted as amended</u>.

HOD ACTION: Resolution 902 be <u>adopted as amended</u>

RESOLVED, That our American Medical Association advocate that the Food and Drug Administration use its authority to require and enforce timely completion of post-marketing trials or studies whenever sponsors rely on surrogate endpoints to support approval (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that the Food and Drug Administration use its authority to require that pharmaceuticals that received approval using surrogate endpoints demonstrate direct clinical benefit in post-market trials as a condition of continued approval (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that the Food and Drug Administration require drug manufacturers to make the findings of their post-market trials publicly available (Directive to Take Action).

Testimony on this item was generally supportive. Most testified to support any and all efforts to make medications safer while still allowing patients to access innovative and life-saving drugs. One comment noted, however, that surrogate endpoints may be the only feasible method for investigating treatments for rare diseases, where patient populations may be prohibitively small for traditional, double-blind trials, and your Reference Committee agrees that this item can be clarified to not negatively impact rare disease research. As such, your Reference Committee recommends that Resolution 902 be adopted as amended.

(17) RESOLUTION 906 - ONLINE CONTENT PROMOTING LGBTQ+ INCLUSIVE SAFE SEX PRACTICES

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 906 be amended by deletion to read as follows:

RESOLVED, that our American Medical Association amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows:

Television Broadcast and Online Streaming of Sexual Encounters and Public Health Awareness on Social Media Platforms, H-485.994
The AMA urges television broadcasters and online streaming services, producers, ~~and~~ sponsors, and any associated social media outlets to encourage education about ~~heterosexual and LGBTQ+~~ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 906 be adopted as amended.

HOD ACTION: Resolution 906 adopted as amended.

RESOLVED, that our American Medical Association amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows:

Television Broadcast and Online Streaming of Sexual Encounters and Public Health Awareness on Social Media Platforms, H-485.994
The AMA urges television broadcasters and online streaming services, producers, ~~and~~ sponsors, and any associated social media outlets to encourage education about heterosexual and LGBTQ+ inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

Your Reference Committee heard mixed testimony on this resolution. The testimony acknowledged that ensuring inclusive safe sex practices in television or online programming is important. A proffered amendment proposed to strike "heterosexual and LGBTQ+" noting that safe sex practices apply to all groups and all forms of sex, and this

description defeats the intent of inclusivity. Testimony also noted that individuals can identify as LGBTQ+ and engage in heterosexual sexual activities. Your Reference Committee agrees with this proffered amendment and therefore, your Reference Committee recommends Resolution 906 be adopted as amended.

(18) RESOLUTION 913 - PUBLIC HEALTH IMPACTS OF INDUSTRIALIZED FARMS

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 913 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association recognizes that concentrated animal feeding operations (CAFOs) ~~as~~ may be a public health hazard; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 913 be adopted as amended.

HOD ACTION: Resolution 913 be adopted as amended.

RESOLVED, that our American Medical Association recognize Concentrated Animal Feeding Operations (CAFOs) as a public health hazard; and be it further

RESOLVED, that our AMA encourage the Environmental Protection Agency and appropriate parties to remove the regulatory exemptions for CAFOs under the Emergency Planning and Community Right-to-Know Act and the Comprehensive Environmental Response, Compensation, and Liability Act and tighten restrictions on pollution from CAFOs.

Your Reference Committee heard mixed testimony on this resolution. Testimony noted universally defining all CAFOs as a “public health hazard” is over-reaching. Testimony also noted that there are many humanitarian arguments against CAFOs and arguments that call for better regulation, but there is limited evidence to categorically define all CAFOs as public health hazards. Your Reference Committee agrees that CAFOs shouldn’t be broadly categorized as a public health hazard but recognizes that they may be a public health hazard. Therefore, your Reference Committee recommends Resolution 913 be adopted as amended.

(19) RESOLUTION 914 - ADVERSE CHILDHOOD EXPERIENCES

RECOMMENDATION A:

Your Reference Committee recommends that the first Resolve of Resolution 914 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA collaborate with the CDC and other relevant interested parties to advocate for the ~~addition~~ inclusion of ~~witnessing violence, experiencing discrimination, living in an unsafe neighborhood, experiencing bullying, placement in foster care, migration-related trauma, and living in poverty, and any~~ additional evidence-based categories ~~as needed and justified by scientific evidence~~ to the currently existing Adverse Childhood Experiences (ACEs) categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them; and be it further

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 914 be adopted as amended.

HOD ACTION: Resolution 914 adopted as amended

RESOLVED, That our AMA collaborate with the CDC and other relevant interested parties to advocate for the addition of witnessing violence, experiencing discrimination, living in an unsafe neighborhood, experiencing bullying, placement in foster care, migration-related trauma, and living in poverty, and any additional categories as needed and justified by scientific evidence to the currently existing Adverse Childhood Experiences (ACEs) categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them; and be it further

RESOLVED, That our AMA work with the CDC and other relevant interested parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions; and be it further *

RESOLVED, that our AMA support the establishment of a national ACEs response team grant to dedicate federal resources towards supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child.

Testimony was mostly supportive of the intent of Resolution 914, with recognition of the importance of improving the awareness of ACEs, which have lasting negative effects on health and wellbeing. As noted in testimony, the original ACEs study was conducted from 1995 to 1997. Since then, the list of ACEs used in studies has been expanded. As a result,

there are different lists of experiences that encompass what is referred to as an ACE. The Council noted that from a policy perspective, it may be prudent to avoid creating a list of ACEs within AMA policy as the evidence evolves. Your Reference Committee agrees with this approach. It is for this reason that inclusion of the concept of epigenetics, which was raised in testimony, is not being recommended for inclusion. Therefore, your Reference Committee recommends that Resolution 914 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU

(20) RESOLUTION 903 - SUPPORTING EMERGENCY ANTI-SEIZURE INTERVENTIONS

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 903 be adopted in lieu of Resolution 903.

RESOLVED, That our AMA encourage awareness efforts to increase recognition of the signs of status epilepticus. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that the title be changed to read as follows:

SUPPORT EDUCATION AND EMERGENCY INTERVENTIONS FOR STATUS EPILEPTICUS

HOD ACTION: Alternate Resolution 903 adopted in lieu of Resolution 903 with a change in title.

RESOLVED, that our American Medical Association support efforts in the recognition of status epilepticus and bystander intervention trainings; and be it further

RESOLVED, that our AMA encourage physicians to educate patients and families affected by epilepsy on status epilepticus and work with patients and families to develop an individualized action plan for possible status epilepticus, which may include distribution of home pharmacotherapy for status epilepticus, in accordance with the physician's best clinical judgment.

Your Reference Committee heard mixed testimony for this item. Proponents noted the need for more awareness across interested parties, such as caregivers and the public, to better support public health efforts. Others voiced concerns that groups were already completing this work and it may be beyond the purview of our AMA. Amendments were proffered to support global efforts of recognition of the signs of status epilepticus. The more general term “seizure” was replaced with status epilepticus, as not all seizures require emergency treatment. Thus, your Reference Committee recommends adoption of the Alternate Resolution.

(21) RESOLUTION 904 - UNIVERSAL RETURN-TO-PLAY PROTOCOLS

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 904 be adopted in lieu of Resolution 904.

RESOLVED, that our AMA encourage evidence-based studies regarding post-injury management protocols and return-to-play criteria that can help guide physicians who are caring for injured athletes.

HOD ACTION: Alternate Resolution 904 adopted in lieu of Resolution 904.

RESOLVED, that our American Medical Association encourage interested parties to: (a) establish a standard, universal protocol for return-to-play recovery for collegiate and professional athletes; (b) promote additional evidence-based studies on the effectiveness of a universal protocol for evaluation and post-injury management course at the collegiate and professional level; (c) support national and state efforts to minimize the consequences of inadequate recovery windows for collegiate and professional athletes.

An alternate resolution was proposed which was supported by the majority of those who testified, including the authors of the original resolution. There were concerns that the original resolution as drafted was both too broad in its coverage of all injuries, and too narrow in the focus on only college and professional athletes. Your Reference Committee agrees that the alternate language is more appropriate and therefore recommends that it be adopted in lieu of Resolution 904.

(22) RESOLUTION 916 - ELIMINATION OF BUPRENORPHINE DOSE LIMITS

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 916 be adopted in lieu of Resolution 916.

RESOLVED, that our American Medical Association support patients' ability to receive buprenorphine doses that exceed dosage limits listed in FDA-approved labeling when recommended by their prescriber for the treatment of opioid use disorder; and be it further

RESOLVED, that our AMA urge interested parties, including federal agencies, manufacturers, medical organizations, and health plans to review the evidence concerning buprenorphine dosing and revise labels and policies accordingly, in light of increasing mortality related to high-potency synthetic opioids.

HOD ACTION: Alternate Resolution 916 adopted in lieu of Resolution 916.

RESOLVED, that our American Medical Association will support flexibility in dosing of buprenorphine by elimination of non-evidence-based dose limits imposed by clinics, health systems, pharmacies and insurance carriers; and be it further

RESOLVED, that our AMA advocate for the elimination of non-evidence-based buprenorphine dose limits imposed by the United States Food and Drug Administration, clinics, health systems, pharmacies and insurance carriers.

Your Reference Committee heard testimony which unanimously supported the intent of the resolution, citing the lifesaving aspects of buprenorphine and the need for utilization of up-to-date evidence regarding appropriate dosing of buprenorphine for treatment. Testimony cited that the original data used for initial FDA labeled dose limits was scant at that time and are now not aligned with current evidence of buprenorphine dose efficacy in the era of synthetic opioid use. Further, other parties, such as payors, can use this information to create barriers to care. Alternate language was proffered and supported in testimony. Therefore, your Reference Committee recommends alternate Resolution 916 be adopted in lieu of Resolution 916.

RECOMMENDED FOR REFERRAL

(23) BOARD OF TRUSTEES REPORT 3 - UPDATE ON CLIMATE CHANGE AND HEALTH – AMA ACTIVITIES

RECOMMENDATION A:

Your Reference Committee recommends that Board of Trustees Report 3 be referred.

HOD ACTION: Board of Trustees Report 3 referred.

In this informational report, the Board of Trustees shared an update on the AMA's plan and activities to address and combat the health effects of climate change sharing activities undertaken since the last report issued at the June meeting. Those who testified indicated that what they are expecting is a strategic plan similar to the AMA's strategic plan to advance health equity. It was noted that this report did not meet their expectations and it was asked that the report be referred back to the Board. Therefore, your Reference Committee recommends referral.

(24) RESOLUTION 915 - SOCIAL MEDIA IMPACT ON YOUTH MENTAL HEALTH

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 915 be referred.

HOD ACTION: Resolution 915 referred.

RESOLVED, that our American Medical Association work with relevant parties to develop guidelines for age-appropriate content and access and to develop age-appropriate digital literacy training to precede social media engagement among children and adolescents; and be it further

RESOLVED, that our AMA amend policy D-478.965 by insertion as follows: (4) advocates for and support media and social networking services addressing and developing safeguards for users, including protections for youth online privacy, effective controls allowing youth and caregivers to manage screentime content and access, and to develop age-appropriate digital literacy training; and be it further

RESOLVED, that our AMA advocate that the federal government requires social media companies to share relevant data for further independent research on social media's effect on youth mental health and fund future federal research on the potential benefits and harms of social media use on youth mental health.

Testimony highlighted the critical importance of this issue for our nation's youth, but the preponderance of testimony indicated that referral for study was warranted. The Council on Science and Public Health also supported referral and indicated that a study on this

topic is underway to make recommendations for teenage use of social media, with a report due back to the House of Delegates at A-24 and this could be considered within that report. Therefore, your Reference Committee recommends referral.

(25) RESOLUTION 922 - PRESCRIPTION DRUG SHORTAGES AND PHARMACY INVENTORIES

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 922 be referred.

HOD ACTION: Resolution 922 referred.

RESOLVED, that our American Medical Association work with the pharmacy industry to develop and implement a mechanism to transfer prescriptions without requiring a new prescription (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for legislation and/or regulations permitting pharmacies to transfer prescriptions to other pharmacies when prescription medications are unavailable at the original pharmacy or the patient requests the prescription be transferred. (Directive to Take Action)

Mixed testimony was heard for this resolution. There was significant support for this resolution based on significant challenges to practice from the limitation of prescription transfers, including inability of patients to access medication and increased administration time for physicians and their staff to find medications at pharmacies. However, testimony was heard from multiple speakers about the complexity of this issue surrounding state laws, recent DEA regulations, and retail pharmacy policies, and requested further study to guide policy. Your Reference Committee agrees that this is an important issue with significant complexities and recommends this resolution for referral.

RECOMMENDED FOR REFERRAL FOR DECISION

(26) RESOLUTION 909 - HIGH RISK HPV SUBTYPES IN MINORITIZED POPULATIONS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 909 be referred for decision.

HOD ACTION: **Resolution 909 referred for decision.**

RESOLVED, that our AMA amend H-440.872, "HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide," by addition as follows:

HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide H-440.872
1. Our AMA (a) urges physicians and other health care professionals to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits; (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations; and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
4. Our AMA encourages appropriate parties to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.
5. Our AMA will study requiring HPV vaccination for school attendance.
6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.
7. Our AMA supports further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.
8. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines.

Your Reference Committee heard testimony that was unanimously supportive of the spirit of this resolution. However, your Reference Committee was alerted to the fact that the

original, underlying resolution was modifying an outdated version of H-440.872 that was hosted in PolicyFinder. Your Reference Committee would note that the policy proposals contained in Resolution 909 are important, timely, and well-supported, and the Reference Committee's recommendation is solely due to a technical error. This technical error was not the fault of the authors and instead due to the internal processing of business from A-23. Your Reference Committee commends the authors for working diligently on this issue and encourages the Board to accept the thrust of the resolution while rectifying the parliamentary glitch. For those reasons, your Reference Committee recommends that Resolution 909 be referred for decision.

RECOMMENDED FOR NOT ADOPTION

(27) RESOLUTION 905 - SUPPORT FOR RESEARCH ON THE ASSOCIATION BETWEEN ESTROGEN AND MIGRAINE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 905 <u>be not adopted</u>.

HOD ACTION: Resolution 905 <u>not adopted</u>.

RESOLVED, that our American Medical Association support further research regarding the role of estrogen as a risk factor for stroke and cardiovascular events at the dosages and routes found in, inclusive of but not limited to combined oral contraceptive pills, vaginal rings, transdermal patches, hormone replacement therapy, and gender affirming hormone therapy in individuals with migraine and migraine with aura (New HOD Policy)

RESOLVED, that our AMA work with relevant stakeholders to advocate for increased resources to allow for appropriate education and assessment, when indicated, of migraine and migraine with aura consistent with current diagnostic guidelines in medical practice sites inclusive of but not limited to primary care, obstetrics and gynecology, endocrinology, neurology, and cardiology clinics. (Directive to Take Action)

Your Reference Committee heard testimony in support of the spirit of the proposed resolution, but ultimately there was significant disagreement on the best path forward for achieving the desired outcome. Specifically, there were several who testified to the active, vigorous investigation currently underway in this area, and that this topic may be more appropriate for action by our AMA once those results are better understood and disseminated. Additionally, several specialty groups cited that the resources requested by this resolution may already exist and are used in practice today. As such, your Reference Committee recommends that this resolution not be adopted.

This concludes the report of Reference Committee K . I would like to thank Kim Yu, MD, Elizabeth Torres, MD, Elizabeth Suschana, Patricia Kolowich, MD, Nancy Ann Ellerbroek, MD, Robert Dannenhoffer, MD, and all those who testified before the Committee.

Kim Yu, MD
American Academy of Family Physicians

Elizabeth Torres, MD
Texas

Elizabeth Suschana (Alternate)
Connecticut

Patricia Kolowich, MD (Alternate)
Michigan

Nancy Ann Ellerbroek, MD
American College of Radiology

Robert Dannenhoffer, MD
Oregon

Elisa Choi, MD
American College of Physicians
Chair