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REPORT 01 OF THE BOARD OF TRUSTEES (I-24)
Augmented Intelligence Development, Deployment, and Use in Health Care
(Resolution 247-A-23) (Resolution 206-I-23) (BOT Report 15-A-24)
(Reference Committee B)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy H-480-935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation." This policy calls on the AMA to "study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24." Additionally, at the 2023 Interim Meeting, the HOD referred Resolution 206-I-23, "The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice." Resolution 206-I-23 asked, "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 health care issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers." At the 2024 Annual Meeting, a previous version of this report (BOT Report 15-A-24) was referred by the HOD for further consideration of testimony received from the online forum and during the Reference Committee B hearing.

Generative augmented intelligence (AI) is a type of AI that can recognize, summarize, translate, predict, and generate text and other content based on knowledge gained from large datasets. There has been increasing discussion about clinical applications of generative AI, including use as clinical decision support to provide differential diagnoses, early detection and intervention, and to assist in treatment planning. Generative AI tools are also being developed to assist with administrative functions, such as generating office notes, responding to documentation requests, and generating patient messages. While generative AI tools show tremendous promise to make a significant contribution to health care, there are a number of risks and limitations to consider when using these tools in a clinical setting or for direct patient care.

As the number of AI-enabled health care tools and systems continues to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent. With a lagging effort towards adoption of national governance policies or oversight of AI, it is critical that the AMA and the physician community engage in the development of policies to help inform patient and physician education, help guide development of these tools in a way that best meets both patient and physician needs, and advocate for governance policies to help ensure that risks arising from AI are mitigated to the greatest extent possible.

This report highlights the AMA's recognition of the issues raised at the A-23, I-23, and A-24 HOD meetings, introduces and explains major themes of the report's recommendations, and provides background information on the evolution of AI policy in health care and the direction that policy appears to be headed.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-I-24

Subject:	Augmented Intelligence Development, Deployment, and Use in Health Care (Resolution 247-A-23) (Resolution 206-I-23) (BOT Report 15-A-24)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy H-480-935, "Assessing the Potentially Dangerous Intersection Between AI and Misinformation." This policy calls on the AMA to "study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24." This policy reflects the intense interest and activity in augmented intelligence (AI) prompted by the arrival of OpenAI's ChatGPT and other LLMs/generative AI.

Additionally, at the 2023 Interim Meeting, the AMA HOD referred Resolution 206-I-23, "The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice." Resolution 206-I-23 asked, "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 health care issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers."

Testimony on Resolution 206-I-23 highlighted the importance of physician understanding of LLMs and the ability to weigh the benefits and risks of these tools as the excitement and eagerness to implement them in everyday practice increases. Testimony emphasized that our AMA is currently in the process of fulfilling the directive in Policy H-480-935 (adopted at 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. The HOD referred Resolution 206 so that the issues raised in this resolution could be considered along with the issues in Policy H-480.935.

At the 2024 Annual Meeting, a previous version of this report (BOT Report 15-A-24) was referred by the HOD for further consideration of testimony received from the online forum and during the Reference Committee B hearing. Some of those who testified expressed concern over omissions in the report regarding the use of AI in the development of scientific literature and its ability to propagate health care misinformation. Others expressed concern over the feasibility of some recommendations relating to transparency and disclosure of the use of AI, primarily that it may add additional burden on health systems, hospitals, and physicians. These issues are addressed in this report.

BACKGROUND

The issue of AI first presented itself as an area of potential interest to AMA physicians and medical students that necessitated creation of AMA policy in 2018. At that time, physicians and medical students primarily considered AI-enabled technologies within the context of medical device and clinical decision support, although administrative applications of AI began to grow exponentially and started to gain traction in the hospital, health system, and insurer space. Since the development of the AMA's foundational AI policy in 2018 and subsequent policy on coverage and payment for AI in 2019, the number of AI-enabled medical devices approved by the U.S. Food and Drug Administration (FDA) has grown to over 800. In 2022, the concept of "generative AI" and what it can do became better understood to the public. Generative AI is a broad term used to describe any type of artificial intelligence that can be used to create new text, images, video, audio, code, or synthetic data. Generative AI and LLMs have rapidly transformed the use cases and policy considerations for AI within health care, necessitating updated AMA policy that reflects the rapidly evolving state of the technologies.

AMA policy adopted in 2018 and 2019 enabled the AMA to be a strong advocate on behalf of patients and physicians and has been the bedrock of AMA's advocacy on AI in the form of lobbying key congressional committees, participating in expert panel discussions, creating educational resources, and working with our Federation colleagues at the federal and state levels. However, as AI has rapidly developed beyond AI-enabled medical devices and into LLMs/generative AI, new policy and guidance are needed to ensure that they are designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent.

As an initial step, in November 2023, the AMA Board of Trustees approved a set of advocacy principles developed by the Council on Legislation (COL) that serve as the framework of this Board report. The main topics addressed in the principles include AI oversight, disclosure requirements, liability, data privacy and security, and payor use of AI. In addition to the COL, these principles have been vetted among multiple AMA business units, and AMA staff has worked with several medical specialty societies that have an expertise in AI and has received additional guidance and input from outside experts that have further refined these principles. These principles build upon and are supplemental to the AMA's existing AI policy, especially Policy H-480.940, "Augmented Intelligence in Health Care," Policy H-480.939, "Augmented Intelligence in Health Care," and Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization," as well as the AMA's Privacy Principles. The Board recommends adoption of these principles as AMA policy to guide our AMA's advocacy and educational efforts on LLM/generative AI issues.

This report highlights the AMA's recognition of the issues raised at the A-23 and I-23 HOD meetings, as well as the comments heard during the A-24 HOD meeting regarding BOT Report 15-A-24. It also introduces and explains major themes of the report's recommendations and provides background information on the evolution of AI policy in health care and the direction that policy appears to be headed.

Current Status of Oversight of Augmented Intelligence-Enabled Technologies

There is currently no whole-of-government strategy for oversight and regulation of AI. The U.S. Department of Health and Human Services (HHS) did establish an AI Office in March 2021 and developed a general strategy to promote the use of trustworthy AI but has not produced a department-wide plan for the oversight of AI. While many other federal departments and agencies also have some authority to regulate health care AI, many regulatory gaps exist. The Assistant

Secretary for Technology Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) recently created a position for a Chief AI Officer. However, the job role is targeted at the internal use of AI within HHS and less about public policy. To address the lack of a national strategy and national governance policies directing the development and deployment of AI, the federal government has largely defaulted to public "agreements" representing promises by large AI developers and technology companies to be good actors in their development of AI-enabled technologies.

In December 2023, the Biden Administration released a reasonably comprehensive executive order on the "Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence." While the executive order does not create new statutory or regulatory requirements, it does serve to direct federal departments and agencies to take action to provide guidance, complete studies, identify opportunities, etc. on AI across several sectors, including HHS. The AMA was pleased to see close alignment between the executive order's direction and AMA principles. However, executive orders do not represent binding policy, so the regulatory status quo remains unchanged at present.

The Biden Administration had also previously released a "Blueprint for an AI Bill of Rights," setting forth five principles that should guide the design, use, and deployment of AI. Those include recommendations for creating safe and effective systems; algorithmic discrimination protections; data privacy; notice and explanation; and human alternatives, considerations, and fallback. Like executive orders, this blueprint does not create new or binding policy with the force of law.

There have been few, but notable, additional actions by federal agencies that may serve to impact patient and physician interaction with AI-enabled technologies. In 2022, the Centers for Medicare & Medicaid Services (CMS) and HHS Office for Civil Rights (OCR) introduced a sweeping liability proposal within its Section 1557 Non-Discrimination in Health Programs and Activities proposed rule. The AMA submitted detailed comments opposing this section of the proposed rule. OCR ultimately finalized the rule, including the new section prohibiting discrimination by clinical algorithms. The final rule requires physicians to make "reasonable efforts" at identifying and mitigating discriminatory harms from algorithms, including AI.

In addition, the ASTP/ONC* proposed and finalized, with some modifications, polices that will require electronic health record (EHR) technology developers to make certain information about AI used in EHRs available to physicians and other users. ASTP/ONC refers to these AI tools as Predictive Decision Support Interventions (Predictive DSI). Starting in 2025, EHR developers that supply Predictive DSIs as part of the developer's EHR offering must disclose specific attributes and inform users if patient demographic, social determinants of health, or health assessment data are used in the Predictive DSI. EHRs will be subject to regulatory requirements regarding the design, development, training, and evaluation of Predictive DSIs along with mandated risk management practices. ASTP/ONC's stated goal is to ensure that physicians understand how these tools work, how data are used, the potential for bias, and any known limitations.

FDA Approved AI-Enabled Medical Devices

The FDA continues to rapidly approve AI-enabled medical devices. While FDA approval and clearance of algorithmic-based devices date back to 1995, clearance and approval of these devices has rapidly accelerated in the last several years. As of May 2024, 882 devices that FDA classifies as Artificial Intelligence/Machine Learning (AI/ML) devices have been approved for marketing.

* On July 25, 2024, HHS announced that ONC will be renamed the Assistant Secretary for Technology Policy and Office of the National Coordinator for Health Information Technology (ASTP/ONC).

The overwhelming number of these devices are classified as radiology devices and this category of devices has seen the steadiest increases in the number of applications for FDA approval. However, the number of applications is increasing in several specialties, including cardiology, neurology, hematology, gastroenterology, urology, anesthesiology, otolaryngology, ophthalmology, and pathology. A significant number of cleared or approved devices are considered diagnostic in nature and many currently support screening or triage functions.

In 2017, the FDA announced that it was evaluating a potentially new regulatory approach towards Software as a Medical Device, which would include AI/ML technologies. The so-called Pre-Certification program, or "Pre-Cert," progressed to an initial pilot program involving nine manufacturer applicants. The program proposed to pre-certify manufacturers of software-based medical devices. Devices developed by pre-certified manufacturers would be subject to varying levels of FDA review based on risk to patients, including potentially being exempt from review if the risk is low. However, the Pre-Cert program has been tabled and the pilot dismantled for the time being, leaving FDA to utilize traditional review pathways for AI-enabled medical devices. In the absence of new regulatory strategies tailored to Software as a Medical Device (SaMD) and AI/ML, FDA has issued some proposed guidance for developers of these devices but has not yet moved forward with additional guidance for important, physician-facing topics, such as transparency and labeling requirements. In June 2024, the FDA released a set of "guiding principles" for AI transparency in conjunction with Health Canada and the Medicines and Healthcare Products Regulatory Agency of the United Kingdom. However, these guiding principles do not represent official FDA guidance nor are they mandatory requirements of applicants for FDA review. The continued lack of transparency mandates leaves a critical gap in the oversight of AI-enabled medical devices.

Data Privacy and Cybersecurity Considerations in Health Care AI

The integration of AI into health care signifies a transformative era, with potential to greatly enhance patient care and operational efficiency. However, this advancement also introduces considerable challenges, particularly in data privacy and cybersecurity. As health care facilities, technology vendors, clinicians, and users increasingly adopt AI, it is vital to focus on protecting patient and user data and securing AI systems against cyber threats. Handling vast amounts of sensitive data raises critical questions about privacy and security. Survey data has shown that nine out of 10 patients believe privacy is a right and nearly 75 percent of people are concerned about protecting the privacy of their health data.[1] Addressing these concerns necessitates a multifaceted approach that includes advanced data privacy techniques, data use transparency, robust cybersecurity strategies, and compliance with regulatory standards.

Ensuring the protection of patient data in the context of AI requires sophisticated privacy techniques. Key methods such as anonymization and pseudonymization can remove or replace personal identifiers in data sets and significantly reduce the risk of re-identification. Additionally, implementing a robust data management system empowers patients by providing clear ways to grant, deny, or revoke consent for the use of their data, enhancing patient trust and ensuring compliance with global data protection regulations such as the General Data Protection Regulation and the Health Insurance Portability and Accountability Act (HIPAA). Moreover, the collection of data should be kept to a minimum. By collecting only the data necessary for the intended purpose, AI systems can mitigate the risks associated with data breaches and misuse.

Cybersecurity plays a crucial role in health care, especially in the context of the increasing digitalization of medical records, patient data, and health care services. The health care sector is a prime target for cyber-attacks due to the sensitivity and value of the data it handles, including

personal health information (PHI), financial data, and intellectual property related to medical research. The integration of technology in health care has undoubtedly brought significant benefits such as improved patient care, streamlined operations, and enhanced data analytics. However, it also introduces vulnerabilities. These include potential unauthorized access, data breaches, and disruptions to health care services, which can have dire consequences for patient privacy and safety. In 2017, 83 percent of surveyed physicians had already experienced a cyberattack and 85 percent stated that they want to share electronic PHI but were concerned about the data security necessary to protect it.[2] This risk is amplified by the recent increased use of interconnected devices and systems, such as EHRs, telemedicine platforms, and mobile health applications.

The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck by a ransomware attack that significantly disrupted the largest health care payment and operations system in the United States. This incident led to widespread disruptions, affecting thousands of medical practices, hospitals, pharmacies, and others. The attack was attributed to ransomware. Despite efforts to recover from this attack, the impact on health care operations was profound, including the disruption of claims processing, payments, and electronic prescriptions leading to financial strain on physicians and delays in patient care. The health care sector's reliance on interconnected digital systems for patient records, billing, and payments, means that the impact of a cyberattack can be both immediate and widespread, affecting patient care and operational continuity.

The implications of cybersecurity in health care AI are multifaceted. AI in health care, encompassing machine learning algorithms, predictive analytics, and robotic process automation, holds immense potential for diagnostic accuracy, personalized medicine, and operational efficiency. However, the deployment of AI in health care settings creates unique cybersecurity challenges. AI systems require large datasets to train and operate effectively, increasing the risk of large-scale data breaches. Additionally, the complexity of AI algorithms can make them opaque and vulnerable to manipulation, such as adversarial attacks that can lead to misdiagnoses or inappropriate treatment recommendations. AI-driven health care solutions often rely on continuous data exchange across networks, escalating the risk of cyber-attacks that can compromise both the integrity and availability of critical health care services.

A model stealing attack represents a significant cybersecurity threat in the realm of AI, where a malicious actor systematically queries an AI system to understand its behavior and subsequently replicates its functionality. This form of intellectual property theft is particularly alarming due to the substantial resources and time required to develop sophisticated AI models. An example of this issue involves a health care organization that has invested heavily in an AI model designed to predict patient health outcomes based on a wide range of variables. If a malicious entity were to engage in model stealing by extensively querying this predictive model, it could essentially duplicate the original model's predictive capabilities along with capitalizing on sensitive health care information and physicians, users, or the entity's intellectual property. Absent strong protections against input manipulation and malicious attacks, AI can become a new conduit for bad actors to compromise health care organizations and harm patients. This not only undermines the original investment but also poses a direct threat to the competitive advantage of the innovating organization.

Moreover, the risk extends beyond intellectual property theft to encompass serious privacy concerns. This is exemplified by incidents where generative AI models, trained on vast datasets, inadvertently reveal sensitive information contained within their training data in response to certain prompts. In the health care sector, where models are often trained on highly sensitive patient data,

including personally identifiable information, the unauthorized extraction of this data can lead to significant breaches of patient confidentiality. The dual threat of intellectual property theft and data privacy breaches underscores the critical need for robust cybersecurity measures in safeguarding AI models, particularly those developed and utilized within the health care industry, to maintain the integrity of both their intellectual property and the confidentiality of the sensitive data they handle.

While there are new federal policies to increase data transparency when AI is used in conjunction with health information technology, such as those issued by ASTP/ONC, these new policies only cover the certified EHR developer and stop short of holding AI developers accountable for robust data governance or data security and privacy practices.[3]

Generative AI

The broad introduction of generative AI into the public sphere in 2022 saw a paradigm shift in how physicians contemplated AI. Open-source LLM Chat GPT presented a new, easily accessible AI-enabled technology with significant capabilities to generate new content and provide readily available access to information from a huge number of sources. Generative AI tools have significant potential to relieve physician administrative burdens by helping to address actions such as in-box management, patient messages, and prior authorization requests. They also show promise in providing clinical decision support and highly personalized treatment recommendations.

However, these generative AI tools can also pose significant risk, particularly for clinical applications. As these LLMs are constantly evolving, they run the risk of providing inconsistent responses on the same fact pattern on potentially a daily, weekly, monthly, or yearly basis. The risks of these tools fabricating content are well known and could serve to propagate the spread of medical misinformation as content fabricated by the AI technologies is more broadly disseminated. They also pose potentially significant data privacy concerns.

At the present time, these technologies are largely unregulated, as there is no current regulatory structure for generative AI clinical decision support tools unless they meet the definition of a medical device regulated by the FDA. The U.S. Federal Trade Commission (FTC) has limited authority to regulate data privacy issues that may be associated with generative AI. The FTC does have some authority to regulate activities considered to be an unfair, deceptive, or abusive business practice and can enforce laws for consumer protection. However, these authorities are not specific to AI and the agency is generally under-resourced in this area. CMS has some authority to regulate use of AI by entities receiving funds from Medicare and Medicaid, including use by Medicare Advantage plans. OCR has some additional authorities to regulate data privacy and nondiscrimination.

While some federal agencies may have oversight and authorities to regulate some aspects of AI, there are many regulatory gaps. These regulatory gaps are particularly significant when considering generative AI, as tools like ChatGPT and others currently fall well outside the definition of a regulated medical device. While generative AI use for clinical applications is relatively limited currently, it is expected to grow and patients and physicians will need assurances that it is providing safe, accurate, non-discriminatory answers to the full extent possible, whether through regulation or generally accepted standards for design, development, and deployment.

Physician Liability for Use of AI

One of the most significant concerns raised by physicians regarding the use of AI in clinical practice is concern over potential liability for use of AI that ultimately performs poorly. The

question of liability for the use of AI is novel and complex given that the use of AI for activities, such as clinical decision making and treatment recommendations, introduces an element of shared decision making between the patient, physician, and now the machine. While it is likely that liability will mostly be determined by the legal system through decisions in courts of law, some federal agencies have considered the idea of physician liability in these instances. Notably, the HHS Office of Civil Rights has finalized a rule creating new liability for physicians utilizing AI that results in discriminatory harms to patients. This could include, for example AI that utilizes algorithms with race adjustments or returns otherwise biased results to physicians and patients. The final rule prohibits discrimination by clinical algorithms and requires physicians, hospitals, health systems, and others to use "reasonable efforts" to both identify algorithmic discrimination and to mitigate resulting harms. While the AMA supports a prohibition on discrimination by clinical algorithms, the AMA strongly opposed efforts to create new physician liability for the use of AI.

Use of AI By Payors

There have been numerous reports recently regarding the use of what has been termed "automated decision-making tools" by payors to process claims. However, numerous reports regarding the use of these tools show a growing tendency toward inappropriate denials of care or other limitations on coverage. Reporting by ProPublica claims that tools used by Cigna denied 300,000 claims in two months, with claims receiving an average of 1.2 seconds of review.[4] Two class action lawsuits were filed during 2023, charging both United Health Care and Humana with inappropriate claims denials resulting from use of the nHPredict AI model, a product of United Health Care subsidiary NaviHealth. Plaintiffs in those suits claim the AI model wrongfully denied care to elderly and disabled patients enrolled in Medicare Advantage (MA) plans with both companies. Plaintiffs also claim that payors used the model despite knowing that 90 percent of the tool's denials were faulty.

There is growing concern among patients and physicians about what they perceive as increasing and inappropriate denials of care resulting from the use of these automated decision-making tools. In his recent Executive Order on AI, President Biden addressed this issue as an area of concern, directing HHS to identify guidance and resources for the use of predictive and generative AI in many areas, including benefits administration, stating that it must take into account considerations such as appropriate human oversight of the application of the output from AI.

There are currently no statutory and only limited regulatory requirements addressing the use of AI and other automated decision-making tools by payors. States are beginning to look more closely at this issue given the significant negative reporting in recent months and are a likely place for near-term action on this issue. Congress has also shown increasing concern and has convened hearings for testimony on the issue; however, there has been no further Congressional action or legislation to pursue further limitations on use of these algorithms. Additionally, CMS has not taken broad regulatory action to limit the use of these algorithms by entities administering Medicare and Medicaid benefits.

AMA POLICY

The AMA has existing policies, H-480.940 and H-480.939 both titled "Augmented Intelligence in Health Care," which stem from a 2018 and 2019 Board report and cover an array of areas related to the consequences and benefits of AI use in the physician's practice. In pertinent part to this discussion, AMA Policy H-480.940 seeks to "promote development of thoughtfully designed, high-quality, clinically validated health care AI, encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI, and explore the legal implications

of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI." This policy reflects not only the significance of attribution on the part of the developer, but furthermore emphasizes that physicians and other end users also play a role in understanding the technology and the risks involved with its use.

AMA Policy H.480.939 also addresses key aspects of accountability and liability by stating that "oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment." Furthermore, this policy asserts that "liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Specifically, developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users."

AMA Policy D-480.956 supports "greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that: (1) is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature; (2) includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review; and (3) requires such reviews include human examination of patient records prior to a care denial."

AMA Policy H-480.935 directs our AMA to study and develop recommendations on the benefits and unforeseen consequences to the medical profession of LLMs such as generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content. In addition to a report back to the HOD, this policy directs AMA to work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; encourage physicians to educate patients about the benefits and risks of consumers facing LLMs including GPTs; and support publishing groups and scientific journals in efforts to ensure transparency and accountability of authors in the use and validation of text generated by augmented intelligence.

DISCUSSION

As the number of AI-enabled health care tools and systems continues to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent. With a lagging effort towards adoption of national governance policies or oversight of AI, it is critical that the physician community engage in development of policies to help drive advocacy, inform patient and physician education, and guide engagement with these new technologies. It is also important that the physician community help guide development of these tools in a way that best meets both patient and physician needs, and help define their own organization's risk tolerance, particularly where AI impacts direct patient care. AI has significant potential to advance clinical care, reduce administrative burdens, and improve clinician well-being. This may only be accomplished by ensuring that physicians engage only with AI that satisfies rigorous, clearly defined standards to meet the goals of the quadruple aim,[5] advance health equity, prioritize patient safety, and limit risks to both patients and physicians.

Oversight of Health Care Augmented Intelligence

There is currently no national policy or governance structure in place to guide the development and adoption of non-medical device AI. As discussed above, the FDA regulates AI-enabled medical devices, but many types of AI-enabled technologies fall outside the scope of FDA oversight.[6] This potentially includes AI that may have clinical applications, such as some generative AI technologies serving clinical decision support functions. While the FTC and OCR have oversight over some aspects of AI, their authorities are limited and not adequate to ensure appropriate development and deployment of AI generally, and specifically in the health care space. Likewise, ASTP/ONC's enforcement is limited and focused on EHR developers' use and integration of AI within their federally certified EHRs. While this is a major first step in requiring AI transparency, it is still the EHR developer that is regulated with few requirements on the AI developer itself. Encouragement of a whole-of-government approach to implement governance policies will help to ensure that risks to consumers and patients arising from AI are mitigated to the greatest extent possible.

In addition to the government, health care institutions, practices, and professional societies share some responsibility for appropriate oversight and governance of AI-enabled systems and technologies. Beyond government oversight or regulation, purchasers and users of these technologies should have appropriate and sufficient policies in place to ensure they are acting in accordance with the current standard of care. Similarly, clinical experts are best positioned to determine whether AI applications are high quality, appropriate, and whether the AI tools are valid from a clinical perspective. Clinical experts can best validate the clinical knowledge, clinical pathways, and standards of care used in the design of AI-enabled tools and can monitor the technology for clinical validity as it evolves over time.

Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies

As implementation of AI-enabled tools and systems increases, it is essential that use of AI in health care be transparent to both patients and physicians. Transparency requirements should be tailored in a way that best suits the needs of the end users. Care must be taken to preserve the integrity of data sets used in health care such that individual choice and data privacy are balanced with preserving algorithms that remain as pristine as possible to avoid exacerbating health care inequities. Disclosure should contribute to patient and physician knowledge without increasing administrative burden. When AI is utilized in health care decision-making at the point of care, that use should be disclosed and documented to limit risks to, and mitigate inequities for, both patients and physicians, and to allow each to understand how decisions impacting patient care or access to care are made. While transparency does not necessarily ensure AI-enabled tools are accurate, secure, or fair, it is difficult to establish trust if certain characteristics are hidden.

Heightened attention to transparency and additional transparency requirements serve several purposes. They help to ensure that the best possible decisions are made about a patient's health care and help patients and physicians identify critical decision points and possible points of error. They can also serve as mechanisms to help shield physicians from liability so that potential issues related to use of AI-enabled technologies can be isolated and accountability apportioned appropriately.

There are currently few federal requirements for transparency regarding AI. The FDA requires product labeling to provide certain information to physicians and other users, but requirements for device labeling are generally considered to be less stringent and have more leeway than drug product labeling. While FDA has stated that transparency is a key priority for the agency to address, they have not taken any additional action to update the labeling requirements for

AI-enabled medical devices or put into place additional transparency requirements for AI-enabled devices. As discussed above, ASTP/ONC also has new transparency requirements applicable to the use of AI within EHRs; however, again, those requirements are limited to AI within an EHR or other applications integrated and made available through the EHR. They will not apply to AI-enabled tools accessible through the Internet, cellular phones, etc. There is an urgent need for additional federal action to ensure AI transparency.

Transparency: Attributes and the Importance of Disclosure

During consideration of an earlier version of this report at the 2024 Annual Meeting, comments were heard during the online forum and Reference Committee B hearing regarding the recommendations on disclosure of use of AI to physicians and, ultimately, to patients. Commentors raised concerns that transparency regarding the use of AI would be overly burdensome to health systems and hospitals deploying AI and that transparency would entail disclosure of use of algorithms in any instance, including those used in EHRs, those for administrative purposes, and others that do not directly impact physician and patient decision-making. There were also concerns that the recommendations around transparency were akin to calling for burdensome informed consent for the use of AI and that disclosure of the use of AI to patients risks damaging the patient-physician relationship.

For the purposes of this report and its recommendations, "disclosure" should be understood to mean communicating to physicians or patients about the use of AI-enabled systems or technologies that directly impact medical decision making and treatment recommendations at the point of care.

Documentation involves recording of an AI system's design, development, and decision-making processes. This is primarily intended for internal teams, regulators, and researchers, and to enhance understanding, maintenance, and improvement of AI systems. Disclosure, on the other hand, refers to communicating essential information about AI systems to external stakeholders, e.g., end users. Disclosure focuses on essential aspects and, in this context, denotes the "when" and not the "what" to disclose. Concise and targeted disclosure is easier to disseminate and understand than comprehensive and nuanced details. It is important to note that disclosure should not be confused with informed consent. Informed consent is multifaceted, including benefits and drawbacks depending on its implementation and context of use. It can introduce burdens such as time-consuming paperwork, complex legal language, and potential delays in receiving care or participating in research. These burdens can deter individuals from providing their medical information or utilizing AI. Disclosure, on the other hand, is a form of transparency that builds trust, ensures accountability, supports risk management efforts, and informs users about the AI system's behavior without adding undue burden. Together, documentation and disclosure foster a comprehensive approach to AI transparency, addressing both internal and external needs.

The National Institute of Standards and Technology (NIST) frames AI risk management as a path to minimize potential negative impacts of AI systems, such as threats to civil liberties and rights, while also providing opportunities to maximize positive impacts. NIST adopted the International Organization for Standardization's (ISO) position that transparency and ethical behavior are a social responsibility when decisions and activities impact society and the environment (ISO 26000:2010).[7] NIST further states that addressing, documenting, disclosing, and managing AI risks and potential negative impacts effectively can lead to more trustworthy AI systems.[8] Moreover, multiple medical specialty organizations, including the American College of Radiology (ACR) and the American College of Physicians (ACP) support disclosure.

ACR's *Ethics of AI in Radiology* states that, for a model to be transparent, it must be both visible and understandable to outsiders, including patients. A practical approach to achieving transparency is through clear disclosure. Further, when AI is the main point of contact in health care, it is ACR's position that patients should be clearly informed that they are interacting with an AI tool. In its 2024 position paper *AI in the Provision of Health Care,* ACP emphasizes that AI transparency is important for patients as well as physicians and other clinicians. Even if patients are not, at present, explicitly informed of all the ways technology is involved in their care—for example, they may or may not be told about computer-assisted electrocardiogram or mammography interpretation—ACP asserts that, due to the novelty of AI and its potential for significant clinical impacts, honesty and transparency about its use are crucial. [9,10]

Given that transparency and disclosure are not static, their practicality or applicability are dependent on the situation and environment. ACP, for example, recognizes that transparency with patients about the integration of AI into certain devices may be reasonably feasible. In these cases, disclosure is more attuned to AI used in medical treatment and decision making and not the underlying algorithm, which could be overly burdensome. Algorithms are not new in health care; they are widely used, and many have become the standard of care. On the other hand, transparency with patients about AI integration into EHR systems and other common sources of information may be less feasible, especially given that physicians are often not made aware of the integration.

Nevertheless, as NIST notes, meaningful transparency should provide access to appropriate levels of information based on the stage of the AI lifecycle and tailored to the role or knowledge of individuals interacting with or using the AI system.

Ethical Considerations for Disclosure of the Use of AI that Impacts Clinical Decision Making

The AMA was founded in part to establish the world's first national code of medical ethics. Opinions included in the AMA Code of Medical Ethics aim to address issues and challenges confronting the medical profession and represent AMA policy. Promoting adherence to the professional standards promulgated in the Code is essential to preserving patient trust and public confidence in the medical profession.

Included as part of the Code are the ethical responsibilities of physicians as they relate to transparency in health care.[11] The Code states that "[p]atients must rely on their physicians to provide information that patients reasonably would want to know to make informed, well-considered decisions about their health care," and that "physicians have an obligation to inform patients about…tools that influence treatment recommendations and care." The Code additionally states that, where treatment recommendations are concerned, "[p]atients 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."[12]

Physician use of AI is not an exception to the Code, nor is there separate ethical guidance for the use of AI at this time. The Code suggests that communication to physicians and patients about the use of AI that may directly impact medical decision making and treatment recommendations is in line with prevailing ethical principles. It may be particularly important seeing that, at this time, patients are expressing broad discomfort with the notion of their physicians relying on AI in their own health care.[13] To best foster trust, both between physicians and developers/deployers, and between physicians and patients, use of AI that may directly impact medical decision making should be communicated to parties involved in that decision making.

Intersections between Physician Liability and Disclosure of the Use of AI in Clinical Practice

AI transparency, both in disclosing use to physicians and to patients as well as disclosure of key information to physicians regarding the tools by AI developers and deployers, is an essential component to managing risk and potentially reducing physician liability resulting from the use of AI. As with hardware devices and other medical products, physicians are ultimately responsible for the appropriate selection and use of devices, diagnostics, and other products in clinical practice. Claims of lack of knowledge or understanding of the system in question will likely weaken a defense in any medical liability case involving AI-enabled technology. Therefore, it is essential that both physicians and patients are aware when AI impacts clinical decision-making and understand how it factors into the process. This ensures that accountability and liability can be appropriately assigned when poor AI performance leads to poor patient outcomes, or where the AI-technology is itself defective (similar to when a device or diagnostic product is defective).

Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

Along with significant opportunity to improve patient care, all new technologies in health care will likely present certain risks and limitations that physicians must carefully navigate during the early stages of clinical implementation of these new systems and tools. AI-enabled tools are no different and are perhaps more challenging than other advances as they present novel and complex questions and risks. To best mitigate these risks, it is critical that physicians understand AI-driven technologies and have access to certain information about the AI tool or system being considered, including how it was trained and validated, so that they can assess the quality, performance, equity, and utility of the tool to the best of their ability. This information may also establish a set of baseline metrics for comparing AI tools. Transparency and explainability regarding the design, development, and deployment processes should be mandated by law where feasible, including potential sources of inequity in problem formulation, inputs, and implementation. Additionally, sufficient detail should be disclosed to allow physicians to determine whether a given AI-enabled tool would reasonably apply to the individual patient they are treating.

Physicians should be aware and understand that, where they utilize AI-enabled tools and systems without transparency provided by the AI developer, their risks of liability for reliance on that AI will likely increase. The need for full transparency is greatest where AI-enabled systems have greater impact on direct patient care, such as by AI-enabled medical devices, clinical decision support, and interaction with AI-driven chatbots. Transparency needs may be somewhat lower where AI is utilized for primarily administrative, practice-management functions.

While some of this information may be provided in labeling for FDA cleared and approved medical devices, the labeling requirements for such devices have not been specifically tailored to clearly convey information about these new types of devices. Updated guidance for FDA-regulated medical devices is needed to provide this critical information. Congress should consider actions to ensure appropriate authorities exist to require appropriate information to be provided to users of AI so that they can best evaluate the technology to determine reported performance, intended use, intended population, and appropriateness for the task. Developers and vendors should provide this information about their products, and physicians and other purchasers should consider this information when selecting the AI tools they use.

Generative AI

Generative AI is a type of AI that can recognize, summarize, translate, predict, and generate text and other content based on knowledge gained from large datasets. Generative AI tools are finding

an increasing number of uses in health care, including assistance with administrative functions, such as generating office notes, responding to documentation requests, and generating patient messages. Additionally, there has been increasing discussion about clinical applications of generative AI, including use as clinical decision support to provide differential diagnoses, early detection and intervention, and to assist in treatment planning. While generative AI tools show tremendous promise to make a significant contribution to health care, there are a number of risks and limitations to consider when using these tools in a clinical setting or for direct patient care. These risks are especially important to consider for clinical applications that may impact clinical decision-making and treatment planning where risks to patients are higher.

Given that there are no regulations or generally accepted standards or frameworks to govern the design, development, and deployment of generative AI, consideration and mitigation of the significant risks are paramount. To manage risk, health care organizations should develop and adopt appropriate polices that anticipate and minimize negative impacts. Physicians who consider utilizing a generative AI-based tool in their practice should ensure that all practice staff are educated on the risks and limitations, including patient privacy concerns, and should have appropriate governance policies in place for its use prior to adoption. Also, as raised in Resolution 206-I-23, physicians should be encouraged to educate their patients about the benefits and risks of using AI-based tools, such as LLMs, for information about health care conditions, treatment options, or the type of health care professionals who have the education, training, and qualifications to treat a particular condition. Patients and physicians should be aware that chatbots powered by LLMs/generative AI could provide inaccurate, misleading, or unreliable information and recommendations. This principle is incorporated in the recommendations in this report and current AMA Policy H-480.940, "Augmented Intelligence in Health Care."

Liability

The question of physician liability for use of AI-enabled technologies presents novel and complex legal questions and poses risks to the successful clinical integration of AI-enabled technologies. It is also one of the most serious concerns for physicians when considering integration of AI into their practice. Concerns also arise for employed physicians who feel they may have no choice but to utilize the AI, should hospitals or health systems mandate its use or utilize an EHR system that incorporates AI-based applications as standard.

The challenge for physicians regarding questions of liability for use of AI is that there is not yet any clear legal standard for determining liability. While there are clear standards for physician liability generally and for medical device liability, AI presents novel and potentially complex legal questions. When AI has suggested a diagnosis, the question of how appropriate it is for a physician to rely on that result is yet to be determined and will likely continue to evolve as AI improves. Ultimately the "standard of care" will help guide physician liability. It is expected that, as it improves over time, AI will be incorporated into what is likely to be specialty-specific standards of care. However, until that occurs, AI-transparency is of critical importance and physicians will need to be diligent in ensuring that they engage with AI tools where performance has been validated in their practice setting.

As AI continues to evolve, there may ultimately be questions regarding liability when physicians fail to use AI and rely only on their professional judgment. Again, this question may ultimately turn on what evolves to be considered the standard of care.

It should be noted that, when using AI, physicians will still be subject to general legal theories regarding medical liability. Negligent selection of an AI tool, including using tools outside their

intended use or intended population, or choosing a tool where there is no evidence of clinical validation, could be decisions that expose a physician to a liability claim.

Data Privacy and Augmented Intelligence

Data privacy is highly relevant to AI development, implementation, and use. The AMA is deeply invested in ensuring individual patient rights and protections from discrimination remain intact, that these assurances are guaranteed, and that the responsibility rests with the data holders. AI development, training, and use requires assembling large collections of health data. AI machine learning is data hungry; it requires massive amounts of data to function properly. Increasingly, more electronic health records are interoperable across the health care system and, therefore, are accessible by AI trained or deployed in medical settings. AI developers may enter into legal arrangements (e.g., business associate agreements) that bring them under the HIPAA Privacy and Security Rules. However, physicians and medical providers are often seen as the sole responsible parties, expected to bear the burden of data protection. This position is not sustainable. Given the newness of AI and its potential for clinically significant effects on care, equitable accountability must be established. While some uses of AI in health care, such as research, are not allowed by HIPAA absent patient authorization, the applicability of other HIPAA privacy protections to AI use is not as clear and HIPAA cannot protect patients from the "black box" nature of AI which makes the use of data opaque. AI system outputs may also include inferences that reveal personal data or previously confidential details about individuals. This can result in a lack of accountability and trust and exacerbate data privacy concerns. Often, AI developers and implementers are themselves unaware of exactly how their products use information to make recommendations.

It is unlikely that physicians or patients will have any clear insight into a generative AI tool's conformance to state or federal data privacy laws. LLMs are trained on data scraped from the web and other digital sources, including one well-documented instance where HIPAA privacy protections were violated.[14] Few, if any, controls are available to help users protect the data they voluntarily enter in a chatbot query. For instance, there are often no mechanisms in place for users to request data deletion or ensure that their inputs are not stored or used for future model training. While tools designed for medical use should align with HIPAA, many "HIPAA-compliant" generative tools rely on antiquated notions of deidentification, i.e., stripping data of personal information. With today's advances in computing power, data can easily be reidentified. Rather than aiming to make LLMs compliant with HIPAA, all health care AI-powered generative tools should be designed from the ground up with data privacy in mind. Additionally, some companies have intentionally misled the public and end-users by labeling their software tools as "HIPAA compliant", when the entity itself was not a covered entity or business associate and therefore not subject to HIPAA Privacy Rules.

The AMA's Privacy Principles were designed to provide individuals with rights and protections and shift the responsibility for privacy to third-party data holders. While the Principles are broadly applicable to all AI developers, e.g., entities should only collect the minimum amount of information needed for a particular purpose, the unique nature of LLMs and generative AI warrant special emphasis on entity responsibility and user education.

Augmented Intelligence Cybersecurity

Data privacy relies on strong data security measures. There is growing concern that cyber criminals will use AI to attack health care organizations. AI poses new threats to health IT operations. AI-operated ransomware and AI-operated malware can be targeted to infiltrate health IT systems and automatically exploit vulnerabilities. Attackers using ChatGPT can craft convincing or authentic

emails and use phishing techniques that entice people to click on links—giving them access to the entire electronic health record system.

AI is particularly sensitive to the quality of data. Data poisoning is the introduction of "bad" data into an AI training set, affecting the model's output. AI requires large sets of data to build logic and patterns used in clinical decision-making. Protecting this source data is critical. Threat actors could also introduce input data that compromises the overall function of the AI tool. Failure to secure and validate these inputs, and corresponding data, can contaminate AI models—resulting in patient harm.

Because stringent privacy protections and higher data quality standards might slow model development, there could be a tendency to forgo essential data privacy and security precautions. However, strengthening AI systems against cybersecurity threats is crucial to their reliability, resiliency, and safety.

Mis- and Disinformation Propagated by AI

Health mis- and disinformation poses a serious threat to public health. It can cause significant confusion among patients, increase patient mistrust in science and in physicians, result in patients making decisions that cause themselves harm, and undermine the ability to manage public health threats. The dissemination of mis- and disinformation in health care significantly increased during the COVID-19 pandemic and shows no signs of abating. Whether intentionally or unintentionally, AI, in particular generative AI, runs the risk of contributing to the creation and dissemination of scientific and medical mis- and disinformation. Physicians, staff, and patients must all be aware of the risks of mis- and disinformation when engaging with generative and other forms of AI. Generative AI can propagate mis- and disinformation in several ways. It can engage in the unintentional or intentional creation of incorrect information on its own. The risk of generative AI "hallucinating," "confabulating," or otherwise fabricating information in response to a user-generated query has been well documented.[15,16] Notably, tools such as ChatGPT have shown a not-uncommon tendency to falsify references cited in response to these queries. Generative AI tools have demonstrated the ability to generate fraudulent scientific/medical literature.[17] They are also capable of plagiarizing, falsifying, or misrepresenting data in ways that could compromise research integrity. Additionally, retracted papers may have the ability to continue to impact the content generated by LLM-based tools, potentially leading to dissemination or inaccurate or otherwise discredited information.

AI can also be responsible for intentionally or unintentionally disseminating false information or intentional misinformation, which can happen when that information is used as part of the training data set for the model, used as a reference in a response to a query, or otherwise presented to a user in a query response. Information presented to users by generative AI models can be extremely convincing, with the users potentially having little reason to doubt what is presented.

There is little opportunity currently to regulate AI's role in propagation of health mis- and disinformation under current oversight structures. The FTC is the most likely agency to take action against mis- and disinformation, as it has broad authorities to regulate unfair and deceptive business practices. However, as discussed above, the FTC will require additional resources to appropriately regulate the role of AI in propagating mis- and disinformation. Regulation of mis- and disinformation is further complicated by the intersection of false and misleading information with free speech rights guaranteed by the First Amendment.

It is critical that the health care industry and health care stakeholders broadly take action to limit AI's ability to create or disseminate mis- or disinformation. Developers of AI should be accountable for their product creating or disseminating false information and should have mechanisms in place to allow for reporting of mis- and disinformation. Federal regulations should seek to eliminate the propagation of mis- and disinformation by AI-enabled tools. Ethical principles for use of AI in medical and scientific research should be in place to ensure continued research integrity. Journals should ensure that they have clear guidelines in place to regulate the use of AI in scientific publications that include documenting and detailing the use of AI in research and to exclude the use of AI systems as authors. Policies should also detail the responsibility of authors to validate the veracity of any text generated by AI. (See Policy H-480.935, Assessing the Potentially Dangerous Intersection Between AI and Misinformation).

Payor Use of Augmented Intelligence in Automated Decision-Making

Payors and health plans are increasingly using AI and algorithm-based decision-making in an automated fashion to determine coverage limits, make claim determinations, and engage in benefit design. Payors should leverage automated decision-making systems that improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. While the use of these systems can create efficiencies such as speeding up prior authorization and cutting down on paperwork, there is concern these systems are not being designed or supervised effectively creating access barriers for patients and limiting essential benefits.

Increasingly, evidence indicates that payors are using automated decision-making systems to deny care more rapidly, often with little or no human review. This manifests in the form of increased denials, stricter coverage limitations, and constrained benefit offerings. For example, a payor allowed an automated system to cut off insurance payments for Medicare Advantage patients struggling to recover from severe diseases, forcing them to forgo care or pay out of pocket. In some instances, payors instantly reject claims on medical grounds without opening or reviewing the patient's medical record. There is also a lack of transparency in the development of automated decision-making systems. Rather than payors making determinations based on individualized patient care needs, reports show that decisions are based on algorithms developed using average or "similar patients" pulled from a database. Models that rely on generalized, historical data can also perpetuate biases leading to discriminatory practices or less inclusive coverage.[18,19,20,21]

While AI can be used inappropriately by payors with severe detrimental outcomes to patients, it can also serve to reduce administrative burdens on physicians, providing the ability to more easily submit prior authorization and documentation requests in standardized forms that require less physician and staff time. Given the significant burden placed on physicians and administrative staff by prior authorization requests, AI could provide much needed relief and help to increase professional satisfaction among health care professionals. With clear guidelines, AI-enabled decision-making systems may also be appropriate for use in some lower-risk, less complex care decisions.

While payor use of AI in well-defined situations with clear guidelines has the potential to reduce burdens and benefit physician practices, new regulatory or legislative action is necessary to ensure that automated decision-making systems do not reduce needed care, nor systematically withhold care from specific groups. Steps should be taken to ensure that these systems do not override clinical judgment. Patients and physicians should be informed and empowered to question a payor's automated decision-making. There should be stronger regulatory oversight, transparency, and audits when payors use these systems for coverage, claim determinations, and benefit design.

[See Policy D-480.956, "Use of Augmented Intelligence for Prior Authorization;" and Policy H-320.939, "Prior Authorization and Utilization Management Reform"]

CONCLUSION

As the number of AI-enabled health care tools and systems continue to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, accurate, and transparent. In line with AMA Policy H-480-935 and Resolution 206-I-23, this report highlights some of the potential benefits and risks to the medical profession and patients of LLMs (e.g., GPTs) and other AI-generated medical decision-making tools, and recommends adoption of policy to help inform patient and physician education and guide engagement with this new technology, as well as position the AMA to advocate for governance policies that help to ensure that risks arising from AI are mitigated to the greatest extent possible.

RECOMMENDATION

The Board of Trustees recommends that the following be adopted as new policy in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

1) General Governance
    a) Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, accurate, and transparent.
    b) Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
    c) Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
    d) AI systems should be developed and evaluated with a specific focus on mitigating bias and promoting health equity, ensuring that the deployment of these technologies does not exacerbate existing disparities in health care access, treatment, or outcomes.
    e) Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the overall potential of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)]
    f) AI risk management should minimize potential negative impacts of health care AI systems while providing opportunities to maximize positive impacts.
    g) Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan. With few exceptions, there generally should be a human in the loop when it comes to medical decision making capable of intervening or overriding the output of an AI model.
    h) Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow and, in

institutional settings, consistent with AMA Policy H-225.940 - Augmented Intelligence and Organized Medical Staff.

i) Medical specialty societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

2) When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies That Impact Medical Decision Making at the Point of Care
   a) Decisions regarding transparency and disclosure of the use of AI should be based upon a risk- and impact-based approach that considers the unique circumstance of AI and its use case. The need for transparency and disclosure is greater where the performance of an AI-enabled technology has a greater risk of causing harm to a patient.
      i) AI disclosure should align and meet ethical standards or norms.
      ii) Transparency requirements should be designed to meet the needs of the end users. Documentation and disclosure should enhance patient and physician knowledge without increasing administrative burden.
      iii) When AI is used in a manner which impacts access to care or impacts medical decision making at the point of care, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
      iv) When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
   b) AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
   c) When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
   d) The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology. Where patient-facing content is generated by AI, the use of AI in generating that content should be disclosed or otherwise noted within the content.

3) What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies
   a) When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
      i) Regulatory approval status.
      ii) Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology.
      iii) Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use.
      iv) Intended population and intended practice setting.
      v) Clear description of any limitations or risks for use, including possible disparate impact.

vi) Description of how impacted populations were engaged during the AI lifecycle.
vii) Detailed information regarding data used to train the model:
(1) Data provenance.
(2) Data size and completeness.
(3) Data timeframes.
(4) Data diversity.
(5) Data labeling accuracy.
viii) Validation Data/Information and evidence of:
(1) Clinical expert validation in intended population and practice setting and intended clinical outcomes.
(2) Constraint to evidence-based outcomes and mitigation of "hallucination"/"confabulation" or other output error.
(3) Algorithmic validation.
(4) External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation.
(5) Comprehensiveness of data and steps taken to mitigate biased outcomes.
(6) Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings.
(7) Post-market surveillance activities aimed at ensuring continued safety, performance, and equity.
ix) Data Use Policy:
(1) Privacy.
(2) Security.
(3) Special considerations for protected populations or groups put at increased risk.
x) Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training.
xi) Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review.

b) Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

4) Generative Augmented Intelligence

a) Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-compliant Business Associate Agreement).

b) Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
i) Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response.
ii) Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations.
iii) Lack of regulatory or clinical oversight to ensure performance of the tool.
iv) Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes.
v) Data privacy.
vi) Cybersecurity.

vii) Physician liability associated with the use of generative AI tools.

c) Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]

d) Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.

e) Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI-driven medical advice.

f) Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content.

g) Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

5) Physician Liability for Use of Augmented Intelligence-Enabled Technologies

a) Current AMA policy states that liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. [See Augmented Intelligence in Health Care H-480.939]

i) Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.

ii) Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

iii) Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

b) When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

6) Data Privacy and Augmented Intelligence

a) Entity Responsibility:

i) Entities, e.g., AI developers, should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.

ii) Individuals should have the right to opt-out, update, or request deletion of their data from generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.

iii) Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive

measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

b) User Education:
   i) Users should be provided with training specifically on generative AI. Education should address:
      (1) Legal, ethical, and equity considerations.
      (2) Risks such as data breaches and re-identification.
      (3) Potential pitfalls of inputting sensitive and personal data.
      (4) The importance of transparency with patients regarding the use of generative AI and their data.

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

7) Augmented Intelligence Cybersecurity
   a) AI systems must have strong protections against input manipulation and malicious attacks.
   b) Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
   c) Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
   d) Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

8) Mitigating Misinformation in AI-Enabled Technologies
   a) AI developers should ensure transparency and accountability by disclosing how their models are trained and the sources of their training data. Clear disclosures are necessary to build trust in the accuracy and reliability of the information produced by AI systems.
   b) Algorithms should be developed to detect and flag potentially false and misleading content before it is widely disseminated.
   c) Developers of AI should have mechanisms in place to allow for reporting of mis- and disinformation generated or propagated by AI-enabled systems.
   d) Developers of AI systems should be guided by policies that emphasize rigorous validation and accountability for the content their tools generate, and, consistent with AMA Policy H-480.939(7), are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
   e) Academic publications and journals should establish clear guidelines to regulate the use of AI in manuscript submissions. These guidelines should include requiring the disclosure that AI was used in research methods and data collection, requiring the exclusion of AI systems as authors, and should outline the responsibility of the authors to validate the veracity of any referenced content generated by AI.
   f) Education programs are needed to enhance digital literacy, helping individuals critically assess the information they encounter online, particularly in the medical field where mis- and disinformation can have severe consequences.

9) Payor Use of Augmented Intelligence and Automated Decision-Making Systems
   a) Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.

b) Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.

c) Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.

d) Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.

e) Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.

f) Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).

g) Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

(New HOD Policy)

Fiscal Note: Less than $500.

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[5] AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team.
6 For example, the 21st Century Cures Act includes several exemptions to FDA's oversight, such as software intended for administrative support of a health care facility, maintaining or encouraging a healthy lifestyle (and is unrelated to the diagnosis, cure, mitigation, prevention, or treatment of a disease or condition), is intended to be used as electronic patient records, is intended for transferring, storing, converting formats, or displaying data or results, and otherwise does not meet the definition of a medical device under the Federal Food, Drug, and Cosmetic Act.
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REPORT 02 OF THE BOARD OF TRUSTEES (I-24)
On-Site Physician Requirements for Emergency Departments (Resolution 207-I-23)
Reference Committee B

EXECUTIVE SUMMARY

This American Medical Association (AMA) Board of Trustees report considers the appropriateness and scope of "limited rural exceptions" to proposed policy requiring the real-time, on-site presence of a qualified physician in the emergency department (ED) at all times, whose primary duty is to treat patients seeking care in that ED.

AMA policy broadly supports physician-led care in all health care settings. It also promotes physician supervision of care in the ED and supports a requirement that a physician must always "staff" the ED. Existing policy does not, however, address whether a 24/7 staffing requirement always implies the on-site presence of the physician in the ED.

Rural EDs—particularly smaller EDs in remote areas—face a different operational situation than those located in urban areas. Physicians report, and the literature supports, that these realities may make a 24/7 on-site physician requirement impracticable for certain rural EDs. While many rural EDs across the country are at risk of closure, hurdles associated with such a requirement are not primarily financial. Problems recruiting and retaining physicians to staff the ED 24/7 in some rural facilities are reported to be a challenge. Further, low census in many rural EDs may warrant different approaches to resource utilization than those pursued by larger metropolitan institutions, which may see higher patient volume.

Assessment, stabilization, and arranging appropriate transfer of high-acuity rural ED patients is critical. Physicians are best equipped to provide this type of emergency care. As such, an ideal ED staffing model will require the presence of a physician to provide care to high-acuity patients who present to the ED. Still, some physician-led care models may appropriately allow a physician to be always staffed in a rural ED 24/7, not necessarily physically present in that ED, but proximate in location and present on-site promptly. Rural hospital staffing challenges due to physician workforce limitations may necessitate limited adoption of specified alternative supervision models. These models include allowing the physician to provide care outside the ED while being on duty in the ED, requiring that the physician be available to be physically present in the ED within a specified timeframe, and certain uses of telehealth.

The application of any rural exception that would allow for this type of extended supervision likely most appropriately applied to the subset of rural EDs located in the country's most remote areas, which are most likely to face insurmountable barriers to adherence to a 24/7 on-site physician policy. However, making proper delineations when it comes to the exception's applicability is difficult, in part because there is no widely agreed-upon definition of rurality, and in part because additional factors, such as patient volume, are relevant. The unique needs of each state should be considered when determining how to apply any rural exceptions.

This report makes a concerted effort to pay due respect to the unique operational realities faced by rural EDs, while balancing the integrity of AMA policy on physician-led care. Ultimately, the recommendations proffered aim both to preserve physician supervision in the ED and to account for the needs of rural EDs—especially those in very remote areas.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-I-24

Subject: On-Site Physician Requirements for Emergency Departments (RES 207-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair,

Referred to: Reference Committee B

INTRODUCTION

This American Medical Association (AMA) Board of Trustees report arises from Resolution 207-I-23, "On-Site Physician Requirement for EDs." As introduced by the Michigan Delegation. Resolution 207 called upon the AMA to develop model legislation and support requirements for the real-time, on-site presence of a physician in the emergency department (ED), whose primary duty is to treat patients seeking care in that ED.

The AMA House of Delegates (HOD) referred the following language for study (Resolution 207-I-23) (emphasis in original):

> 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 ED. (Directive to Take Action)

Testimony in favor of Resolution 207 suggested that the AMA should take a firm stance on physician supervision in the ED based on existing AMA policy related to physician-led team-based care and as part of AMA's robust campaign promoting physician-led care. At the same time, robust testimony was heard against this resolution—exclusively from physicians representing rural delegations—expressing that the proposed requirement would be untenable for many rural hospitals and could lead to closures, ultimately depriving patients access to emergency care.

BACKGROUND

Brief Overview of Relevant AMA Policy

AMA policy that pre-dated this resolution, as well as policy that was passed concurrent with the drafting of this report, provides necessary context for the referred language. AMA has extensive policy promoting physician-led care. For example, AMA Policy H-160.949, "Practicing Medicine by Non-Physicians," provides that the AMA vigorously supports appropriate physician supervision of non-physician clinical staff in all areas of medicine, and AMA Policy H-160.947, "Physician

Assistants and Nurse Practitioners," establishes that the physician should be responsible for managing the health care of patients in all settings.

More specifically to care provided in EDs, AMA Policy D-35.976, "Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians," establishes AMA's support for laws that "ensure only physicians supervise the provision of emergency care services in an ED."[1] On top of that, after the referral of Resolution 207 at the AMA 2023 Interim Meeting and concurrent with the drafting of this report, the HOD at the 2024 Annual Meeting adopted new policy stating that, "AMA will support that all EDs be staffed 24/7 by a qualified physician."[2] Altogether, AMA policy promotes physician supervision of care in the ED and supports a requirement that a physician must staff the ED at all times. Notably, however, policy does not address whether a 24/7 staffing requirement always implies the real-time, on-site presence of the physician in the ED as suggested by Resolution 207.

Scope of This Report

Given the purview of the referred language and the strength of existing policy addressing physician-led care in the ED and in all health care settings, this report is narrow in scope and specific in focus. It considers the possibility of limited rural exceptions to potential legislation or regulation that would require the real-time, on-site presence of a physician in the ED, whose primary duty is to treat patients in that ED. In so doing, this report explores challenges faced by rural EDs that may impact their staffing decisions. It gives special consideration to the operational realities experienced by EDs in the country's most remote rural areas, and takes care to appreciate concerns, expressed by physicians with lived experience in rural areas, that a round-the-clock, on-site physician supervision requirement would be untenable and possibly devastating for many rural hospitals, many of which are at risk of closure.

The aforementioned AMA policies guide the Board's approach to this report. To summarize, existing AMA policy demands that any rural exceptions to a requirement that the ED be supervised by an on-site physician who is primarily responsible for care in that ED must (a) preserve physician-led care and (b) ensure that the ED remains "staffed 24/7" by a physician. To evaluate the appropriateness of limited rural exceptions to the requirement proposed by the resolution, the Board is therefore called to consider models of physician supervision that ensure the ED is adequately "staffed 24/7" by a physician and address the challenges rural EDs face in implementing the proposed model. In so doing, this report takes very seriously the concerns raised by rural physicians. It strives to pay due respect to these considerations while preserving the integrity of AMA policy on care in the ED. Ultimately, the recommendations proffered in this report aim to address the most salient challenges faced by rural EDs surrounding the proposed requirement (for the real-time, on-site presence of a physician in the ED whose primary duty is to provide care in that ED), while maintaining alignment with relevant AMA policy.

Laws Related to Physician-led Care in EDs

While federal law requires hospitals to maintain a list of physicians who are on call to provide treatment necessary to stabilize an individual with an emergency medical condition,[3] there is no requirement that care in an ED be led by a physician. Under the relevant federal regulations, the "qualified member of the medical staff" who must supervise an ED may be a non-physician practitioner such as a physician assistant or a nurse practitioner where state law allows.[4] As such, federal law does not demand that EDs be supervised by a physician.

Governance of this issue is therefore left to the states. While most states do not have laws that expressly require physician supervision of emergency care services provided in the ED, there are a few notable exceptions. In the past two years, Indiana and Virginia have each passed state legislation requiring the on-site presence of a physician in the ED. Indiana enacted legislation in 2023 requiring that an ED must have at least one physician on site and on duty who is responsible for the ED whenever the ED is open.[5] Similarly, Virginia's 2024 law requires at least one physician who is primarily responsible for the ED to be on duty and physically present at all times at each hospital that operates or holds itself out as operating an emergency service.[6] Neither of these laws includes a rural exception. Comparable legislation has been considered but not yet enacted in a handful of additional states.

California and New Jersey also have in place longstanding regulations that promote physician-led care in the ED. California requires that a trained physician have overall responsibility for a hospital's emergency services and makes this physician responsible for ensuring that emergency services are staffed 24 hours a day by an experienced physician.[7] New Jersey's regulations around ED staffing require that at least one licensed physician be present in the ED to attend to all emergencies.[8] Both of these regulatory approaches effectively require "24/7 staffing" by a physician in the ED, with New Jersey specifically requiring the on-site presence of a physician in the ED.

State laws governing the scope of practice of non-physicians also influence the use of non-physicians in EDs. Hospitals or EDs in states where physician assistants or nurse practitioners are permitted to practice without physician supervision are more likely to employ a non-physician to supervise an ED in lieu of a physician. EDs in states that do require physician involvement in the practice of non-physicians are more likely to leverage non-physicians under some kind of physician supervision or collaboration model pursuant to state law—these models may or may not require the 24/7 on-site presence of a physician.

American College of Emergency Physicians Campaign

In June 2023, the American College of Emergency Physicians (ACEP) issued a policy statement on the role of nurse practitioners and physician assistants in emergency departments,[9] in which ACEP advocates for physician-led care teams in all EDs. As part of this campaign, ACEP has developed model legislative and regulatory language for use by states interested in advocating for on-site physician supervision in EDs. ACEP's model legislation requires that "[a] hospital with an emergency department must have a physician onsite and on duty who is primarily responsible for the emergency department at all times the emergency department is open."[10] Further, ACEP policy would require that the physician on duty in the ED solely determine what level of supervision is appropriate for patients being cared for by a nurse practitioner or a physician assistant in the ED. However, ACEP's policy statement on care in EDs also acknowledges the workforce limitations faced by certain rural hospitals and provides for the limited adoption of specified alternative supervision models where necessary in those rural hospitals facing staffing challenges.

Current ED Staffing Practices

EDs across the country are staffed by physicians from varying specialties as well as non-physicians such as nurse practitioners or physician assistants. A 2020 study found that of 48,835 clinically active emergency physicians, 92 percent were in urban areas, 6 percent were in large rural areas, and two percent were in small rural areas.[11] Those emergency physicians in urban areas were substantially younger than rural emergency physicians.[12] International medical graduates (IMGs) also make up a sizeable portion—about nine percent—of the emergency medicine workforce.

About 20 percent of these IMGs are trained in specialties other than emergency medicine, and eight percent work in small rural areas.[13] Further, a 2018 study found that of all emergency medicine clinicians (i.e., inclusive of both physicians and non-physician practitioners), about 61.1 percent were physicians residency-trained in emergency medicine and about 14.3 percent were physicians trained in other specialties such as family practice or internal medicine.[14] Non-physician practitioners such as physician assistants or nurse practitioners made up about 24.5 percent of the total emergency medicine workforce.[15]

Rural EDs may directly employ physicians or other clinicians, or they may contract with management groups or individual clinicians to meet all or part of their staffing needs. In any case, the role each practitioner plays on the care team in the ED varies depending on state law and institutional policy. As this report will explore, rural EDs often face unique challenges that impact staffing decisions.

While some EDs only staff physicians who are residency-trained and board certified in emergency medicine, it is also common for EDs to staff physicians from other specialties. A 2020 study on the emergency physician workforce found that 81 percent of practicing emergency medicine physicians were residency trained or board certified in emergency medicine, while 19 percent were trained in other specialties such as family medicine, internal medicine, or surgery.[16] There is evidence that physicians trained in specialties outside of emergency medicine are more prevalent in rural EDs than in urban ones.[17] Both literature and anecdote suggest that the staffing of these physicians may be crucial to the success of some rural EDs. The option to staff physicians from specialties outside emergency medicine emergency allows rural EDs to overcome recruitment hurdles and keep their doors open while preserving physician-led emergency care.[18] AMA policy supports all care in the ED that is physician-led and does not specify that a physician be board certified in emergency medicine or residency-trained in emergency medicine to be qualified to supervise an ED.[19]

That said, the unfortunate reality is that physician-led care in the ED is not guaranteed. Some EDs are run by nurse practitioners or physician assistants rather than by physicians. To indicate, a study of Iowa EDs found that nurse practitioners or physician assistants provided solo coverage for at least part of the week in 60 percent of the state's EDs in 2012—a number that jumped from about 39 percent in 2008.[20] More recent national research found that nearly a quarter of clinicians in EDs across the country were non-physicians (over two-thirds of whom were physician assistants and the rest nurse practitioners),[21] but notably, this study did not capture whether these non-physicians worked on physician-led teams or whether they worked in a supervisory role over the ED; other research suggests that physicians were involved with nearly 90 percent of ED visits between 2010 and 2017.[22] Still, there is speculation that use of non-physicians as a replacement for physicians in EDs is increasing,[23] and ongoing and anticipated physician shortages in rural areas support this hypothesis.[24]

Several factors may contribute to the replacement of physicians with non-physicians in both urban and rural EDs nationally, including private equity's increasing influence on health care.[25] However, there is a body of evidence that EDs in rural areas are more likely to be staffed by a non-physician than EDs in urban areas.[26] This includes workforce studies showing that urban counties have a higher proportion of emergency physicians compared with rural counties,[27] and research finding that physician assistants in rural areas are more likely to work without on-site physician supervision and to have a broader scope of practice in the ED than their urban counterparts.[28] Physicians who work in rural areas also report that recruitment challenges create the need to staff non-physicians instead of physicians in the ED, which may contribute to a trend toward use of non-physicians in rural EDs.

Rural Hospitals

Rural EDs—especially small institutions in very remote areas—face a different financial and operational situation than most EDs associated with larger metropolitan hospitals or otherwise located in urban areas. The realities associated with these differences may make a 24/7 on-site physician requirement impracticable for certain rural EDs.

Financial Vulnerability and Risk of Closure

Rural hospitals serve communities outside metropolitan areas and are often geographically isolated. EDs in these rural hospitals can be a keystone of the health care infrastructure in some areas—for example, especially in areas that are particularly remote, a single ED may serve as the sole health care safety net for patients experiencing medical emergencies. And yet, despite their role as a crucial health care resource, rural hospitals across the country are struggling to keep their doors open. Some research estimates that more than 30 percent of all rural hospitals in the U.S. are at risk of closing, and a third of those hospitals face risk of immediate closure.[29] Government Accountability Office data from 2020 reveals that more than 4 percent of rural hospitals closed from 2013 through 2020. [30] Closures have a serious impact on access to emergency services in rural areas, including by increasing the time and distance patients must travel to reach an ED. The closure of a rural ED raises grave concerns for the surrounding community's patients, as rural hospital closures have been linked to greater patient mortality.[31]

Rural hospitals confront a unique financial situation that often makes them more vulnerable than hospitals in metropolitan areas. In short, many insurers simply do not pay rural hospitals enough to cover the cost of providing services in low-population and rural communities,[32] which directly threatens the viability of many rural hospitals and EDs. Financial vulnerability and challenges covering the cost of round-the-clock physician services may play some role in a rural hospital's ability to staff a physician 24/7 in the ED, at least insofar as it can be more cost-effective for a rural hospital to use a physician's services somewhere outside the ED for higher reimbursement than in the ED.

However, while the cost associated with hiring physicians to be on-site in the ED 24/7 could contribute to a rural ED's financial vulnerability, the hurdles associated with such a requirement are not primarily financial. These organizations also experience challenges with recruitment and retention of qualified physicians to staff an ED 24/7. On top of that, low census and low patient acuity in many rural EDs may warrant different approaches to resource utilization than those pursued by larger metropolitan EDs, which may see higher patient volumes.

Physician Recruitment and Retention Issues

Rural hospitals offering emergency services grapple with workforce challenges. Because a relatively small percentage of physicians choose to practice in rural communities, the workforce inherently differs in rural areas from that of more metropolitan areas.[33] Physicians who work in rural areas report that they struggle to attract and retain physicians to staff the ED, and workforce data tends to support this. As mentioned above, a 2020 study found that only eight percent of emergency physicians were located in rural areas, with a mere two percent located in small rural areas.[34] Physicians in rural areas were also, on average, significantly older than their urban counterparts and nearing the retirement age, with most having completed their training at least 20 years prior to 2020.[35] And despite the fact that rural EDs may be more likely to staff physicians who are not specialty trained in emergency medicine, workforce research shows that less than a quarter of clinically active family medicine-trained emergency physicians practice in rural areas.[36]

Physicians who work in rural areas report that staffing challenges sometimes compound on themselves: for example, rural hospitals may require new physicians to help meet ED staffing needs as a condition of employment—such as by requiring that the physician staff the ED multiple nights per week—which may be unattractive to physicians not keen on providing emergency medical services or keeping nighttime hours.

The density of physicians providing care in EDs decreased in both large and small rural areas between 2008 and 2020.[37] One group of researchers identified a band of underserved states from North Dakota to Texas with particularly bad shortages of emergency physicians (both residency-trained in emergency medicine and in other specialties). These shortage areas are represented in white and light green on the map below (Figure A).

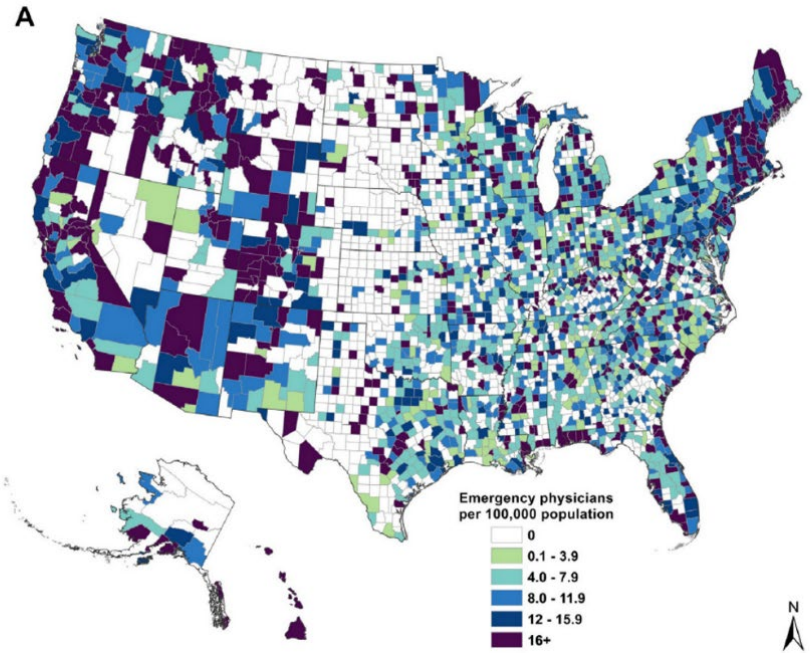

Figure A: density of emergency physicians across the country—emergency physicians per 100,000 population—includes physicians who are residency-trained or certified in emergency medicine and physicians trained in a non-emergency specialty. [38]

As a consequence of the physician shortage in rural areas—especially small rural areas—problems recruiting and retaining physicians to staff the ED emerge as a primary barrier to the ability of some rural hospitals to adhere to a 24/7 on-site physician requirement. Anecdotally, physicians on the ground in Nebraska, where at least 29 rural hospitals are at risk of closure,[39] report that "finances are not the problem"—rather, staffing is, and mention that a job listing seeking a physician to staff one ED in a remote area has been open for more than 18 months.[40] There is a concern that the inability to attract or retain a sufficient number of physicians to staff the ED on-site 24/7 in severe rural areas could result in ED closure should the proposed requirement be implemented. Further, the AMA Health Workforce Mapper and Geographic Mapping Initiative demonstrate that non-physician health care providers do not gravitate to rural areas even in states without a requirement for physician supervision or collaboration—as such, non-physicians cannot be assumed to be a robust workforce alternative to physicians.

Low Patient Volume and Low Acuity

Patient volume impacts the viability of rural hospitals and plays a role in staffing decisions. The patient volume of rural hospitals and affiliated EDs might vary significantly for several reasons, including the population of the community, the age and health status of the population, the availability of primary care options, and the accessibility of the hospital. However, rural physicians report that for many EDs—particularly ones in very remote areas—census is consistently low. Low census impacts the hospital's financial viability, in part due to a lack of service-based revenue, and because many commonly used quality measures cannot be employed when there are too few patients to reliably measure performance.[41] Patient volume also complicates decision-making around staffing models. EDs in remote areas may see lighter patient volume than urban EDs. Even though there are higher-volume EDs in some rural areas, and lower-volume EDs in some urban areas, one study found that a full 79 percentage of lower-volume EDs were located in rural areas.[42]

Survey data by non-medical chart reviewers using "a five-point scale, based on the immediacy with which the patient should be seen" provides some evidence that while visits to rural EDs have, on the whole, risen in the past 10 years, lower-acuity ED visits in rural areas may also be increasing.[43] However, that data contrasts with reports from the Emergency Department Benchmarking Alliance utilizing clinician determinations for ED patients' CPT codes that show an increase in acuity.[44] Rural physicians report that in the case of low-volume, low-acuity EDs—that is, where the ED sees light patient volume and where true emergencies are few and far between—it might become inefficient to staff the ED 24/7 with an on-site physician whose only duty is to see patients in the ED. Tending to support this, one study found that the presence of non-physician practitioners is higher among EDs that see fewer than 5,000 visits annually.[45] As discussed in more detail below, physician-led care that allows supervising physicians to provide services in areas of the hospital beyond just the ED may be appropriate for rural EDs with these characteristics.

The Importance of a Physician in Rural EDs

Even where patient volume is generally low, it is expected that patients facing life-threatening medical emergencies will present to the ED. When they do, it is critical that a physician be available to be on-site to provide care. A nurse practitioner or a physician assistant is not an adequate substitute for a physician in the ED: only physicians have the requisite training and experience to lead patient care. This remains true in rural hospitals. In rural hospitals—where there may be a dearth of community-based physicians in certain specialties that may be necessary to provide care for very high-acuity patients—assessment, stabilization, and arranging appropriate transfer of high acuity ED patients becomes critical. Physicians, who are trained in performing differential diagnosis and experienced in treating a broad range of acute illness and injury, are best equipped to provide this type of emergency care. As such, ideal rural ED staffing models will require the physical presence of a physician who might directly provide care to high-acuity patients.

24/7 Staffing Models and the On-site Presence of a Physician

As referenced in the Introduction to this report, AMA policy requires that all EDs be "staffed 24/7 by a qualified physician." This language does not necessarily imply the round-the-clock physical presence of a qualified physician. While the on-site presence of a qualified physician solely responsible for the ED is the preferred model for providing emergency medical services, some appropriate physician-led care models may allow a physician to be always staffed in certain rural EDs 24/7 but not necessarily physically present in that ED round the clock. This report explores three types of extended supervision models that require the staffing of and supervision by a

physician in the ED (in alignment with AMA policy) but forego requirements that the physician be physically on-site in the ED 24/7 or primarily responsible for care in that ED. Approaches like these may be appropriate for limited application in certain rural EDs, such as those facing the threat of closure or experiencing consistently low patient volume.

AMA policy supports physician-led care in all health care settings.[46] To be clear, for all the staffing models mentioned below, in any instance where a non-physician practitioner is on-site in the ED, that non-physician practitioner should be working as part of a physician-led care team under an appropriate collaboration or supervision agreement.

Permit Physicians to Perform Duties Beyond Staffing the ED

The proposed requirement would demand that an on-site physician in the ED be primarily responsible for supervising care in that ED. However, policies that allow supervising physicians to perform other duties in the hospital or health system beyond just staffing the ED may help rural EDs overcome staffing challenges and more efficiently leverage physician resources. This approach—sometimes called the "upstairs physician" model—may allow a physician who is supervising an especially low volume ED to perform rounds at the hospital or see patients at an outpatient clinic nearby to the ED (i.e., across the street or next door) in addition to seeing patients who present to the ED. Extending the reach of the ED physician in this way may make particular sense for rural EDs with low census.

Require that Supervising Physicians be Available but not Necessarily Physically Present

Some rural EDs currently require the *availability* of a supervising physician rather than the on-site physical presence of a physician. Under these staffing models, a supervising physician must be available to be physically present in the ED within a reasonable timeframe upon noticing that their services are necessary, for example within 20 minutes. These models work particularly well when emergency medical services are able to contact the ED or the supervising physician directly to inform them that a patient will be arriving by ambulance, thereby allowing the physician to meet the patient at the ED to provide emergency care. For lower-acuity patients, these physicians provide supervision under a supervision agreement.

Incorporation of Telehealth

Other models of extended supervision allow a physician to provide a degree of supervision via telehealth. Most recent research around telehealth use in the ED focuses on Tele-ED, a model that connects practitioners at rural or remote EDs, which may lack emergency medicine physicians or other specialists, to physicians at a well-resourced central hub ED through video technology. Literature suggests that most implementations of Tele-ED involve the connection of rural EDs to physicians who are "on call" for the rural ED (i.e., enlisted to provide consultation to fulfill the ED's obligations under the Emergency Medical Treatment and Active Labor Act) but they are often not supervising operations in that ED.[47] This is a great approach for bringing specialty expertise to under-resourced rural areas.

However, utilizing telehealth to supervise non-physicians in an ED raises other challenges. AMA Policy H-160.937, "The Promotion of Quality Telemedicine," supports the supervision of non-physicians via telehealth within certain parameters, recognizing that the physician retains the authority for, and safety and quality of services provided by the non-physician. The supervising physician must also be immediately available for consultation with ED non-physician staff and patients via telehealth. Importantly, AMA's Code of Medical Ethics 1.2.12, "Ethical Practice in Telemedicine" and other AMA policy on telehealth states that physicians have an obligation to

ensure that the use of telehealth as a modality is appropriate for the type of medical care sought and individual patient needs. In other words, as a modality, telehealth must be medically appropriate for the care provided and needs of the individual patient, as well as aligned with clinical guidelines.

Real-time telehealth consultation may be part of an extended model of physician supervision of non-physicians in the ED. However, a telehealth-only supervision model does not allow for the physician to perform a physical examination or necessary interventions which may be crucial for high-acuity patients in an ED setting. Given the type of life saving, high-acuity care that may need to be provided in an ED and which necessitates the physical presence of a physician, a telehealth-only option may be inappropriate. Consequentially, telehealth-based supervision models may be best leveraged with local physicians and combined with other extended supervision models—for example, a requirement that a physician supervising via telehealth also be in close proximity and available in-person on-site promptly to provide emergency care when needed.

Defining the Applicability of "Limited Rural Exceptions" to a 24/7 On-Site Physician Requirement

The preferred model of physician-led care in the ED is the full-time, on-site presence of a physician. However, "limited rural exceptions" to this ideal may be appropriate given the operational realities faced by certain rural EDs. The notion of "limited rural exceptions" to an on-site physician requirement calls for criteria to determine which rural EDs would qualify for such an exception. A blanket exception applicable to any ED located in a rural area may be so sweeping in breadth as to defeat the purpose of the requirement. This is supported by data from the American Hospital Association which suggests that a full 35 percent of American hospitals are located in rural areas,[48] as well as older research specific to emergency care finding that approximately 42 percent of American EDs are located in rural counties and estimating that these rural EDs see about 17 percent of all ED visits.[49] Further, not every rural hospital faces the challenges that make an on-site physician requirement impractical. Differences in EDs across the spectrum of rurality call for some nuance in determining which rural EDs might be most appropriately subject to an exception.

Likely, it is most appropriate to apply any exception to the subset of rural EDs located in the country's most remote areas that are likely to face insurmountable barriers to adherence to a 24/7 on-site physician policy. However, making proper delineations when it comes to the exception's applicability is difficult because there is no widely agreed-upon definition of "rural" or concrete spectrum of rurality. Also, rurality itself may not be determinative of the challenges most salient to the on-site supervision issue, such as low patient volume. Determinations made based on an EDs patient volume may therefore be worth considering; however, even low volume EDs may still see high acuity patients.

This report provides a few imperfect options for defining "rurality" and determining the subset of rural EDs that may most appropriately qualify for the exception at issue. Ultimately, there is no single best apparent one-size-fits-all approach; the characteristics and unique needs of each state will need to be considered when determining the scope of "limited rural exceptions" to a requirement that a physician always be on-site in the ED and primarily responsible for care in that ED.

<u>Critical Access Hospital or Rural Emergency Hospital Status</u>

One approach might base applicability of an exception on the U.S. Centers for Medicare & Medicaid Services' Critical Access Hospital (CAH) or Rural Emergency Hospital (REH) designation.

Hospitals classified as CAHs receive certain benefits that aim to reduce financial vulnerabilities, including cost-based reimbursement for Medicare services. A hospital's designation as a CAH would seem to imply a degree of rurality and the existence of an ED. Among other requirements, to become a CAH, a hospital must provide 24/7 emergency care and be located more than 35 miles from the nearest hospital (or 15 miles in mountainous terrain). Qualifying hospitals are also relatively small, maintaining 25 or fewer inpatient beds.[50] Given the ease of determining whether an ED is part of a CAH, and the fact that CAH designation would largely implicate small rural EDs, using CAH status as a basis for an exception to the on-site physician requirement might be an attractive option to policymakers. However, whether this approach would be adequately narrow in scope is worth considering. CAHs make up a sizeable portion of total hospitals across the country—about 22 percent of American hospitals (1,368 of the 6,120 hospitals in the United States). [51,52] Further, not all CAHs are in true rural areas; certain CAHs located within urban areas are "treated as being located in a rural area" for purposes of CAH designation.[53] As such, basing eligibility on CAH status alone may be overly inclusive.

Effective January 2023, CAHs and other small rural hospitals became eligible to apply for REH status in order to receive special Medicare payment for providing emergency services. Conversion to an REH is thought to prevent rural hospital closures.[54] To qualify for REH status, a hospital must be an acute care hospital with 50 or fewer inpatient beds, located in a rural area, and provide 24-hour emergency services as well as laboratory services, diagnostic radiologic services, and a pharmacy.[55] REHs generally provide outpatient care and cannot exceed an annual length of stay of 24 hours per patient. While REH status may indicate a degree of rurality and a small hospital size, the designation is quite new and not yet broadly utilized; further, not every state has passed legislation required to support REH status, and REH conversion may not be appropriate or feasible for all small rural hospitals.

U.S. Department of Agriculture Urban Influence Codes

The U.S. Department of Agriculture's (USDA) Urban Influence Codes (the Codes), which are applied at the county level, were developed to capture differences in economic opportunities among U.S. counties. The Codes distinguish metropolitan and nonmetropolitan areas, using population size of a metro area or the size of the largest city and proximity to both metro- and micropolitan areas.[56] The Codes are divided into a 12-part county classification made up of two metro and 10 nonmetro categories. Micropolitan and "noncore nonmetro" counties are classified by adjacency to and population of the county's largest town, which allows for a relatively fine rural-urban gradation that can be used by policy makers. [57] In short, the Codes may be useful in identifying rural counties, including remote areas—to indicate, Code 12 captures 182 "noncore" counties that are "not adjacent to [a] metro or micro area and [do not] contain a town of at least 2,500 residents."[58] As such, the Codes may be a feasible basis for determining rurality for the purpose of the limited rural exception at issue here. However, some concerns have been raised about the appropriateness of county-level determinations, both because there may be some very remote EDs on the outskirts of counties that are not considered remote under the Codes, and similarly, there may be non-remote EDs on the outskirts of counties that are generally considered very rural by the Urban Influence Code classification system.

Rural Urban Commuting Areas

The Economic Research Service (ERS) has established Rural Urban Commuting Areas (RUCA) codes using population data from the U.S. Census, urban area delineations from the U.S. Census Bureau, and commuting data from the American Community Survey. These codes apply to census tracts and make classifications using population density, urbanization, and daily commuting

measures. USDA has published a version of the RUCA classifications that makes delineations by ZIP code, which makes it easy to determine a rural hospital's classification. RUCA classification contains 10 primary and 21 secondary codes. The primary codes reflect a spectrum of metropolitan and nonmetropolitan areas, with levels 4-10 loosely indicating a rural area. Notably, the U.S. Veteran's Health Administration relies on RUCA codes to determine rurality, making designations for urban, rural, and highly rural areas, whereby highly rural areas are tracts with a RUCA score of 10, (meaning that less than 10 percentage of workers travel to urbanized areas).[59] Importantly, though, these codes are not designed to represent a continuum of rurality—rather, each code has a specific meaning, and RUCA codes are interpreted and applied differently for every purpose for which they are used, which adds a layer of complication to the application of RUCA codes for the purpose considered here. Finally, there is some concern about the fact that some census tracts and ZIP codes are geographically very large, meaning that certain classifications may seem inappropriate.

Frontier and Remote Area Codes

Frontier and Remote Area (FAR) Codes were developed by USDA Economic Research Service and the Federal Office of Rural Health Policy to assist in policy-related considerations related to isolated areas of country, that is, areas with low population size and high geographic remoteness.[60] FAR codes were specifically designed to classify frontier and remote areas.[61] They apply at the zip-code level, are determined based on the time it takes to travel by car to nearby urban areas, and are assigned based on population size and travel time. FAR designations reflect a range of degree of remoteness, distributed from Level 1 to 4, with Level 4 being the most remote. While these codes uniquely reflect a spectrum of rurality that identifies frontier and remote areas, they have not been updated since 2010 and the literature suggests they are not widely used. Some research, however, determines that the FAR definition may work well for considerations of access to health care resources,[62] which may make them a viable option for determining rurality for purposes of an exception.

AMA POLICY

As mentioned in the Introduction to this report, AMA has extensive policy supporting physician-led care in all health care settings in addition to policy specific to physician-led care in EDs.

AMA policy supports physician-led, team-based care in all health care settings and covers the appropriate supervision of nurse practitioners and physician assistants. Relevant AMA polices include the following: Support for Physician Led, Team Based Care (D-35.985); Practicing Medicine by Non-Physicians (H-160.949); Scopes of Practice of Physician Extenders (H-35.973); Supervision of Non-Physician Practitioners by Physicians (D-35.978); Physician Assistants (H-35.989); Physician Assistants and Nurse Practitioners (H-160.947); and Guidelines for Integrated Practice of Physician and Nurse Practitioner (H-160.950).

AMA policy specific to care in EDs establishes AMA's support for legislation and regulation requiring physician-led care in the ED as well as AMA's support for "24/7 staffing" of EDs by physicians. See the following policies: On-Site Emergency Care (H-130.976) and Promoting Supervision of Emergency Care Services in EDs by Physicians (D-35.976).

Regarding telehealth, AMA Policy H-160.937 supports the supervision of non-physicians via telehealth within certain parameters.

DISCUSSION

The Board of Trustees is tasked with considering "limited rural exceptions" to a requirement, to be included in model legislation, that a physician always be on-site at the ED and primarily responsible for care in that ED always. To address this question, existing AMA policy and operational realities of rural EDs which may make the proposed requirement difficult to meet must be meaningfully examined.

AMA policy on this issue is robust and cannot be ignored. Our AMA has extensive policy supporting physician-led care in all health care settings, including the ED. AMA policy specific to care provided in EDs provides that only physicians should supervise care provided in EDs—this means that according to AMA policy, care should not be provided by non-physicians such as physician assistants or nurse practitioners in the absence of adequate physician supervision. On top of that, a new policy passed at the AMA 2024 Annual Meeting calls for "24/7 staffing" of the ED by a physician. In its consideration of possible rural exceptions to the proposed requirement, the Board must honor this codified AMA policy.

At the same time, it is clear that certain rural hospitals and EDs experience different financial and workforce challenges than those faced by EDs in metropolitan areas. This is evident based on a review of relevant literature as well as a series of focus-group style conversations with physicians and experts who work in very rural areas. Even though rural EDs are a key lifeline for patients in their communities, many are at risk of closure. Even so, while financial challenges are salient, physician recruitment and retention issues emerge as the most pressing barrier standing in the way of staffing certain EDs with an on-site, full-time physician. Further, if there is low patient volume and low patient acuity, this can make it inefficient to staff the ED with a physician who is only responsible for care in that ED—sometimes the physician's services may be most effectively put to use in other areas of the hospital or health system, even while that physician is supervising the ED. Altogether, the proposed requirement for an on-site, round the clock physician who is primarily responsible for care in the ED emerges as unfeasible for certain EDs, namely those in very remote rural areas which face both recruitment challenges and low patient volume. Indeed, should such a requirement be implemented in these very remote rural areas, EDs may face closure that would deprive local patients of access to emergency care.

The preferred model of physician-led care is the full-time, on-site presence of a physician. This is due to the nature of emergency medicine, in which, as articulated by ACEP, "patients present with a broad spectrum of acute, undifferentiated illness and injury, including critical life-threatening conditions."[63] As such, the on-site presence of a physician should be pursued in all cases and required wherever feasible. Model legislation developed by ACEP may be used in advocacy toward this objective. However, given the vulnerabilities and workforce limitations experienced by certain rural hospitals, "limited rural exceptions" to this preferred model may be acceptable if necessary. Round-the-clock physician-led care in the ED may still exist even in the absence of the on-site, full-time presence of a physician in the ED who is primarily responsible for care in that ED. It may be appropriate for the AMA to aid state medical associations who, based on the needs of the state, may choose to pursue certain alternative supervision models for care provided in EDs in remote rural areas, which may constitute a "limited rural exception" to the proposed requirement.

Possible supervision models may include requirements that a supervising physician be at all times available to be physically present in the ED within a reasonable amount of time, or they may include arrangements that allow a supervising physician to provide care in other, nearby areas of the hospital or health system in addition to managing care in the ED. Telehealth, when used

appropriately, may also be incorporated into an appropriate alternative supervision model. In all cases, however, it is important that a physician maintain supervision of the ED and to ensure that a physician can be present to assess, stabilize, and manage high-acuity patients presenting to the ED. Without the availability of a physician's expertise, patient safety is put at risk.

While researchers have identified a band of localities—primarily rural—that face extreme emergency physician shortages, developing hard-and-fast criteria for the proper applicability of these rural exceptions is difficult to do at the national level. The composition of each state is highly variable, and the spectrum of rurality across the United States is broad. In any case, these rural exceptions likely most appropriately apply in very remote rural areas that face consistently low patient volume.

The recommendations provided herein aim to adhere to existing AMA policy while addressing the unique needs of rural EDs.

RECOMMENDATIONS

The AMA Board of Trustees recommends that the following be adopted in lieu of Resolution 207-I-23 entitled, "On-Site Physician Requirement for EDs," and the remainder of the report be filed:

1. That our American Medical Association recognize that the preferred model of emergency care is the on-site presence of a physician in the emergency department (ED) whose primary duty is to provide care in that ED, and support state and federal legislation or regulation requiring that a hospital with an ED must have a physician on-site and on duty who is primarily responsible for the emergency department at all times the emergency department is open. (New HOD Policy)

2. That our AMA, in the pursuit of any legislation or regulation requiring the on-site presence of a physician who is primarily responsible for care in the emergency department (ED), will support state medical associations in developing appropriate rural exceptions to such a requirement if, based on the needs of their states, the association chooses to pursue certain alternative supervision models for care provided in EDs in remote rural areas that cannot meet such a requirement due to workforce limitations, ensuring that exceptions only apply where needed. These exceptions shall preserve 24/7 physician supervision of the ED and provide for the availability of a physician to provide on-site care. (New HOD Policy)

Fiscal Note: Less than $500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 03-I-24

Subject: Stark Law Self-Referral Ban
(Res. 227-I-23)

Presented by: Michael Suk, MD, JD, MPH, MBA, Chair

Referred to: Reference Committee B

At the 2023 Interim Meeting, the House of Delegates referred Resolution 227-I-23, sponsored by the Private Practice Physicians Section. Resolution 227-I-23 asks the American Medical Association (AMA) to: 1) recognize the substantial impact of the Stark law's unequal restrictions on independent physicians; 2) support comprehensive Stark law reform aimed at rectifying the disparities by ending the ban on self-referral practices; and 3) advocate for equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care.

The Reference Committee heard mixed testimony concerning Resolution 227. Some testimony stated that the Stark law has contributed to health care market consolidation. Other testimony noted that AMA policy opposes and calls on the AMA to continue to advocate against the misuse of the Stark law and regulations to cap or control physician compensation. Testimony highlighted that the Stark law includes an exception (the in-office ancillary services exception) that allows physicians in independent practices to self-refer Medicare and Medicaid patients, subject to certain requirements. For these reasons, the HOD referred Resolution 227 for a report to be considered at the 2024 Interim Meeting.

BACKGROUND

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies. Financial relationships include both ownership/investment interests and compensation arrangements. For example, if a physician invests in an imaging center, the Stark law requires the resulting financial relationship to fit within an exception or the physician may not refer patients to the facility and the entity may not bill for the referred imaging services.

"Designated health services" are:

- clinical laboratory services;
- physical therapy, occupational therapy, and outpatient speech-language pathology services;
- radiology and certain other imaging services;
- radiation therapy services and supplies;
- DME and supplies;
- parenteral and enteral nutrients, equipment, and supplies;
- prosthetics, orthotics, and prosthetic devices and supplies;

- home health services;
- outpatient prescription drugs; and
- inpatient and outpatient hospital services.

The Stark law is a strict liability statute, which means proof of specific intent to violate the law is not required. The Stark law prohibits the submission, or causing the submission, of claims in violation of the law's restrictions on referrals. Penalties for physicians who violate the Stark law include fines as well as exclusion from participation in federal health care programs.

AMA POLICY AND ADVOCACY

The AMA has longstanding policy on the issue of self-referral by physicians. AMA Policy H-140.861, "Physicians' Self-Referral," states that physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services, when they have a financial interest in that facility.

In a similar vein, the AMA has well developed policy regarding physician ownership and referral for imaging services. AMA Policy D-270.995, "Physician Ownership and Referral for Imaging Services," states that the AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary services exception to physician self-referral laws, including as they apply to imaging services.

In addition, the AMA has adopted principles emphasizing that, in regard to their involvement with Accountable Care Organizations (ACOs), the physician's primary ethical and professional obligation is the well-being and safety of the patient. AMA Policy H-160.915, "Accountable Care Organization Principles," emphasizes in Clause 5 that federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs.

Also, H-385.914, "Stark Law and Physician Compensation," calls on the AMA to oppose and continue to advocate against the misuse of the Stark law and regulations to cap or control physician compensation.

Finally, AMA Code of Medical Ethics 9.6.9, "Physician Self-Referral," states that, in general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility.

DISCUSSION

The Board understands and recognizes the challenges the Stark law may pose on many physician practices. The Board also recognizes that restrictions on self-referral may be a contributing factor to market consolidation. Some Stark waivers for integrated systems may put independent physicians at a disadvantage and thus contribute to consolidation. Although there is some overlap between the Anti-Kickback Statute and the False Claims Act, without an increase in Stark law waivers independent physicians are not on an even playing field. An additional waiver to allow hospitals to support independent physicians in quality improvement initiatives could lead to better care coordination and efficiency. The Stark law also includes a physician-owned hospital exception for existing physician owned hospitals. H.R. 1330 specifically targets the Stark law prohibition on

physician ownership of hospitals. Current AMA policy, however, generally addresses the concerns expressed in this resolution. For example, AMA policy opposes and advocates against the misuse of the Stark law and regulations to cap or control physician compensation. Resolution 227 indicates that the Stark law provides a "blanket ban on self-referral practices." This, however, is not the case. The Stark law contains numerous exceptions, which if met, allow physicians to self-refer, e.g., when physicians self-refer to risk-bearing arrangements. Most importantly for the purposes of this report, the Stark law has a broad exception for both ownership interests and compensation arrangements that applies specifically to physician practices—the in-office ancillary services exception. Regarding any contributing factor the Stark law may have on consolidation, the AMA has extensive policy addressing issues raised by consolidated hospital markets and advocates aggressively with the goal of preventing further consolidation in those markets and restoring competition in those markets. If the Stark law were repealed, then the consolidated systems would have even less restriction, which may disadvantage the independent physician even more. Thus, a more focused approach may be better in addressing specific issues. The AMA supports the development of additional Stark law waivers that allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives which may address issues including care coordination and efficiency.

RECOMMENDATION

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 227-I-23, and the remainder of the report be filed.

1. That our American Medical Association reaffirm AMA Policies H-140.861, "Physicians Self-Referral," D-270.995, "Physician Ownership and Referral for Imaging Services," and H-385.914, "Stark Law and Physician Compensation," be reaffirmed. (Reaffirm HOD Policy)

2. That our American Medical Association supports initiatives to expand Stark law waivers to allow independent physicians, in addition to employed or affiliated physicians, to work with hospitals or health entities on quality improvement initiatives to address issues including care coordination and efficiency. (New HOD Policy)

Fiscal Note: Less than $500.

APPENDIX AMA POLICY

H-140.861, Physicians' Self-Referral
Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships--including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices--are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:
(1) Ensure that referrals are based on objective, medically relevant criteria.
(2) Ensure that the arrangement:
(a) is structured to enhance access to appropriate, high quality health care services or products;
(b) within the constraints of applicable law:
(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
(iii) adheres to fair business practices vis-a-vis the medical professional community--for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
(3) Take steps to mitigate conflicts of interest, including:
(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
(b) establishing mechanisms for utilization review to monitor referral practices; and
(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

D-270.995, Physician Ownership and Referral for Imaging Services
Our AMA will work collaboratively with state medical societies and specialty societies to actively oppose any and all federal and state legislative and regulatory efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.

H-385.914, Stark Law and Physician Compensation
Our AMA opposes and continues to advocate against the misuse of the Stark Law and regulations to cap or control physician compensation.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-I-24

Subject:	Addressing Work Requirements For J-1 Visa Waiver Physicians (Resolution 217-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2023 Interim Meeting of the American Medical Association (AMA) House of Delegates (HOD), Resolution 217 entitled, "Addressing Work Requirements for J-1 Visa Waiver Physicians," was introduced by the International Medical Graduates Section and called on the AMA to:

- 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; and
- 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.

Resolution 217 was referred to the Board of Trustees. One of the primary reasons for referral was the need for additional information concerning the accuracy of the 40-hours of direct patient care requirement as it relates to J-1 visa waivers.

BACKGROUND

J-1 Visas

A J-1 visa is a nonimmigrant exchange visitor visa that allows an individual to participate in an exchange visitor program in the United States.[1] In order to receive a J-1 visa there is a significant process that takes place that includes (but is not limited to) applying for the visa, participating in a visa interview, being accepted into a qualifying program, demonstrating certain competencies, providing a statement of need from the country of last permanent residence, and, except in very limited circumstances, being sponsored by the Educational Commission for Foreign Medical Graduates (ECFMG).[2] Once a J-1visa is acquired, the physician is expected to advance through training in the U.S. for up to seven years, though the length of the visa is usually limited to the time typically required to complete a program per the Accreditation Council of Graduate Medical Education (ACGME) and/or the American Board of Medical Specialties (ABMS).[3]

As part of these requirements, an individual who is in the U.S. on a J-1 visa must be enrolled in a "full course of study." For international medical graduates (IMGs), this means that they must participate "in a program in which a foreign medical school graduate will receive graduate medical education or training, which generally consists of a residency or fellowship program involving

health care services to patients, but does not include programs involving observation, consultation, teaching or research in which there is no or only incidental patient care. This program may consist of a medical specialty, a directly related medical subspecialty, or both."[4] No specific hour requirements are given in the definition of a "full course of study." However, per ACGME, the clinical and educational work hours of residents "must be limited to no more than 80 hours per week, averaged over a four-week period, inclusive of all in-house clinical and educational activities, clinical work done from home, and all moonlighting."[5]

H-1B Visa

An H-1B visa is a nonimmigrant visa for individuals who want to perform a specialty occupation in the U.S.[6] In order to qualify for an H-1B visa the individual must engage in an occupation that requires the "theoretical and practical application of a body of highly specialized knowledge," attain a bachelor's degree or higher, and must engage in a job that requires the individual to have a bachelor's degree or higher.[7] For an H-1B worker, full-time employment is defined as 40 hours per week unless the employer can demonstrate that less than 40 hours per week is the regular course of business for the profession. However, full-time work may not drop below 35 hours of work per week.[8] Moreover, the statutes do not define what tasks the H-1B visa holder must undertake during the 35-to-40-hour work week.

J-1 Visa Waiver

If an individual participates in the J-1 visa program, and is in graduate medical education or training, a strict two-year home country physical presence requirement attaches to the individual per section 212(e) of the Immigration and Nationality Act.[9,10] This requirement is commonly referred to as the "home country return requirement" and means that the individual must return to their home country for a total of at least two years before they can change status, adjust status, receive an immigrant visa, or receive a temporary worker visa.[11]

To forgo the home country return requirement, some IMGs choose to participate in a waiver program. The waiver programs require that IMGs:

- Have been admitted to the U.S. in J-1 visa status to receive graduate medical training.
- Obtain a statement of "no objection" from their home country.
- Demonstrate a bona fide offer of full-time employment at an accepted facility.
- Begin employment within 90 days of receiving the waiver.
- Agree to work for not less than three years in that position.
- Upon acceptance into a waiver program, the Attorney General will change the IMG's visa status from J-1 to H-1B.

The U.S. Department of State (DOS) considers full-time employment to be 40 hours per week.[12] Additionally, U.S. Citizen and Immigration Services has noted that if a noncitizen physician averages, or will average, 40 hours per week, while working a minimum of 35 hours per week, that individual may be considered to have met the full time employment requirement.[13] However, these requirements do not specify what type of work must be undertaken within those hours.

Federal Government Agency Waivers

Any U.S. federal government agency can request a J-1 waiver for a physician.[14] However, at the federal level these requests are most frequently made for IMGs by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Veterans Affairs (VA).

HHS has its own U.S. Exchange Visitor Program related to health research and clinical care. HHS can submit a waiver request to DOS on behalf of a physician that either preforms research in an area of priority or significant interest to the agency or provides health care services for a minimum of three years in a mental health or primary care Health Professional Shortage Area (HPSA).[15] To qualify for an HHS waiver, the physician must have completed their residency training no more than 12 months before the start of their employment through HHS.[16] Moreover, through the HHS waiver the physician must agree to work 40 hours per week providing primary care (family practice, general internal medicine, general pediatrics, or obstetrics/gynecology) or general psychiatric services.[17] This requirement does not specify that the services rendered must include 40 hours of direct patient care.[18]

The VA can also request visa waivers on behalf of physicians. For physicians that work for the VA the VA hospital that they work at does not have to be in an underserved area and instead of a three-year contract, the physicians must have a signed memorandum of agreement between themselves and the hospital.[19] Through the VA waiver the physician must agree to work 40 hours per week fulfilling the duties of the position including using 51 percent or more of their time engaging in patient care duties at the Veterans Health Administration (VHA).[20] Again, this requirement does not specify that the services rendered must include 40 hours of direct patient care.

Conrad 30 Waiver Work Hour Requirements

One of the main waiver programs is the Conrad 30 Waiver Program, which is run through Regional Commissions and State Departments of Public Health or their equivalent.[21] In order to be eligible for the Conrad 30 Waiver Program, the physician must:

- Hold a J-1 visa.
- Have a bona fide full-time employment contract to practice medicine in H-1B nonimmigrant status for at least 3 years at a health care facility located in an area designated by HHS as a HPSA, Medically Underserved Area (MUA), or Medically Underserved Population (MUP) or serving patients who reside in a HPSA, MUA, or MUP geography.
- Have a "no objection" statement from their home country.
- Begin working at the approved health care facility within 90 days of receiving the waiver.[22]

Conrad 30 waiver recipients are required to work full time, which is defined as 40 hours per week.[23] There are no statutory requirements that these 40 hours must be comprised solely of direct patient care. However, individual states can set work hour requirements in their Conrad 30 waiver employment contracts.

As shown in Appendix A, the work hour requirements of individual states and regional commissions varies. While most states only require 40 hours of work per week in their Conrad 30 waiver contracts, without noting specific requirements about how that time must be spent, there are several states that do require a minimum number of hours of direct patient care (e.g., 32 hours, 40 hours).

Also, there are other federal programs intended to encourage physicians to practice in underserved areas, similar to the J-1 waiver program, that do require a minimum number of hours of direct patient care. For example, the National Health Service Corps requires physicians that are accepted to the program to work full-time which is defined as working "a minimum of 40 hours per week in a clinical practice, for a minimum of 45 weeks per service year, in a National Health Service Corps approved service site."[24] Of those 40 hours at least 36 hours each week must be spent providing direct patient care.[25] Other federal programs specify clinical practice hours without specifying direct patient care hours. The Indian Health Service Loan Repayment Program requires physicians to engage in full-time clinical practice which is defined "as working a minimum of 80 hours every two-week period for an average of at least 40 hours per week."[26] Moreover, for those physicians engaging in the Public Service Loan Forgiveness Program, they must work full-time which is defined as meeting the employer's definition of "full-time" or working at least 30 hours per week, whichever is greater.[27]

DISCUSSION

One of the whereas clauses in Resolution 217 states that "for a waiver application, physicians must possess a full-time employment contract, involving at least 40 hours of work per week as a direct care physician." This, however, is inaccurate. Though all J-1 waivers require IMGs to engage in full-time employment, which is considered to be an average of 40 hours per week, there is no statutory requirement that an IMG provide 40 hours of "direct" patient care per week. Instead, as noted in Appendix A, the work hour requirements that apply to J-1 waivers vary by state, regional commission, and federal agency. Moreover, the majority of states do not specify that an IMG utilizing a waiver must engage in 40 hours of direct patient care a week. Since the federal statutes that govern J-1 waivers do not have a requirement that IMGs must provide 40 hours of direct patient care each week, there is no need to advocate for a revision in the J-1 waiver requirements. Instead, it is up to the states to decide if they will require their J-1 waiver recipients to provide direct patient care or not.

It is important to acknowledge, however, the burden that IMGs experience when they do provide 40 hours of direct patient care per week, including having trouble balancing administrative tasks and not having opportunities for professional growth. Testimony from the 2023 Interim Meeting noted that physicians who are required to provide 40 hours of direct patient care a week find it difficult to navigate the complexities of continuous patient care while also aiming to dedicate time to administrative responsibilities and pursue non-clinical leadership roles. Testimony noted that this rigid structure hampers IMGs' abilities to effectively deliver high-quality medical services while fostering their own professional progress.

CONCLUSION

Given that there is no federal statutory requirement for physicians utilizing J-1 visa waivers to provide direct patient care, the Board believes that Resolution 217-I-23 should not be adopted. However, as discussed above, some states and federal programs have established minimal direct patient care requirements. IMGs in these states may experience challenges balancing administrative tasks and may not have the same opportunities for professional growth as IMGs in other states. The Board is not in a position to determine where the balance lies, but believes that, generally, J-1 visa waiver recipients should have time within their 40-hour work week to provide direct patient care, engage in administrative duties, participate in professional development opportunities, and undertake other professional responsibilities. The Board therefore recommends adoption of policy consistent with this goal.

RECOMMENDATIONS

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 217-I-23, and the remainder of the report be filed:

> Our American Medical Association supports federal visa and visa waiver policies that include time within the federally mandated work week requirements for direct patient care, administrative tasks, professional development opportunities, and other professional responsibilities. (New HOD Policy)

Fiscal Note: Less than $500.

APPENDIX A: STATE WORK REQUIREMENTS FOR J-1VISA WAIVER RECIPIENTS

State	Work Hour Requirements
States With 40 Hour Direct Patient Care Requirement	
Alabama	Primary care and mental health physicians must engage in direct patient care at least 40 hours per week (exclusive of hospital rounds and inpatient care).[28]
Florida	The physician will practice a minimum of 40 hours per week of direct patient care.[29]
Iowa	Direct care services must be provided for a minimum 3-year term and not less than forty (40) hours per week starting the first day of employment.[30]
Kansas	The physician must serve in the clinical practice of his/her profession full time, a minimum of 40 hours per week providing direct patient care at the approved practice site(s).[31]
New Mexico	Physicians must provide direct patient care services 40 hours per week.[32]
Ohio	The physician must spend a minimum of 40 hours per week in direct clinical care.[33]
Pennsylvania	The physician must practice a minimum of 40 clinical hours in direct patient care per week.[34]
South Carolina	The physician must spend a minimum of 40 hours weekly to provide care only.[35]
Utah	Physicians must provide direct patient care services 40 hours per week.[36]
Vermont	Physicians must work a minimum of 40 hours weekly to provide patient care only.[37]
Virginia	The physician will provide direct patient care for at least 40 hours per week.[38]
Washington	The physician will work not fewer than 40 hours per week providing direct clinical patient services.[39]
West Virginia	Full-time practice means providing hands-on, direct patient care for a minimum of 40 hours per week.[40]
Appalachian Regional Commission	The physician must agree to provide direct patient care for at least forty (40) hours a week.[41]
Delta Regional Authority	The physician must agree to provide 40 hours per week or 160 hours per month of direct patient care.[42]
Southeast Crescent Regional Commission	The physician must agree to provide 40 hours per week or 160 hours per month of direct patient care.[43]
States with 32 Hour Direct Patient Care Requirement	
Louisiana	The contract must state that the physician is a full-time employee working a minimum of 40 hours per week or 160 hours per month. The hours may include 8 hours of administrative time per week. This will not include hours in teaching settings, supervising residents, fellows, or students, supervising a clinic, or other administrative work.[44]
Maine	The physician must be employed full-time with the facility with 32 of the 40 hours spent providing direct patient care.[45]
Maryland	The physician must practice a minimum of 40 hours per week (at least 32 of the required 40 hours must be in direct patient care).[46]
New Hampshire	Physicians must work a minimum of 40 hours per week in an outpatient, clinical setting. At least 32 hours of the required 40 hours per week must be

	spent providing direct patient care in the outpatient ambulatory care setting at the approved service site. The remaining eight (8) hours must be spent providing clinical services for patients in the approved service site(s), in alternative settings (e.g., hospitals, nursing homes, shelters, etc.) as directed by the approved site(s), or in administrative activities. OB/GYN physicians, Family Practice physicians (who practice obstetrics on a regular basis) and Psychiatrists: the majority of the 40 hours per week (no less than 21 hours per week) is expected to be spent providing direct patient care. The remaining 19 hours must be spent providing inpatient care at the approved service site; providing clinical services in alternative settings (e.g., hospitals, nursing homes, shelters, etc.), as directed by the approved practice site(s); or performing practice related administration. Practice–related administrative activities shall not exceed 8 hours of the minimum 40 hours per week.[47]
North Carolina	The physician will provide at least forty (40) hours per week of clinic time that includes at least 32 hours per week in direct face-to-face patient care.[48]
South Dakota	The physician will perform an average of 40 hours of medical practice per week, meaning a four-week minimum of 128 hours seeing patients on an ambulatory or in-patient basis and 32 hours of administrative work for at least 48 weeks per year. Subject to approval by the Department, the physician may opt to practice down to a minimum of 64 hours per four-week period of direct patient care within the shortage area identified in the contract. In such instances, the J-1 physician will provide up to 96 additional hours per week under any of the following conditions: providing care to patients in either the hospital inpatient or outpatient department if the hospital is shown to serve a significant portion of shortage area residents; clinical outreach to underserved populations residing in a shortage area, whether directly in person or by electronic means; public health services if approved by the department; or direct patient care in a facility or setting that serves the underserved.[49]
Wisconsin	The physician must agree to work full-time (40 hours per week), with at least 32 hours per week spent in direct patient care.[50]
States With No Specific Direct Patient Care Requirement	
Alaska	Physicians will work for no less than 40 hours a week for three years.[51]
Arizona	Physicians must work 40 hours per week at an eligible service site.[52]
Arkansas	Physicians must provide primary or specialty medical care to patients for a minimum of 40 hours per week.[53]
California	The physician must practice medicine full-time.[54]
Colorado	The physician must practice full time in an underserved area for three years.[55]
Connecticut	The Physician Applicant will commit to three (3) years of full-time employment.[56]
Delaware	The site will employ the physician on a full-time basis (minimum of 40 hours per week).[57]
Georgia	The physician will practice medicine at least 40 hours per week (or at least 80 hours per two-week period) at the approved practice site(s) in the approved discipline for a minimum of three years.[58]
Hawaii	The physician must secure an employment contract to provide patient care for at least 40 hours per week.[59]
Idaho	The physician will engage in full-time (40 hours) employment at a health facility.[60]

Illinois	The physician will engage in full-time (40 hours) employment at a health care facility.[61]
Indiana	The physician will engage in full-time employment (at least 40 hours per week) at one or more eligible service sites.[62]
Kentucky	Physicians must work full-time (at least 40 hours per week at the approved worksite).[63]
Massachusetts	The physician must agree to practice medicine for a minimum of 40 hours per week providing clinical care only. Clinical care can include paperwork and phone calls related to patient care.[64]
Michigan	The physician will practice medicine (as defined by the signed contract with employer) for at least 40 hours per week.[65]
Minnesota	The physician must agree to work at the health care facility for at least 40 hours per week. Contracts that include protected time for activities other than patient care, such as research or teaching, must specify how many hours per week will be dedicated to those activities and how many hours per week will be dedicated to patient care.[66]
Mississippi	The physician must have an employment contract indicating full-time (40 hours per week) employment with the sponsoring medical facility.[67]
New Jersey	The physician must work for a minimum of forty (40) hours per week.[68]
New York	The physician will practice on a full-time basis providing patient care for a minimum of 40 hours per week.[69]
North Dakota	The physician will work full time (40 hours per week).[70]
Oklahoma	Full-time employment is defined as an average of 40 hours per week.[71]
Oregon	The physician will provide not less than 40 hours per week of patient services.[72]
Rhode Island	The physician must have a 40-hour, three-year position in a job consistent with the Department's mission.[73]
Tennessee	Each physician specialist must agree to practice his or her specialty in affiliation with the hospital for a minimum of forty (40) hours per week.[74]
Texas	The physician will provide patient care for a minimum of 40 hours per week.[75]
Wyoming	The physician must practice medicine a minimum of 40 hours per week.[76]
Northern Border Regional Commission	The physician must agree to practice primary medical care at least forty (40) hours a week.[77]

APPENDIX B: AMA POLICY

The following AMA policy is relevant to this Board Report:

J-1 Visas and Waivers D-255.993

1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.

2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.

3. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03.

4. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B visas for their J-1 visa waiver, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.

5. Our AMA will work with state medical societies to study and report back on the feasibility of having a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.

Conrad 30 - J-1 Visa Waivers D-255.985

1. Our AMA will:

    a. lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program;
    b. advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state;
    c. advocate for expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages;
    d. publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program;
    e. advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the US in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage;
    f. work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and
    g. continue to communicate with the Conrad 30 administrators and IMGS members to share information and best practices in order to fully utilize and expand the Conrad 30 program.

2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.

3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.

4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.

5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA Litigation Center, if it meets the Litigation Center's established case selection criteria.

Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas D-255.976

Our American Medical Association will advocate that physicians who are on J-1 visas be granted a waiver and H-1B status for serving in underserved areas, be given highest priority in visa conversion to green cards upon completion of their service commitment, and be exempt from the per country limitation of H-1B visa to green card conversion.

J-1 Exchange Visitor Program (J-1 Visa) H-255.975

1. Policy of the AMA states: the purpose of the physician J-1 Visa Exchange Program is to ameliorate physician specialty shortages in other countries; and the AMA will work to correct the problems of inconsistency, lack of accountability, and non-compliance in the administration of the physician J-1 Visa Exchange Program.

2. Our AMA supports a model employment contract specific to J-1 Visa Waiver physicians.

AMA Principles on International Medical Graduates H-255.988

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.

2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.

3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.

4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.

5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.

6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.

7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.

8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.

11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.

12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. State medical licensing boards are encouraged to allow an alternate set of criteria for granting licensure in lieu of this requirement: (a) completion of medical school and residency training outside the U.S.; (b) extensive U.S. medical practice; and (c) evidence of good standing within the local medical community.

13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.

14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils, the Accreditation Council for Graduate Medical Education and its review committees, the American Board of Medical Specialties and its specialty boards, and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries

from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

23. Continued efforts to protect the rights and privileges of all physicians duly licensed in the U.S. regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background.

24. Continued study of challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce.

25. Advocacy to Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements.

Visa Complications for IMGs in GME D-255.991

1. Our AMA will:

    a. work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice;

b. promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and
c. work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.

2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs inability to complete accredited GME programs.

3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.

4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our American Medical Association recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.

2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.

5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-I-24

Subject:	Health Technology Accessibility for Aging Patients (Resolution 213-I-23)
Presented by:	Michael Suk, MD, JD, MPH, MBA, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 213-I-23, "Health Technology Accessibility for Aging Patients," sponsored by the Medical Student Section (MSS). Resolution 213-I-23 asked our American Medical Association (AMA) to:

> "support the development of a standardized definition of 'age-friendliness' in health information technology (HIT) advancements; encourage appropriate parties to identify best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults; 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; and require EHR providers to provide standardized, easily accessible digital storage space for advanced care paperwork."

Testimony was largely in support for the spirit of this resolution. Testimony highlighted the need for electronic health record (EHR) vendors to design applications that better assist the needs of aging patient populations to enable them to fully realize the potential of evolving devices and technologies. Others expressed that, while specific standards for EHR functionalities aimed at older adults is desired, a more holistic approach to addressing issues that affect a broader population, including underserved and marginalized patients and their barriers to fully utilizing health information technology, may be a more effective route for AMA advocacy.

BACKGROUND

The COVID-19 public health emergency (PHE) was the catalyst to a seismic shift in the way technology to deliver and receive care is utilized. With telehealth visits being the only mechanism to continue receiving most forms of care during the PHE, it was essential that patients could connect to their physician through video or audio technology. Aside from the known issues stemming from lack of access to a quality broadband connection for some, a separate issue persists pertaining to whether a patient has the technical ability or familiarity to successfully access an online portal, operate and troubleshoot audiovisual equipment, and communicate without the cues available during an in-person visit.[1] This is a major obstacle to achieving equitable access to telehealth and the optimal use of ancillary digital services such as a patient portal application to view clinical care summaries.

Disparities surrounding the use and adoption of technology in health care are varied and multidimensional and range from issues such as patients being unable to navigate the health care system to physician-patient communication difficulties, which are sometimes exacerbated despite implementation of new technologies.[2,3] Digital health literacy limitations as one example, create foundational barriers that are hard to overcome without the help from a physician or caretaker. Enhancements in technology may be extremely helpful in streamlining communications and other administrative functions; however, patients of any age with a mental or physical disability may be unable to experience the benefits because of that disability. More broadly, patients may have limitations due to inexperience with technology. Telehealth and other forms of health information technology (health IT) have proven to be essential tools for physicians but, the breadth of those who benefit is limited since it is not always designed in a way that is accessible to all.

AMA POLICY

Existing AMA policy 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 (H-480.937).[4] Additionally, this policy 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.

AMA Code of Medical Ethics (Code) recognizes that "[i]nnovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another." The Code states that collectively, through their professional organizations and health care institutions, physicians should:

(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
(k) Routinely monitor the telehealth/telemedicine landscape to:
    (i) identify and address adverse consequences as technologies and activities evolve; and
    (ii) identify and encourage dissemination of both positive and negative outcomes.

Policy H-480.937, however, does not explicitly address the needs for electronic structured advance care planning or adequate space to be available in the EHR to be accessible quickly. The Code states that physicians should routinely engage their patients in advance care planning in keeping with the following guidelines including incorporating notes from the advance care planning discussion into the medical record.[5]

DISCUSSION

<u>Addressing Equity in Telehealth and Health IT</u>

Access to telehealth services can be a lifeline to patients across the country and facilitates unprecedented expansion in access to crucial health care services. Also, telehealth and the use of other digital modalities will continue to be integrated into the health care system framework for treating patients and managing their care. Unfortunately, using technology to access care does not

come easily for all older adults. In a 2020 *JAMA* study measuring the prevalence of telemedicine unreadiness among older adults, the authors found that in 2018 an estimated 13 million of all older adults in the United States were not ready for video visits, predominantly owing to inexperience with technology.[6] The authors defined "unreadiness" as meeting any of the following criteria for disabilities or inexperience with technology: (1) difficulty hearing well enough to use a telephone, (2) problems speaking or making oneself understood, (3) possible or probable dementia, (4) difficulty seeing well enough, (5) owning no internet-enabled devices or being unaware of how to use them, or (6) no use of email, texting, or internet.[7] In policy H-480.937, Addressing Equity in Telehealth, our AMA 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. Telehealth must address a broad spectrum of patients with both physical and mental disabilities, of all ages and backgrounds. To help ensure equitable access including appointment scheduling, patients who are without technological proficiency or access may require a method other than electronic communication.

Electronic Advanced Care Planning

In emergent situations, the patient's EHR information may be the only means of getting physicians and the care team advanced care planning (ACP) information in the event the patient is incapacitated or when there is no family or caregiver to ensure that the patient's wishes are respected in an imminent situation. Relying on a system where ACP documentation standards are low may expose physicians to unnecessary liability with the risk of incomplete or inaccurate forms that purport to officially represent patient's preferences when in fact the information may be inaccurate or out of date.[8] One challenging aspect of ACP documentation is the non-standardized nature of documentation methods. However, there is a movement to promote structured advance care planning (S-ACP) documentation within the EHR that better facilitates the transition of most medical documentation to the EHR and allows for ACP documentation to be rapidly disseminated across diverse ambulatory settings.[9] S-ACP may provide important advantages to free-text ACP documentation, including standardization, ease-of-access, lower provider-level variability, and auditability; recognizing that it is of value to maintain a level of flexibility to capture unique, patient-centered details.[10]

CONCLUSION

The Board of Trustees (Board) recognizes that the need for accessibility considerations for health IT tools is critically important to achieve equity among aging populations, as well as underserved, marginalized, and disabled populations. The Board shares the goal of supporting efforts aimed at addressing telehealth and equity, as well as associated barriers to patients being able to fully realize the potential of technology that can increase access to care and promote better health outcomes. Resolution 213-I-23 provides an example of one population, namely the aging population, that can benefit from stronger considerations being given to developers of health IT. As discussed above, the AMA has existing policy that more broadly addresses the issue of equity and telehealth but welcomes the opportunity to further refine and enhance existing policy to be aligned with the spirit of this resolution. The Board recognizes the importance of ensuring safeguards for those who are without technological access or access. The Board, therefore, recommends amending existing policy H-480.937 in lieu of Resolution 213-I-23.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 213-I-23, and the remainder of the report be filed.:

That our American Medical Association amend Policy H-480-937 by addition and the title be changed by addition.

Policy H-480-937, ADDRESSING EQUITY IN TELEHEALTH AND HEALTH TECHNOLOGY

(1) Our American Medical Association recognizes access to broadband internet as a social determinant of health.
(2) Our AMA encourages initiatives to measure and strengthen digital literacy, with appropriate education programs, and with an emphasis on programs designed with and for historically marginalized and minoritized populations.
(3) Our AMA 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) Our AMA supports efforts to design and to improve the usability of existing electronic health record (EHR) and 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 other mental or physical disabilities.
(5) Our AMA 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) Our AMA 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) Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
(8) Our AMA 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.
(9) Our AMA 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.
(10) Our AMA encourages the development of improved solutions to incorporate structured advance care planning (ACP) documentation standards that best meet the requisite needs for patients and physicians to easily store and access in the EHR complete and accurate ACP documentation that maintains the flexibility to capture unique, patient-centered details.
(11) Our AMA encourages hospitals, health systems, and physician practices to provide a method other than electronic communication for patients who are without technological proficiency or access. (Modify Current HOD Policy)

Fiscal Note Less than $500

REFERENCES

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[5] 5.1 Advance Care Planning.
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REPORT 09 OF THE BOARD OF TRUSTEES (I-24)
Corporate Practice of Medicine Prohibition (Resolution 233-I-23)
Reference Committee B

EXECUTIVE SUMMARY

At the American Medical Association (AMA) 2023 Interim Meeting, the House of Delegates (HOD) referred Resolution 233 entitled, "Corporate Practice of Medicine Prohibition." Resolution 233 was introduced by the Private Practice Physicians Section and the Organized Medical Staff Section. The HOD referred the following amendment to existing AMA Policy H-215.981 entitled, "Corporate Practice of Medicine:"

> 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.

This report begins by discussing: (1) the different perspectives that physicians may have regarding corporate investment in physician practices; (2) the purpose of the corporate practice of medicine prohibition; and (3) the proposals that some state legislatures are considering, including corporate practice of medicine prohibitions, to restrict and scrutinize corporate investors' influence on physician practices and health care generally.

This report then examines the prospects for the federal legislation called for by Resolution 233. The Board of Trustees (Board) describes its concerns and the unintended consequences that might be the result of the AMA developing federal legislation.

Critically, however, the Board believes that the AMA should be heavily engaged in fighting the negative influence that private equity and other corporate investors are having on the practice of medicine, and that this engagement should include influencing federal legislative proposals and continuing to work closely with state medical associations in the state advocacy arena.

To this end, the Board recommends that, in lieu of adopting Resolution 233, the AMA HOD amend AMA Policy H-215.981 by: (1) adding new policy to vigorously oppose any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine; (2) adding new policy that AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups; (3) amending existing policy so that AMA will work with interested state medical associations the federal government and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the health care sector such that physician clinical autonomy and operational authority are preserved and protected; and (4) adding new policy that directs the AMA to create a state corporate practice of medicine template to assist the Federation on these issues.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-I-24

Subject: Corporate Practice of Medicine Prohibition (RES 233-I-23)

Presented by: Michael Suk, JD, MPH, MBA, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

This American Medical Association (AMA) Board of Trustees report arises from Resolution 233"Corporate Practice of Medicine Prohibition", introduced at the 2023 Interim Meeting by the Private Practice Physicians Section (PPPS) and the Organized Medical Staff Section (OMSS). The AMA House of Delegates (HOD) referred the following amendments to existing policy:

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).

Testimony was largely supportive of the resolution's underlying objectives to: (1) strengthen corporate practice of medicine prohibitions and (2) limit the controlling influence of corporate investors in health care. Much of the debate centered on the appropriateness of federal legislation to achieve this goal, in part because corporate practice of medicine (CPOM) prohibitions is governed at the state level.

BACKGROUND

The health care sector has become attractive to corporate investors. Private equity (PE) and other corporate investors are well-positioned to capitalize on the vulnerability of independent physician

practices. At the same time, an array of factors related to the complexity of care delivery—including changes in payment and delivery models, physician payment challenges, and increased administrative and regulatory burdens, health care consolidation, etc. (all of which contribute to physician practice instability and physician burnout)—drive some physicians toward corporate investment to remain independent. For many, the only other option is employment with a hospital, health insurer, etc.

Physicians are on Both Sides of this Issue

Reasons Why Physicians May Value Corporate Investment in Medical Practices

Physicians may find value in corporate investment for several reasons. Some physicians consider corporate investment as the only way to stay independent. A corporate investor may be able to manage the financial and administrative aspects of practice operations, leaving more time for physicians to focus on patient care. Other benefits may include financially attractive deals for physicians looking to exit ownership of their practices; access to capital for practice expenses or expansions; potentially reduced medical liability costs; and centralized resources for certain functions such as information technology, marketing, or human resources. To this end, some physician practices have invited corporate investors into their practices.

Reasons Why Physicians May Oppose Corporate Investment in Medical Practices

On the other hand, some physicians oppose corporate investment in physician practices because in some cases corporate investors have taken control over physician practices and exerted undue influence over clinical matters that should be reserved exclusively to the physicians. Furthermore, some investors employ a short-term business model whereby once they invest in and/or start managing a practice, they make drastic cost-cutting changes to both the practice's business operations and clinical operations. Examples of these changes include hiring non-physician practitioners to replace physicians, altering physician working conditions for the worse, and forcing physicians to do more with less. Moreover, it is not unusual for physicians to be bound by physician noncompete agreements that hinder their ability to leave the practice. There are also instances where, after the investor has extracted all profits that it can from the practice, the investor may exit and leave the practice in debt if not bankruptcy. All of this has the potential to create uncertainties for non-owner early- and mid-career physicians, placing physicians under inordinate stress and further contributing to physician burnout.

Purpose of the CPOM

To date, CPOM prohibitions have been governed at the state level—as states use their police power to protect the health and welfare of their citizens by preventing the commercialization of medicine. One of the common ways states have tried to limit lay control over physicians is by restricting lay entity or non-physician ownership in physician practices, a strategy recognized by Resolution 233. The majority of states take this approach.

For example, some of these states prohibit lay entities or non-physician practitioners from having any ownership in a practice, meaning that the practice must be wholly owned by physicians. Other states allow lay entities or individuals to own part of the practice but require that physicians must have a majority interest in the practice. In California, for example, at least 51 percent of the shares of a physician practice must be owned by a licensed physician or surgeon.

From what has been stated, it is clear that some states do not prohibit corporate investors from owning a physician practice. It is important to note, however, that these states often have in place other requirements that are designed to prohibit those investors from controlling the practice of medicine, e.g., actively enforcing fee-splitting prohibitions.

In states that prohibit or limit corporate investors from owning physician practices (in whole or in part), the only corporations that are permitted to practice medicine are physician-owned legal entities, typically known as a professional corporation or professional medical corporation (PC). States have specific requirements regarding how a PC can be structured, including but not limited to, who can serve as shareholders or owners and the composition of the board of directors.

Use of the "Friendly PC" or "Friendly Physician" Model in States that Prohibit or Limit Non-Physician Ownership in a PC

In the states that do not permit corporate investors from having a controlling interest in a PC, investors typically use an arrangement often referred to as the "friendly physician" model to invest indirectly in the practice. This is done through forming a corporation often referred to as a "management services organization" (MSO). Here the PC is frequently consolidated into one (or a small number) of the designated physician owners, some of whom will serve as "friendly physicians," i.e., sympathetic to the MSO (such that they will effectively control the PC entity on the MSO's behalf). The MSO may designate a "friendly physician" owner with whom it has a prior relationship, and who may be totally unknown to the PC's current owner physicians. Further, the MSO may have the right to replace the physician owners either at will or based upon the occurrence of a variety of events (e.g., incurrence of additional debt, initiating bankruptcy proceedings, etc.). Finally, the PC pays the MSO for providing administrative services and oftentimes, the MSO buys the practice's nonclinical assets, e.g., the office building, real estate, furniture, computers and other IT—and then leases those back to the practice. Unfortunately, as noted by the California Medical Association in an amicus brief submitted in a lawsuit filed by the American Academy of Emergency Medicine Physician Group (*American Academy of Emergency Medicine Physician Group (AAEMPG) v. Envision Healthcare Corp.*),

> Such "friendly" medical corporation arrangements are common, and in many cases can be desirable because they enable medical corporations to access and take advantage of needed capital and market resources. However, in some instances the "friendly" alignment between a lay entity and a medical corporation can cross over into prohibited territory, wherein the lay entity gains undue influence or control over the medical corporation.

Notably, the American College of Emergency Physicians also filed an amicus brief in this case.

Recent State Legislative Activity

While it is widely recognized that in many states the CPOM has been underenforced, the situation is rapidly changing. States are very aware of the harm that some PE and corporate investors have wrought in health care. State legislatures are closely scrutinizing the role of corporate interests in health care and considering diverse legislative proposals to limit the control that corporate investors have with respect to the practice of medicine, hospitals, and health care generally. What follows is a brief description, for illustrative purposes, of three state legislative strategies from 2024—strategies that other states are considering, including but not limited to strengthening the CPOM doctrine.

California AB 3129, which is currently being considered by the state senate (as of the writing of this report), would require a PE group or a hedge fund to notify and obtain the consent of the California attorney general before a transaction between the PE group or hedge fund and a health care facility, provider, or provider group, and any of those entities under common control or affiliated with a payer, can be completed. (AB 3129 amends a current prenotification law to include PE groups and hedge funds.) These notice and consent requirements, combined with a description of specific practices over which corporate interests may not intrude, may bolster the CPOM ban in California. Specifically, they call attention to transactions that may pose a threat to independent practice of medicine by physicians and provide a clearer basis for a stronger exercise of state enforcement authority. At least 10 states have enacted similar prior notice laws.

Further, per AB 3129, a PE group or hedge fund would be prohibited from interfering with the professional judgment of physicians in making health care decisions, including but not limited to: (1) determining what diagnostic tests are appropriate for a particular condition; (2) determining the need for referrals to, or consultation with, another physician; (3) being responsible for the ultimate overall care of the patient, including treatment options available to the patient; and (4) determining how many patients a physician shall see in a given period of time or how many hours a physician shall work.

Massachusetts has also been considering different bills that would help the state impose greater scrutiny and control over PE and corporate investors in the state, e.g., H 4620. As of the writing of this report, among many other provisions, H 4620, like California AB 3129, would impose notice and reporting requirements for PE acquisitions, including the size and market share of any significant equity investor in a physician practice. It also would authorize the state attorney general to collect information from PE groups and MSOs (the bill has other requirements specific to MSOs). Finally, H 4620 would also require practices to provide notice of "significant transfers of assets including, but not limited to, real estate sale lease-back arrangements," and would ban the future leasing of land from real estate investment trusts for the operation of a hospital's in-patient facilities. It would also require increased disclosure of other lease arrangements.

Finally, Oregon considered HB 4130. HB 4130 attracted much attention, and refiling is expected next session. HB 4130 would prohibit a shareholder, director or officer of a PC from participating in managing the PC or having voting shares in the corporate action that bears on the ownership, management, or governance of the PC, if the shareholder, etc., is simultaneously a shareholder, director, member, officer or employee of an MSO serving the PC. HB 4130 provides that a PC cannot remove a director or an officer by means other than majority vote of directors or officers, as appropriate, who are licensed Oregon physicians. Physician noncompete clauses would be banned except in limited circumstances by enactment of HB 4130. Further, the bill prohibits an MSO from disciplining a physician for violating a non-competition, non-disclosure, or non-disparagement agreement or for disclosing or reporting information that the physician in good faith believes is a violation of federal or state law, rules, or regulations.

As stated, while the CPOM doctrine may have historically been unenforced in many states, things are rapidly changing. State legislatures are greatly concerned about the negative impact that some corporate investors have caused in health care markets, and there is a revived interest in enforcing existing CPOM prohibitions, strengthening prohibitions, and utilizing other legislative strategies to increase corporate oversight and scrutiny of corporate investors. The AMA's state Advocacy Resource Center is closely monitoring this legislative activity and is working closely with interested state medical associations and national medical specialty societies on addressing their concerns, as they arise.

Prospects for Federal Legislation

Resolution 233 raises the issue of AMA advocating for federal legislation to prohibit CPOM. There are several concerns about "federalizing" this issue.

As noted above, historically, CPOM has been a state issue—with state legislatures working on solutions that reflect their unique health care environments. For example, while some states mandate that PCs be wholly physician owned or restrict non-physician ownership to not more than 49 percent, other states have determined that it is best not to prohibit corporate investors from owning physician practices and instead place appropriate requirements and limitations on said models. A concern with advocating for federal legislation any time there are existing variations at the state level is that the new federal legislation that is passed may supersede an existing state protection that is stronger. Thus, depending on the nature of the federal legislation, some physicians may oppose weaker federal legislation, and unfortunately the federal legislative and subsequent regulatory processes leave no guarantee as to the strength of the final version of the federal legislation.

With respect to authority over practice operations, i.e., how a practice is "run," as was just mentioned above, the Board recommends that AMA policy distinguish between corporate investment, corporate ownership, and corporate control in physician practices. A corporate entity may invest in a practice but not have ownership nor operational control of the practice. Thus, a corporate investor may offer financing without physician practices giving up clinical autonomy or operational authority. On the other hand, a corporate entity may not technically own a practice but effectively exercises corporate control of the physician practice. The previous discussion concerning the "friendly physician" model illustrates this point—under that model the desire for corporate profits may interfere with clinical decision-making and physician autonomy even though technically corporate investors' ownership interests are limited or prohibited outright. To clarify, retaining operation authority does not stop a practice from outsourcing or delegating its management or even day-to-day operations. However, management would be a contracted service or some other structure in which, if there is a conflict, the physician or designated physician partners have the final authority. Importantly, most of the time a controlling interest by a corporate entity will confer operational authority of a practice either directly or indirectly.

Obviously, while lay entities must not—under any circumstances—control the practice of medicine, the Board believes that decisions made by a corporate investor on matters often characterized as operational or administrative may in some cases intrude on clinical decision-making and physician autonomy, as well as affect quality of care and patient outcomes. This is not simply in cases where the difference may be blurred—even matters that may be typically characterized as operational, e.g., coding, billing and collections, administration and non-clinical management; risk managements, etc., may themselves be implemented in ways that interfere with clinical decision-making and physician autonomy and/or expose physicians to liability. Thus, the Board also believes that regardless of a physician practice's ownership structure, physician clinical autonomy and operational authority must be preserved and protected. The Board further recognizes that beyond patient care and physician autonomy at the practice level, allowing the corporatization of medicine has led to further consolidation of healthcare, increased costs, and siphoning of health care dollars to shareholders and non-health care entities in the larger health care system. Notably, allowing the corporate ownership of a medical practice also has implication for scope of practice issues—both in the supervision of non-physician practitioners (NPP) in the practice, as well as the potential conflict if an NPP has an ownership in the practice.

While the Board does not recommend developing federal legislation called for by Resolution 233 given the potential pitfall of initiating federal legislation as discussed above, the Board does believe that the AMA should be heavily engaged in fighting the negative influence that PE and other corporate investors are having on the practice of medicine. The Board also believes that the AMA must vigorously oppose any removal or weakening of existing state laws prohibiting the corporate practice of medicine legislation or regulation. This advocacy should include closely monitoring federal legislative proposals and engaging where appropriate, as well as continuing to work closely with state medical associations and national medical specialty societies in the state advocacy arena.

In this regard, it must be noted that at the AMA 2024 Annual Meeting, the HOD amended AMA Policy H-215.981 "Corporate Practice of Medicine," that directs AMA Advocacy as follows: "Our AMA will work with the state and federal government and other interested parties to develop and advocate for regulations pertaining to corporate control of practices in the health care sector such that physician autonomy in clinical care is preserved and protected." Importantly, the AMA was already engaged in federal advocacy, as well as advocacy at the state level—as directed by Resolution 710 (A-24). For example, prior to the AMA 2024 Annual Meeting on June 5, 2024, the AMA sent an extensive letter to the Federal Trade Commission (FTC), U.S. Department of Justice (DOJ), and the U.S. Department of Health and Human Services, expressing its concerns about PE, its impact on physicians, and how PE is exacerbating consolidation in health care markets generally. Given the current political environment, the Board believes that continued federal regulatory advocacy is much more likely to be successful (as compared to federal legislative advocacy). Both the FTC and DOJ are subjecting PE in health care to unprecedented scrutiny, including "strip and flip" tactics. The Board supports the preservation of the restrictions of ownership and operational authority of physician medical practices to physicians or physician owned groups. and expects AMA Advocacy to seek every opportunity to advocate consistent with our HOD policy at the federal level, as well as in the states.

With regard to AMA state level advocacy, the Board strongly recommends that the AMA's state government affairs team, the Advocacy Resource Center, develop a comprehensive corporate investor state legislative template modeled after the Advocacy Resource Center's "Legislative Template: Covenants not-to-Compete in Physician Contracts"—to advance AMA engagement at the state level on CPOM issues. State medical associations and national medical specialty societies interested in seeing how the corporate investor template will be structured can view the Advocacy Resource Center's covenant not-to-compete template here.

Notably, the AMA has also developed a number of excellent resources to help physicians understand and negotiate contracts with PE and venture capital firms, including, but not limited to, sample contract language. Finally, the Board would like to note that during its 2024 Annual Meeting, the HOD amended existing AMA Policy D-215.982 entitled, "The Corporate Practice of Medicine, Revisited" which calls on the AMA to create a new report that will study and report back by AMA 2025 Annual Meeting with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets. This report is just one example of continuing studies that the AMA is conducting regarding the negative impact that corporate interests are having on the practice of medicine, and the Board expects that AMA Advocacy will take full advantage of new findings to prohibit corporate investors' intrusion into the practice of medicine, in its federal and state level work.

AMA POLICY

The following AMA policy is relevant to this Board Report:

Policy D-160-904 entitled, "The Regulation of Private Equity in the Healthcare Sector," which states that: Our American Medical Association will propose appropriate guidelines for the use of private equity in healthcare, ensuring that physician autonomy and operational authority in clinical care is preserved and protected.

Policy H-160.891 entitled, "Corporate Investors," which states that:
(1) Our American Medical Association encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
(a) Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
(b) Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
(c) External legal, accounting and/or business council should be obtained to advise during the exploration and negotiation of corporate investor transactions.
(d) Retaining negotiators to advocate for the best interests of the practice and its employees should be considered.
(e) Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
(f) Physicians should consider the potential impact of corporate investor partnerships on physicians and practice employee satisfaction and future physician recruitment.
(g) Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
(h) Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
(i) Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
(j) Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non- physician practitioners.
(k) Physicians should retain primary and final responsibility for structured medical education inclusive of undergraduate medical education including the structure of the program, program curriculum, selection of faculty and trainees, as well as education and disciplinary issues related to these programs.
(l) Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
(m) Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
(n) Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.
AMA Policy H-160.887 entitled "Corporate Practice of Medicine"
(1) Our American Medical Association acknowledges that the corporate practice of medicine:
(a) has the potential to erode the patient-physician relationship.
(b) may create a conflict of interest between profit and best practices in residency and fellowship training.

Policy H-215.981 entitled. "Corporate Practice of Medicine," which states that:
(1) Our American Medical Association vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.

(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.
(4) Our AMA will work with state and federal government and other interested parties to develop and advocate for regulations pertaining to corporate control of practices in the healthcare sector such that physician autonomy in clinical care is preserved and protected.

Policy D-215.982 entitled, "The Corporate Practice of Medicine, Revisited" which states that: Our American Medical Association will revisit the concept of restrictions on the corporate practice of medicine, including, but not limited to, private equities, hedge funds and similar entities, review existing state laws and study needed revisions and qualifications of such restrictions and/or allowances, in a new report that will study and report back by Annual 2025 with recommendations on how to increase competition, increase transparency, support physicians and physician autonomy, protect patients, and control costs in already consolidated health care markets; and to inform advocacy to protect the autonomy of physician-directed care, patient protections, medical staff employment and contract conflicts, and access of the public to quality health care, while containing health care costs.

Policy H-310.904 entitled, "Graduate Medical Education and the Corporate Practice of Medicine," which states that:
(1) Our American Medical Association recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs.
(2) Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources.
(3) Our AMA will continue to monitor issues, including waiver of due process requirements, created by corporate control of graduate medical education sites.

RECOMMENDATIONS:

The Board of Trustees recommends that in lieu of Resolution 233-I-23, existing AMA Policy H-215.981 entitled, "Corporate Practice of Medicine," be amended by addition and the remainder of the report be filed:

1. Our American Medical Association vigorously opposes any effort to pass federal legislation or regulation preempting state laws prohibiting the corporate practice of medicine. (Reaffirm HOD Policy)

2. Our AMA vigorously opposes any effort to pass legislation or regulation that removes or weakens state laws prohibiting the corporate practice of medicine. (New HOD Policy)

3. Our AMA opposes the corporate practice of medicine and supports the restriction of ownership and operational authority of physician medical practices to physicians or physician-owned groups. (New HOD Policy)

4. 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. (Reaffirm HOD Policy)

5. 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)

6. Our AMA will work with interested state medical associations, the federal government, and other interested parties to develop and advocate for regulations and appropriate legislation pertaining to corporate control of practices in the healthcare sector such that physician clinical autonomy ~~in clinical care~~ and operational authority ~~is~~ are preserved and protected. (Modify Current HOD Policy)

7. Our AMA will create a state corporate practice of medicine template to assist state medical associations and national medical specialty societies as they navigate the intricacies of corporate investment in physician practices and health care generally at the state level and develop the most effective means of prohibiting the corporate practice of medicine in ways that are not detrimental to the sustainability of physician practices. (New HOD Policy)

Fiscal note: Less than $500.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-24)

Introduced by: Tennessee

Subject: Boarding Patients in the Emergency Room

Referred to: Reference Committee B

Whereas, due to multiple issues including staffing shortages it has become common practice to board admitted patients for extended periods of time in the emergency room; and

Whereas, boarding of admitted patients in the emergency room greatly increases demands on the emergency room staff and physicians; and

Whereas, burnout is a very real complication of a medical system that allows staffing ratios to be bypassed in an emergency room setting; and

Whereas, this overcrowding of and boarding within the emergency room has created a public health crisis; and

Whereas, patient safety and HIPAA compliance are secondary goals in an overcrowded emergency room with admitted patients boarding in the halls; therefore be it

RESOLVED, that our American Medical Association immediately collaborate with stakeholders such as hospitals, insurance companies, CMS, and joint commission to resolve this issue (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate strongly for appropriate staffing ratios and appropriate care for patients and the emergency room and those admitted but still physically located in the emergency room to decrease patient harm and physician and nurse burnout. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/3/2024

REFERENCES

1. “Clinicians’ Insights on Emergency Department Boarding: An Explanatory Mixed Methods Study Evaluating Patient Care and Clinician Well-Being,” by Dana E. Loke, MD, MS; Kelsey A. Green, MD; Emily G. Wessling, MD; Elizabeth T. Stulpin, MD; and Abra L. Fant, MD, MS. The article appears in The Joint Commission Journal on Quality and Patient Safety (JQPS), volume 49, number 12 (December 2023)
2. American College of Emergency Physicians/Morning Consult poll October 2023.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(I-24)

Introduced by: North American Spine Society

Subject: Illicit Drugs: Calling for a Multifaceted Approach to the “Fentanyl” Crisis

Referred to: Reference Committee B

Whereas, there is an illicit opioid crisis in the United States (U.S.) with an escalating number of drug-related illnesses, overdoses, and deaths, placing a growing burden on patients, families, medical professionals and our society; and

Whereas, these illicit drugs serve no legitimate medical purpose, endanger the lives of first responders and healthcare workers, put a drain on our medical system and the medical resources needed to treat victims, including people with a substance use disorder (SUD); and

Whereas, the shift from plant-based drugs, like marijuana, heroin and cocaine, to synthetic, chemical-based drugs, like fentanyl and carfentanil is much easier and less costly to manufacture and easier to distribute, has resulted in the most dangerous and lethal drug crisis U.S. history; and

Whereas, illicit fentanyl is a highly potent synthetic opioid that has resulted in the overdose deaths of infants, children and adults of all ages, especially those who suffer from SUD; and

Whereas, the total number of illicit fentanyl seizures by law enforcement surged by more than 1700% between 2017 and 2023, enough to the kill the entire American population many times over; and

Whereas, overdose deaths exceed 100,000 U.S. citizens/year, a vast majority due to illicit fentanyl which is now the number one killer of all adults ages 18-45, including 20 high school deaths/week; and

Whereas, this illicit-drug crisis has rapidly evolved to include many chemical compounds beyond fentanyl, such as 3-methylfentanyl and carfentanil which are 6,000-to-10,000-times more potent than morphine, respectively, making it difficult for our government agencies and healthcare systems to adapt to; and

Whereas, at least one third of illegally manufactured recreational pills are laced with fentanyl and/or carfentanil and are pressed to resemble legal prescription drugs (e.g. oxycodone, Xanax, Adderall), they create a significant risk of accidental overdose for users who are unaware of the laced drugs; and

Whereas, these illicit drugs, undetectable by sight, smell or taste, are on the black market in various forms, including liquid, powder and/or aerosolized, have been found in vape pens, nasal sprays, eye drops, gummies, small candies and paper; and

Whereas, the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 criminalizes the use of a biological agent to cause death, disease (e.g. addiction), or other harm; and

Whereas, the Chemical Weapons Convention defines chemical weapons as a toxic chemical or its precursors specifically designed to cause death or other harm (e.g., addiction) through toxic properties; and

Whereas, according to the Department of Homeland Security (DHS), “a weapon of mass destruction (WMD) is a nuclear, radiological, biological or chemical (e.g. illicit fentanyl, carfentanil), intended to harm a large number of people”, and many organizations have called for illicit fentanyl and similar illicit drugs to be classified as WMDs; and

Whereas, carfentanil has been used as a WMD and in 2018, the Federal Bureau of Investigation's Weapons of Mass Destruction Directorate assessed that fentanyl’s highly toxic properties, make it a “very viable option for a chemical weapon attack”; and subsequently the Department of Defense proposed that fentanyl receive a WMD designation; therefore be it

RESOLVED, that our American Medical Association advocate for public education and awareness about the rapidly evolving US illicit drug crisis due to dangers of fentanyl and carfentanil-laced products (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that federal, state and local government officials and agencies implement measures to curb and/or stop the manufacturing, importation, and distribution of illicit drugs and related chemical compounds (Directive to Take Action); and be it further

RESOLVED, that our AMA support federal legislation that would help Customs and Border Protection (CBP) stop the flow of illicit goods, including fentanyl and counterfeit medications (New HOD Policy); and be it further

RESOLVED, that our AMA, based on the Public Health Security and Bioterrorism Preparedness and Response Act of 2002 (which criminalizes the use of a biological agents to cause death, disease, or other harm), request our government to determine if expansion should include illicit chemicals and drugs such as fentanyl, carfentanil, 3-methylfentanyl, Xylazine, etc. (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage our government to clarify if, and in what circumstances, these types of illicit drugs (e.g. fentanyl, carfentanil, etc.), or their precursors, should be considered chemical weapons as defined by The Chemical Weapons Convention and/or a WMD as defined by the DHS (New HOD Policy); and be it further

RESOLVED, that our AMA assess the likelihood that illicit drugs such as carfentanil may be used as a WMD and what steps healthcare workers, hospital systems and first-responders should take to prepare for such an event. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 9/18/2024

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RELEVANT AMA POLICY

Addressing Emerging Trends in Illicit Drug Use H-95.940

1. Our American Medical Association recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat.
2. Our AMA supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, other educational materials, and public awareness campaigns.
3. Our AMA supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders.
4. Our AMA encourages adequate federal and state funding of agencies tasked with addressing the emerging drugs of abuse health threat.
5. Our AMA encourages the development of continuing medical education on emerging trends in illicit drug use.
6. Our AMA supports efforts by federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner.
Sub. Res. 901, I-14 Modified: CSAPH Rep. 02, A-17 Reaffirmed: Res. 503, A-18 Reaffirmed in lieu of: Res. 512, A-18 Reaffirmation I-22

Drug Policy Reform H-95.901

1. Our American Medical Association supports elimination of criminal penalties for drug possession for personal use as part of a larger set of related public health and legal reforms designed to improve carefully selected outcomes.
2. Our AMA supports federal and state efforts to automatically expunge, at no cost to the individual, criminal records for drug possession for personal use upon completion of a sentence or penalty
3. 3Our AMA supports programs that provide comprehensive substance use disorder treatment and social support to people who use or possess illicit drugs for personal use as an alternative to incarceration-based penalties, including for persons under parole, probation, pre-trial, or other civic, criminal, or judicial supervision.
4. Our AMA, concurrently, supports robust policies and funding that facilitate people's access to evidence-based prevention, early intervention, treatment, harm reduction, and other supportive services – with an emphasis on youth and racially and ethnically minoritized people – based on individualized needs and with availability in all communities.
BOT Rep. 17, A-24

Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications H-95.932

1. Our American Medical Association supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications .

3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
4. Our AMA encourages private and public payers to include all forms of naloxone and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications to receive appropriate education to enable them to do so effectively.
7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
9. Our AMA supports the legal access to and use of naloxone and other safe and effective overdose reversal medications in all public spaces regardless of whether the individual holds a prescription.
10. Our AMA supports efforts to increase the availability, delivery, possession and use of mail-order overdose reversal medications, including naloxone, to help prevent opioid-related overdose, especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations.
11. Our AMA supports the expansion of naloxone availability through colocation of intranasal naloxone with AEDs in public locations.
BOT Rep. 22, A-16 Modified: Res. 231, A-17 Modified: Speakers Rep. 01, A-17 Appended: Res. 909, I-17 Reaffirmed: BOT Rep. 17, A-18 Modified: Res. 524, A-19 Reaffirmed: BOT 09, I-19 Reaffirmed: Res. 219, A-21 Modified: Res. 505, A-23 Reaffirmed: BOT Rep. 11, A-24 Modified: Res. 512, A-24

Prevention of Drug-Related Overdose D-95.987

1. Our American Medical Association:
    a. recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs.
    b. urges that community-based programs offering naloxone and other safe and effective overdose reversal medications and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area.
    c. encourages the education of health care workers and people who use drugs about the use of naloxone and other safe and effective overdose reversal medications and other harm reduction measures in preventing opioid and other drug related overdose fatalities.
    d. will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: advocate for the removal of **fentanyl** test strips (FTS) and other testing strips, devices or testing equipment used in identifying or analyzing whether a substance contains **fentanyl** or other adulterants from the legal definition of drug paraphernalia.
3. Our AMA will:
    a. advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug- related overdose.
    b. support the development of adjuncts and alternatives to naloxone to combat synthetic opioid-induced respiratory depression and overdose.
    c. encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
4. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
5. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
6. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
7. Our AMA supports efforts to increase access to **fentanyl** test strips and other drug checking supplies for purposes of harm reduction.

Res. 526, A-06 Modified in lieu of Res. 503, A-12 Appended: Res. 909, I-12 Reaffirmed: BOT Rep. 22, A-16 Modified: Res. 511, A-18 Reaffirmed: Res. 235, I-18 Modified: Res. 506, I-21Appended: Res. 513, A-22 Modified: Res. 211, I-22 Appended: Res. 221, A-23 Reaffirmation: A-23 Modified: Res. 505, A-23 Reaffirmed: BOT Rep. 18, A-24

Chemical and Biological Weapons H-520.992

Our AMA condemns the use of chemical and biologic weapons.
Res. 175, I-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CSAPH Rep. 1, A-10 Reaffirmed: CSAPH Rep. 01, A-20

Federal Drug Policy in the United States H-95.981

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization. BOT Rep. NNN, A-88 Reaffirmed: CLRPD 1, I-98 Reaffirmed: CSAPH Rep. 2, A-08 Modified: CSAPH Rep. 2, I-13 Reaffirmed: BOT Rep. 14, I-20

Altered Illicit Substances D-95.997

Our AMA will pursue appropriate revisions of the relevant federal laws and regulations as a means of interdicting the manufacture, distribution or sale of such **substances**. Sub. Res. 401, I-99Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed: CSAPH Rep. 01, A-19

Substance Use Disorders as a Public Health Hazard H-95.975

Our AMA: (1) recognizes that **substance use disorders** are **a** major **public health** problem in the United States today and that its solution requires **a** multifaceted approach;
(2) declares **substance use disorders** are **a public health** priority;
(3) supports taking **a** positive stance **as** the leader in matters concerning **substance use disorders**, including addiction;
(4) supports studying innovative approaches to the elimination of **substance use disorders** and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or **use** of such substances.
Res. 7, I-89 Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99 Reaffirmed: CSAPH Rep. 1, A-09 Modified and Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-24)

Introduced by: Medical Student Section and American College of Emergency Physicians

Subject: Support for Physician-Supervised Community Paramedicine Programs

Referred to: Reference Committee B

Whereas, physician-supervised community paramedicine programs send paramedics on home visits to patients recently discharged from emergency departments (ED) to assist with remote patient monitoring and video support, coordinating with primary care and specialist physicians and pharmacies, and arranging transportation[1-6]; and

Whereas, community paramedicine pilots in several states address geographic barriers physicians, especially in rural areas, that lead to delayed care and ED overcrowding[1-4]; and

Whereas, a rural Ontario program showed a 24% reduction in 911 calls, 20% reduction in ED visits, and 55% reduction in hospitalizations after 1 year[7]; and

Whereas, a Minnesota study showed decreases in readmissions and ED visits, savings of over $400,000, and higher reported quality of life[8,9]; and

Whereas, an Abbeville County (population 25,000) program showed a nearly 60% decrease in ED visits and nearly 70% decrease in admissions over 4 years, while also reducing blood pressure and blood glucose[10]; and

Whereas, community paramedicine is funded by public and private grants, partnerships with hospitals and nursing homes to share savings, Medicare's Emergency Triage, Treat, and Transport (ET3) alternative payment model, and Medicaid in some states including Arizona, Georgia, Minnesota, Nevada, and Wyoming[11-12]; therefore be it

RESOLVED, that our American Medical Association support federal and state efforts to establish, expand, and provide coverage for community paramedicine programs supervised by physicians, especially in rural areas. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Date Received: 09/19/2024

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RELEVANT AMA POLICY

Incentives to Encourage Efficient Use of Emergency Departments H-130.931
Our AMA will support: (1) continued monitoring, by the Centers for Medicare & Medicaid Services and other stakeholders, of strategies and best practices for reducing non-emergency emergency department (ED) use among Medicaid/Children's Health Insurance Program (CHIP) enrollees, including frequent ED users; and (2) state efforts to encourage appropriate emergency department (ED) use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services. [CMS Rep. 1, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-24)

Introduced by: Medical Student Section

Subject: Native American Medical Debt

Referred to: Reference Committee B

Whereas, the Indian Health Service (IHS) Purchased and Referred Care (PRC) program pays for services for American Indian and Alaska Native (AI/AN) patients provided at non-IHS facilities[1]; and

Whereas, limited PRC funds often result in denial or deferral of payments until the next fiscal year, making IHS patients pay out-of-pocket[2]; and

Whereas, unpaid and late PRC payments result in IHS patients being sent to collections and paying debts to avoid impacting their credit[2]; and

Whereas, since 2016, IHS has declined PRC payments for over 500,000 patients, saddling them with over $2 billion in debt[2-3]; and

Whereas, medical debt-related collection adversely impacts AI/AN patients' credit scores, which results in higher interest rates for mortgages and consumer loans and, in some cases, the inability to obtain credit or financing altogether[4]; and

Whereas, medical debt is linked to increased financial vulnerability, delayed or foregone treatment due to cost, use of high-risk short-term loans, and costly overdraft and late payment fees[5]; and

Whereas, the 2018 National Financial Capability Study found that AI/AN patients are more likely to have medical debt and not fill prescriptions due to cost than non-Hispanic whites [6]; and

Whereas, the Protecting Veterans Credit Act of 2017 requires credit agencies to remove debt and collections activity from veterans' credit reports for medical bills that should have been paid by the Department of Veterans Affairs[7]; and

Whereas, unlike the process established for users of the Department of Veterans Affairs' health system in the Protecting Veterans Credit Act of 2017, no comparable process exists for users of the IHS system to require credit reporting agencies to remove debts or collections activity on their credit reports for bills that the IHS should have but did not pay[7-8]; and

Whereas, currently, two bipartisan bills are under consideration to hold the IHS accountable for unpaid bills and protect Native Americans' credit from unpaid bills under PRC[8]; therefore be it

RESOLVED, that our American Medical Association support federal legislation requiring credit reporting agencies to remove information on the credit reports of Indian Health Service (IHS)

beneficiaries that relate to debts or collections activities for medical services that should have been paid by the IHS. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/19/2024

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RELEVANT AMA POLICY

Indian Health Service H-350.977
The policy of the American Medical Association is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. Our AMA specifically recommends:

1. Indian Population:
    a. In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently;
    b. Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care;
    c. Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and
    d. Improvement in transportation to make access to existing private care easier for the American Indian population.
2. Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
3. Personnel:
    a. Compensation scales for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service;
    b. Consideration should be given to increased compensation for specialty and primary care service in remote areas;

   c. In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers and other federal health agencies, thus increasing both the available staffing and the level of professional expertise available for consultation;
   d. Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served without detracting from physician compensation;
   e. Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation and burnout; and
   f. Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
4. Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
5. Our AMA also supports the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
6. Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
7. Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
8. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate, but incremental, loan forgiveness when they practice in an Indian Health Service, Tribal, or Urban Indian Health Program.
9. Our AMA supports reform of the Indian Health Service (IHS) Loan Repayment Program eligibility for repayment with either a part-time or full-time employment commitment to IHS and Tribal Health Programs.

[CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23; Reaffirmed: CMS Rep. 03, A-24; Reaffirmed: Res. 244, A-24; Reaffirmed: BOT Rep. 31, A-24; Modified: CMS Res. 305, A-24]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-24)

Introduced by: Women Physicians Section

Subject: Protect Infant and Young Child Feeding

Referred to: Reference Committee B

Whereas, more than half of all infants in the United States consume formula, either exclusively or as a supplement, by three months of life;[1] and

Whereas, a recent investigation into Nestlé identified nutritional discrepancies between the infant formula sold in high-income countries and low- and middle-income countries, specifically elevated levels of sugar in formula sold in low- and middle-income countries;[2] and

Whereas, within the United States, infant formula is advertised as similar to breast milk, but research has identified up to 7.7 g/100 kcal of added sugars in certain formulas which could prime the developing brain's reward circuit to prefer high-sugary foods and contribute to the significant rates of obesity in pediatric populations;[3,4] and

Whereas, numerous structural and systemic barriers prevent caregivers from pursuing breastfeeding, and disproportionately affect marginalized groups;[5] and

Whereas, donor breast milk costs $14.37/100 mL and formula costs $3.30/100 mL, making donor milk prohibitively expensive;[6,7] and

Whereas, in 2021, 16% of children in the United States lived below the poverty line, thus making purchase of donor breast milk a nonviable option for many families;[8] and

Whereas, the use of donor breast milk is associated with decreased risk of early childhood pathology and increased likelihood of continuation of breastfeeding relative to infant formula;[9] and

Whereas, premature infants that are exclusively fed human breast milk have significantly reduced rates of necrotizing enterocolitis, one of the leading causes of death in premature infants;[27] and

Whereas, research conducted in Florida determined that, in addition to avoiding more infant deaths, using pasteurized donor human milk in neonatal intensive care units would avoid an estimated $4 million in annual health care expenditures;[28] and

Whereas, seventeen states and the District of Columbia have passed legislation that requires Medicaid coverage of donor human milk;[7] and

Whereas, birthing parents who undergo chemotherapy, and those who have certain infections, are not able to breastfeed due to the impact of radiation and the risk of transmitting diseases to the infant;[10,11] and

Whereas, thousands of infants, older children, and adults with metabolic, gastrointestinal and allergic disorders rely on specialty formulas to meet their nutritional needs;[12] and

Whereas, four companies: Abbott Nutrition, Nestle, Mead Johnson, and Perrigo control nearly 90% of the infant formula market in the United States;[13] and

Whereas, the dominant formula companies have further consolidated an already concentrated market by relying on just a few manufacturing facilities to produce the majority of their products;[14] and

Whereas, reports of bacterial contamination in the manufacturing facility responsible for producing 40% of Abbott Nutrition's products led to a mass formula recall and subsequent plant closure in 2022;[15] and

Whereas, Abbott Nutrition's 2022 formula recall and plant closure caused a mass shortage with the national out-of-stock rate for infant formula spiking to 74%;[16] and

Whereas, on average, formula companies with sole-source WIC contracts hold 84% of the market share in each of their respective states, resulting in highly concentrated individual state formula markets that are particularly vulnerable to supply disruptions and shortages;[17] and

Whereas, unsafe infant feeding practices including rationing, diluting, and using homemade formula rose from 8% to 48.5% during the 2022 formula shortage;[18] and

Whereas, despite introducing several bills that would address the underlying causes of the formula recall and subsequent shortage, the federal government's lack of action left the nation vulnerable and susceptible to future formula crises;[19] and

Whereas, the U.S. Food and Drug Administration (FDA) and the U.S. Department of Agriculture (USDA) announced plans to enhance inspections of formula production facilities, promote new market entry, and support WIC agencies in the event of future formula crises but failed to address the issue of sole-source WIC contracts exacerbating market concentration;[14] and

Whereas, infant formula tariff rates reaching 17.5% serve as significant barriers to entry into the U.S. formula market for foreign manufacturers and further reduce healthy competition;[20] and

Whereas, the bipartisan "Formula Act" (H.R. 8351) that waived tariffs on imported infant formulas through January 1, 2023 helped replenish the national supply and doubled the number of manufacturers selling baby formula in the United States before expiring;[21] and

Whereas, the expiration of the "Formula Act" (H.R. 8351) and the return of import tariffs caused formula supply to drop again and led to price increases of as much as $8.00 per can;[22] and

Whereas, competition and market diversity benefit consumers by keeping costs low, increasing the quality of goods, providing consumers with greater variety, and ensuring a reliable and sustainable infant formula supply for American families;[23, 24, 25] and

Whereas, the short-term solutions enacted in 2022, such as tariff reductions and amended regulatory requirements for imported formulas, alleviated the strain of the infant formula shortage but did not solve the underlying structural issues of limited suppliers, thus demonstrating the need for long-term solutions in order to prevent future formula crises;[26] therefore be it

RESOLVED, that our American Medical Association support Medicaid coverage of donor human breast milk (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for an adequate supply and consistent sources of infant milk formula. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 09/19/2024

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RELEVANT AMA POLICY

Collective Bargaining: Antitrust Immunity D-383.983

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy. [BOT Action in response to referred for decision Res. 209, A-07 and Res. 232, A-07; Reaffirmed: Res. 215, A-11; Reaffirmed: Res. 206, A-19]

Adequate Funding of the WIC Program H-245.989

Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children. [Res. 269, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-24)

Introduced by: Women Physicians Section

Subject: Accountability for G-605.009: Requesting A Task Force to Preserve the Patient-Physician Relationship Task Force Update and Guidance

Referred to: Reference Committee B

Whereas, a task force to preserve the patient-physician relationship when evidence-based, appropriate care is banned or restricted was established at A-22 by policy G-605.009; and

Whereas, the G-605.009 created a task force to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources; and

Whereas, the G-605.009 created an ad hoc committee or task force to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care; and

Whereas, this G-605.009 task force was established in 2022, but there have been no updates delivered to the AMA membership on its progress; and

Whereas, the lack of updates impedes further AMA HOD advocacy due to lack of findings and recommendations from the task force; and

Whereas, in many states in the U.S. with restrictive abortion laws, many physicians and other clinicians face confusion around what is legally permissible[1]; and

Whereas, some states have proposed legislation, for example South Dakota House Bill 1224, which requires the creation of an informational video and other materials describing the state's abortion law and medical care for a pregnant woman experiencing life-threatening or health-threatening medical conditions[2]; and

Whereas, the infant mortality rate in Texas increased to a greater degree than in the rest of the United States following the introduction of strict abortion restrictions[3]; therefore be it

RESOLVED, that our American Medical Association's Task Force to Preserve the Patient-Physician Relationship will present annual updates on their findings at AMA Annual Meetings until the objectives have been completed (Directive to Take Action); and be it further

RESOLVED, that our AMA's work on the Task Force continues for a minimum of three years with reevaluation of need and relevance at I-29 (Directive to Take Action); and be it further

RESOLVED, that our AMA amend G-605.009 with the addition of text as follows:

2h. Work with interested parties to publish public-facing guidance for what is medically allowable for physicians practicing in states with

restrictions potentially impeding on the patient-physician relationship.
(Modify Current HOD Policy)

Fiscal Note: To Be Determined

Received: 09/19/2024

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RELEVANT AMA POLICY

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted G-605.009

1. Our American Medical Association will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.
2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:
    a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities.
    b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines.
    c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities.
    d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements.
    e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance.
    f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need.
    g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.
3. Our American Medical Association will 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. [Res. 621, A-22; Appended: Res. 816, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 208
(I-24)

Introduced by: Senior Physicians Section

Subject: Medicare Part B Enrollment and Penalty Awareness

Referred to: Reference Committee B

Whereas, Medicare provides essential health insurance for those aged 65 and older, as well as for those receiving Social Security disability benefits[1]; and

Whereas, individuals aged 65 or older already receiving Social Security have the option to either enroll in or refuse Medicare Part B coverage; and

Whereas, individuals working past age 65 who are offered COBRA coverage upon retirement or dismissal may find the cost prohibitive, thereby affecting their Medicare enrollment decisions; and

Whereas, Medicare allows for re-enrollment in Part B, but will incur a late enrollment penalty that will apply for as long as they retain Part B coverage[1]; and

Whereas, many seniors approaching retirement may be unaware of Medicare's sign-up rules, which can result in significant penalties if they do not enroll during the Initial Enrollment Period (IEP)—a seven-month window beginning three months prior to their 65th birthday and ending three months after[1]; and

Whereas, seniors may incur a late enrollment penalty (LEP) of 10% of the standard Part B premium for each 12-month period they were not enrolled, which will be added to their monthly premium for the duration of their life[2]; and

Whereas, a straightforward checklist could help clarify the lifelong penalties associated with late Medicare enrollment and provide a smoother transition into Medicare Part B, addressing issues such as (1) failure to enroll when first eligible; (2) missing the special enrollment period and (3) switching from Medicare Advantage to traditional Medicare; and

Whereas, physicians and their patients must be well-informed about Medicare sign-up rules to ensure timely and affordable coverage for all eligible individuals; and

Whereas, these penalties are not sufficiently advertised to seniors, leading to potential financial hardship; therefore be it

RESOLVED, that our American Medical Association review the current penalties for declining Medicare Part B coverage with the Centers for Medicare and Medicaid Services (CMS), and advocate for changes to improve awareness of the risk and financial burdens associated with discontinuing coverage before reaching age 65 (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate to CMS for the creation of a comprehensive checklist for seniors approaching age 65 to facilitate Medicare enrollment and avoid gaps in insurance

coverage or permanent increases in Part B premiums (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for enhanced public awareness regarding the risks of not enrolling in Medicare Part B, and support making information about these risks more accessible and widely available to prevent lifetime penalties (Directive to Take Action); and be it further

RESOLVED, that our AMA explore with AARP and other interested organizations a mechanism for auto enrollment in Medicare Part B for those who take Social Security benefits before age 65 that would include additional premium support for those making less than $1,000 in monthly Social Security benefits. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 9/23/2024

REFERENCES

1. The Centers for Medicare and Medicaid Services (CMS). Medicare 2024 Website, https://www.ssa.gov/pubs/EN-05-10043.pdf (accessed July 20, 2024).
2. The Centers for Medicare and Medicaid Services (CMS). Avoid late enrollment penalties Medicare 2023 Website, https://www.medicare.gov/basics/costs/medicare-costs/avoid-penalties (accessed August 19, 2024).

RELEVANT AMA POLICY

H-330.924 Changes In COBRA Federal Regulations

(1) The AMA, in cooperation with other organizations interested in the welfare of seniors, urge Congress to change existing law to allow COBRA coverage for employed seniors changing employment, irrespective of Medicare eligibility. (2) That for this population (i.e., persons still employed at the time of attaining age 65, who have no need, to enroll in Medicare Part B), an elimination of the 90-day waiting period for eligibility for Medicare Part B, together with an elimination of the penalties applied for a delayed application, be sought.
[Res.144, A-98; Reaffirmed: BoT Rep. 23, A-09; Reaffirmed: CMS Rep. 01, A-19]

D-330.925 Medicare Enrollment and Re-enrollment Delays

Our AMA will seek legislation mandating that the Centers for Medicare and Medicaid Services impose a requirement on its carriers and Medicare administrative contractors (MACs) that enrollment and re-enrollment applications must be processed within thirty days of receipt with appropriate feedback to the applicant, and that financial penalties be imposed on carriers and MACs for unjustified delays in enrollment and re-enrollment.
[Res. 205, I-08; Reaffirmed: BoT Rep. 09, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-24)

Introduced by: American Academy of Ophthalmology

Subject: Laser Surgery

Referred to: Reference Committee B

Whereas, American Medical Association policy defines surgery as "the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles[1]"; and

Whereas, AMA policy calls on our AMA to support legislation prohibiting optometrists from performing surgical procedures and encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures[2]; and

Whereas, AMA policy states that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services and calls on our AMA to encourage state medical associations to support state legislation and rulemaking in support of this policy[3]; and

Whereas, optometrists in 9 states are currently licensed to perform laser surgery; and

Whereas, optometry's laser surgery training consists of a 16 hour didactic course with no training on live patients; and

Whereas, H-475.980, Addressing Surgery Performed by Optometrists cross-references an incorrect section of AMA Policy and should instead cross-reference H-475.989, Laser Surgery[2]; therefore be it

RESOLVED, that our American Medical Association amend policy H-475.989, "Laser Surgery" to read that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners <u>appropriately trained</u> and currently licensed by the state to perform surgical services (Modify Current HOD Policy); and be it further

RESOLVED, that our AMA amend policy H-475.980 Addressing Surgery Performed by Optometrists to read:
1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and <u>H-475.989</u>~~H-475.988~~, "Laser Surgery." 2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, "Definition of Surgery," and <u>H-475.989</u>~~H-475.988~~, "Laser Surgery". (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 9/23/2024

References
1. H-475.983 Definition of Surgery
2. H-475.980 Addressing Surgery Performed by Optometrists
3. H-475.989 Laser Surgery

Relevant AMA Policy

H-475.980 Addressing Surgery Performed by Optometrists
1. Our AMA will support legislation prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, “Definition of Surgery,” and H-475.988, “Laser Surgery.”
2. Our AMA encourages state medical associations to support state legislation and rulemaking prohibiting optometrists from performing surgical procedures as defined by AMA policies H-475.983, “Definition of Surgery,” and H-475.988, “Laser Surgery”. (Res. 229, I-18)

H-475.983 Definition of Surgery
Our American Medical Association adopts the following definition of 'surgery' from American College of Surgeons Statement ST-11:
Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.

Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards. (Res. 212 A-07 Reaffirmed: BOT Rep. 16, A-13 Reaffirmed: CCB/CLRPD Rep. 01, A-23)

H-475.989 Laser Surgery
Our American Medical Association adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services. Our AMA encourages state medical associations to support state legislation and rulemaking in support of this policy. (Sub. Res. 39, I-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CMS Rep. 6, A-10 Reaffirmed: BOT Rep. 16, A-13 Reaffirmed: BOT Rep. 09, A-23)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-24)

Introduced by: American Academy of Ophthalmology

Subject: Water Bead Injuries

Referred to: Reference Committee B

Whereas, from January 1, 2007, through December 31, 2022, there were 8,159 U.S. emergency room visits reported in the National Electronic Injury Surveillance System by individuals under 20 years old associated with water beads, of which ingestion was the most common mechanism of injury (45.9%), followed by ear canal insertion (32.6%), nasal insertion (11.7%), and eye injury (8.8%)[1]; and

Whereas, H.R. 6468 (Pallone), currently pending in the Subcommittee on Innovation, Data, and Commerce of the House Energy and Commerce Committee, would classify a water bead product as a banned hazardous product, regardless of the date of manufacture or importation [2]; and

Whereas, H.R. 6468 would define a water bead product as any item designed, intended, or marketed as a toy, educational material, or art material [2]; and

Whereas, the U.S. Consumer Product Safety Commission (CPSC) established ASTM F963-23, the Standard Consumer Safety Specification for Toy Safety, as the mandatory consumer product safety standard for toys[3]; and

Whereas, Section 4.40 of ASTM F963-23 includes specific requirements for toys made of 'Expanding Materials,' including, but not limited to, water beads[3]; and

Whereas, on November 8, 2024, the comment period ended for a Notice of Proposed Rulemaking (NPR) by the CPSC to establish additional performance and labeling requirements for water bead toys and toys containing water beads to address all known associated hazards[4]; and

Whereas, the NPR would also require the CPSC to publish a Notice of Requirement (NOR) for the accreditation of third-party conformity assessment bodies (laboratories) to assess compliance with children's product safety rules applicable to water bead toys and toys containing water beads[4]; and

Whereas, the estimated injuries cited in the NPR excluded incidents involving water bead gel blaster projectiles, which commonly result in eye injuries and may include products that are not classified as children's toys under the scope of the proposed rule[4]; and

Whereas, ocular injury resulting from gel pellet projectiles can result in serious visual impairment and may require surgical intervention, most commonly for uncontrolled intraocular pressure (IOP) in the setting of hyphema[5,6]; therefore be it

RESOLVED, that our American Medical Association urge the U.S. Consumer Product Safety Commission (CPSC) to promptly promulgate and enforce stringent performance and labeling requirements for water bead toys and toys containing water beads to effectively mitigate associated health hazards (New HOD Policy); and be it further

RESOLVED, that our AMA continue to urge Congress to enact legislation to classify water bead products as banned hazardous items to protect consumers, particularly children, from associated risks (New HOD Policy); and be it further

RESOLVED, that our AMA encourage businesses that sell gel blasters to make appropriate and safe protective eye wear available and encourage its use to their customers and to distribute educational materials on the safe use of gel guns (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the development of national safety standards for gel blasters that include requirements for product design modifications such as lower velocity limits, safer projectile designs, or integrated safety mechanisms to reduce the risk of eye injuries. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/23/2024

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2. H.R.6468 - Ban Water Beads Act (https://www.congress.gov/bill/118th-congress/house-bill/6468/text)
3. 16 CFR Parts 1112 and 1250 (https://www.federalregister.gov/documents/2024/01/18/2024-00741/safety-standard-mandating-astm-f963-for-toys)
4. Safety Standard for Toys: Requirements for Water Beads, 89 Fed. Reg. 73024, (September 9, 2024), Notice of Proposed Rulemaking, (https://www.federalregister.gov/documents/2024/09/09/2024-19286/safety-standard-for-toys-requirements-for-water-beads)
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6. Hayes R, Dai S. Ocular injuries from gel blasters: not just a harmless toy. BMJ Case Rep. 2019 Jun 9;12(6):e229629. doi: 10.1136/bcr-2019-229629. PMID: 31178435; PMCID: PMC6557336.

Relevant AMA Policy

D-60.967 Support for Detergent Poisoning and Child Safety Act
1. Our AMA will advocate to the state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements and that these products are manufactured to be less attractive to children in color and in design and to include conspicuous warning labels.
2. Our AMA will advocate that the detergent product package labeling be constructed in a clear and obvious method so children know that the product is dangerous to ingest.
3. Our AMA encourages the Consumer Product Safety Commission in conjunction with the American Association of Poison Control Centers to study the impact of “F3159-15 - Consumer Safety Specification for Liquid Laundry Packets” to ensure that the voluntary ASTM standard adequately protects children from injury, including eye injury. (Res. 430, A-16 Appended: Res. 413, A-17)

H-145.982 Prevention of Ocular Injuries from BB and Air Guns
The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns. Res. 416, I-96 Reaffirmed: CSAPH Rep. 3, A-06 Reaffirmed: CSAPH Rep. 01, A-16

H-245.985 Mandatory Labeling for Waterbeds and Beanbag Furniture
Our American Medical Association urges the Consumer Product Safety Commission to require waterbed manufacturers and manufacturers of similar type furnishings to affix a permanent label and to distribute warning materials on each waterbed and other furnishings sold concerning the risks of leaving an infant or handicapped child, who lacks the ability to roll over, unattended on a waterbed or beanbag. Res. 414, A-92 Reaffirmed: CSA Rep. 8, A-03 Modified: CSAPH Rep. 1, A-13 Reaffirmed: CSAPH Rep. 08, A-23

H-470.974 Athletic Helmets
1. Our AMA urges the Consumer Product Safety Commission and other appropriate agencies and organizations to establish standards to ensure that athletic and recreational equipment produced or sold in the United States provide protection against head and facial injury.
2. Our AMA: (a) supports requiring the use of head and facial protection by children and adolescents while engaged in potentially dangerous athletic and recreational activities; (b) encourages the use of head and facial protection for adults while engaged in potentially dangerous athletic and recreational activities; (c) encourages physicians to educate their patients about the importance of head and facial protection while engaged in potentially dangerous athletic and recreational activities; and (d) encourages the availability of rental helmets at all commercial settings where potentially dangerous athletic and recreational activities take place. (Sub. Res. 16, I-88 Res. 419, A-93 Reaffirmed: CSA Rep. 8, A-03 Appended: Sub Res. 911, I-10 Modified: Res. 404, A-12 Reaffirmed: CSAPH Rep. 3, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-24)

Introduced by: Michigan

Subject: Addressing the Unregulated Body Brokerage Industry

Referred to: Reference Committee B

Whereas, the for-profit body broker industry's (a.k.a., non-transplant tissue banks) lack of regulation gives rise to significant ethical dilemmas and public health hazards; and

Whereas, body brokers are firms or individuals that acquire whole bodies/cadavers donated to science, for the purpose of dissecting them to sell or lease the parts for profit; and

Whereas, brokers make money - anywhere from $5,000 to $10,000 - by providing bodies and dissected parts to companies and institutions that specialize in advancing medicine and other trades through training, education, and research; and

Whereas, a Reuters review of court, police, and internal broker records and interviews identified more than 2,357 body parts obtained by brokers from at least 1,638 people that were misused, abused, or defiled; and

Whereas, in 2017, a Midwest couple was charged with defrauding customers by selling body parts infected with hepatitis and HIV; and

Whereas, in 2016, more than 20 bodies donated to an Arizona broker were used in United States Army blast experiments, without the consent of the deceased or next of kin; and

Whereas, body brokers are known to prey on underserved and minoritized populations, profiting on exploitation while demand for organs, skeletons, and tissues unceasingly rise; and

Whereas, the Uniform Anatomical Gift Act (1967) is a federal framework that specifies how organ donations can be made and aims to maintain the current organ donation and transplantation systems in the U.S.; and

Whereas, current regulations only cover body parts intended for transplant, such as hearts, livers, and tissue; and

Whereas, no such regulatory body exists for the body broker industry; and

Whereas, only ten states provide any oversight, and only some require licensing or disclosure of body brokers; therefore be it

RESOLVED, that our American Medical Association amend existing policy H-460.890, "Improving Body Donation Regulation," by addition to read as follows:

Our AMA: (1) recognizes the need for ethical, transparent, and consistent body and body part donation regulations~~.~~; (2) will collaborate with interested organizations to actively advocate for

the passage of federal legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; (3) will develop model state legislation to provide necessary minimum standards, oversight, and authority over body broker entities that receive donated human bodies and body parts for education and research; and (4) encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation. (Modify Current HOD Policy)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 9/23/2024

REFERENCES

1. In a warehouse of horrors, a body broker allegedly stacked human heads (reuters.com)
2. Murphy, Tillis, Bilirakis, Fletcher Introduce Bipartisan, Bicameral Bill To Stop The Brokering Of Body Parts, Preserve Integrity Of Organ Donation Process (senate.gov)
3. Body Broker Bill Introduced in the Senate > National Funeral Directors Association (NFDA)
4. For Congress - CDRI Info 12-6-2023.pdf (nfda.org)
5. uaga_final_aug09.pdf (pitt.edu)
6. https://www.uniformlaws.org/committees/community-home?CommunityKey=015e18ad-4806-4dff-b011-8e1ebc0d1d0f

RELEVANT AMA POLICY

Improving Body Donation Regulation H-460.890
Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-24)

Introduced by: American Academy of Child and Adolescent Psychiatry

Subject: Sustainable Long-term Funding for Child Psychiatry Access Programs

Referred to: Reference Committee B

Whereas, there is a shortage of child psychiatrists in the United States[1]; and

Whereas, primary care physicians (PCPs), such as pediatricians and family physicians, may manage mental health conditions in primary care settings[2,3]; and

Whereas, Child Psychiatry Access Programs (CPAPs) are centralized coordinated-care programs that provide quick remote pediatric psychiatry mental health consultations to PCPs[4]; and

Whereas, CPAPs are promising in addressing the shortage of child and adolescent psychiatrists in the United States by leveraging the existing child and adolescent psychiatry workforce and enhancing PCPs' ability to manage psychiatric conditions in primary care settings[5]; and

Whereas, at the time of a 2022 paper by Lee et al., CPAPs exist in 46 states and can be funded by multiple entities, including federal grants, Medicare, state funding, and commercial insurance[4]; and

Whereas, the federal Health Resources and Services Administration funds CPAPs in 46 states, the District of Columbia, the U.S. Virgin Islands, the Republic of Palau, the Chickasaw Nation, the Red Lake Band of Chippewa Indians, the Federated States of Micronesia, the Commonwealth of Northern Mariana Islands, and Guam, through its Pediatric Mental Healthcare Access Program; and

Whereas, few CPAPs have permanent sustainable funding[4]; and

Whereas, CPAPs are temporarily funded and vulnerable to budget cuts and could benefit from some federal oversight[5]; and

Whereas, federal involvement in the Child Nutrition and WIC Reauthorization Act of 2004 successfully mandated School Wellness Programs in all states[5]; and

Whereas, the federal government has the authority to enact legislation encouraging states to develop and fund CPAP programs[5]; therefore be it

RESOLVED, that our American Medical Association advocate that the federal government work to achieve adequate sustained funding of child psychiatry consultation programs,

such as Child Psychiatry Access Programs and Pediatric Mental Health Care Access Program. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/23/2024

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3. Patel A, Medhekar R, Ochoa-Perez M, et al. Care Provision and Prescribing Practices of Physicians Treating Children and Adolescents With ADHD. Psychiatr Serv. Published online February 15, 2017. doi:10.1176/appi.ps.201600130
4. Lee CM, Yonek J, Lin B, et al. Systematic Review: Child Psychiatry Access Program Outcomes. JAACAP Open. Published online August 1, 2023. doi:10.1016/j.jaacop.2023.07.003
5. Addressing National Workforce Shortages by Funding Child Psychiatry Access Programs | Pediatrics | American Academy of Pediatrics. Accessed September 12, 2023. https://publications.aap.org/pediatrics/article/147/1/e20194012/33432/Addressing-National-Workforce-Shortages-by-Funding?autologincheck=redirected

RELEVANT AMA POLICY

H-345.981 Access to Mental Health Services
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment. [CMS Rep. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 07, A-24]

H-345.977 Improving Pediatric Mental Health Screening
Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives. [Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18]

H-345.975 Maintaining Mental Health Services by States
Our American Medical Association supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services. Our AMA supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions. Our AMA supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness. Our AMA supports enforcement of the Mental Health Parity Act at the federal and state level. Our AMA will take these resolves into consideration when developing policy on essential benefit services. [Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22]

D-345.972 Mental Health Crisis
Our American Medical Association will work expediently with all interested national medical organizations, national mental health organizations, and appropriate federal government entities to convene a federally-sponsored blue ribbon panel and develop a widely disseminated report on mental health treatment availability and suicide prevention in order to: Improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services, including, but not limited to, the National Suicide Prevention Lifeline. Increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce. Expand research into the disparities in youth suicide prevention. Address inequities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate. Develop and support resources and programs that foster and strengthen healthy mental health development. Develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis. Our AMA supports physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training.
Our AMA along with other interested parties will advocate that children's mental health and barriers to mental health care access for children represent a national emergency that requires urgent attention from all interested parties.
Our AMA will join with other interested parties to advocate for efforts to increase the mental health workforce to address the increasing shortfall in access to appropriate mental health care for children. [Res. 425, A-22; Appended: Res. 422, A-23]

H-60.929 National Child Traumatic Stress Network
Our American Medical Association recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative. Our AMA will work with mental health organizations and relevant health care organizations to support full funding of the National Child Traumatic Stress Initiative. [Res. 419, A-11; Modified: CSAPH Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-24)

Introduced by: American College of Obstetricians and Gynecologists, South Dakota

Subject: Advocating for Evidence-Based Strategies to Improve Rural Obstetric Health Care and Access

Referred to: Reference Committee B

Whereas, rural Americans experience significant health disparities, with mortality rates 20% higher and preventable hospitalizations 57% higher compared to urban populations, and disproportionately higher rates of cardiovascular disease, stroke, cancer, diabetes and respiratory illness;[1] and

Whereas, the risk of pregnancy-related mortality is highest for rural populations in the United States (US) compared to micropolitan or metropolitan populations, and rural women have a consistently higher probability of severe maternal morbidity;[2] and

Whereas, 6.9 million women in the US live in areas with limited or no access to maternity care services, and 36% of all US counties are designated as maternity care deserts, and 61% of those are rural counties;[3] and

Whereas, closure of rural maternity units is associated with longer driving distances to maternity care, with half of rural women living more than a thirty-minute drive to a maternity unit, with higher rates of preterm birth, births outside of hospitals and births in hospital emergency rooms;[4] and

Whereas, physicians and personnel in hospitals without maternity units often do not have the training and infrastructure to recognize, stabilize, obtain consultation, and safely transfer a patient with pregnancy-related complications;[5] and

Whereas, the Alliance for Innovation on Maternal Health (AIM) program is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based algorithms to improve maternal safety and outcomes, through implementation and data support of evidence-based and evidence-informed patient safety bundles, funded by the United States Department of Health and Human Services Administration (HRSA) Maternal and Child Health Bureau (MCHB);[6] and

Whereas, there are existing telemedicine programs around the US that have shown success in providing training and infrastructure for community physicians to deliver best-practice care for patients with complex conditions, and improve health outcomes such as Project ECHO (Extension for Community Healthcare Outcomes)[7] Project ANGELS (Antenatal & Neonatal Guidelines, Education and Learning System);[8] therefore be it

RESOLVED, that our American Medical Association strongly supports federal legislation that provides funding for the creation and implementation of a national obstetric emergency training program for rural health care facilities with and without a dedicated labor and delivery unit (New HOD Policy); and be it further

RESOLVED, that our AMA supports the expansion and implementation of innovative obstetric telementoring/teleconsultation models to address perinatal health disparities and improve access to evidence-informed perinatal care in rural communities (New HOD Policy); and be it further

RESOLVED, that our AMA encourages academic medical centers and health systems to actively participate in obstetric telementoring/teleconsultation models to support rural physicians and advanced practice providers and improve perinatal health outcomes in rural communities (New HOD Policy); and be it further

RESOLVED, that our AMA supports ongoing research to evaluate the effectiveness of national implementation of obstetric telementoring/teleconsultation models to improve rural perinatal health outcomes and reduce rural-urban health disparities (New HOD Policy).

Fiscal Note: Minimal – less than $1,000

Received: 9/23/2024

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RELEVANT AMA POLICY

H-478.980 Increasing Access to Broadband Internet to Reduce Health Disparities
Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

H-480.937 Addressing Equity in Telehealth
(1) Our American Medical Association recognizes access to broadband internet as a social determinant of health.
(2) Our AMA encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations.
(3) Our AMA 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) Our AMA 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) Our AMA 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) Our AMA 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) Our AMA supports efforts to ensure payers allow all contracted physicians to provide care via telehealth.
(8) Our AMA 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.
(9) Our AMA 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.

H-185.917 Reducing Inequities and Improving Access to Insurance for Maternal Health Care
(1) Our American Medical Association acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
(2) Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
(3) Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
(4) Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
(5) Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be:
    a. Informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories),
    b. Carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections.
(6) Lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.
(7) Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
(8) Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.
(9) Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.

(10)Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
(11)Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
(12)Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.

H-130.976 On-Site Emergency Care
(1) The AMA reaffirms its policy endorsing the concept of appropriate medical direction of all prehospital emergency medical services. (2) The following factors should be considered by prehospital personnel in making the decision either to provide extended care in the field or to evacuate the trauma victim rapidly: (a) the type, severity and anatomic location of the injury; (b) the proximity and capabilities of the receiving hospital; (c) the efficiency and skill of the paramedic team; and (d) the nature of the environment (e.g., rural or urban). (3) Because of the variability of these factors, no single methodology or standard can be applied to all accident situations. Trauma management differs markedly between locales, settings, and types of patients receiving care. For these reasons, physician supervision of prehospital services is essential to ensure that the critical decision to resuscitate in the field or to transfer the patient rapidly is made swiftly and correctly.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-24)

Introduced by: American College of Obstetricians and Gynecologists, South Dakota, American Academy of Dermatology Association, American Society for Dermatologic Surgery Association

Subject: Advocating for Federal and State Incentives for Recruitment and Retention of Physicians to Practice in Rural Areas

Referred to: Reference Committee B

Whereas, rural residents of the United States (US) often have higher rates of chronic disease and die younger than their urban counterparts, with significant health disparities and reduced access to care; and

Whereas, there is a projected shortage of up to 87,000 physicians by 2036, with rural areas disproportionately affected; and

Whereas, the number of medical school graduates from rural areas declined by 28% between 2002 and 2017, with only 4-5% of incoming medical students now from rural backgrounds;[1] and

Whereas, rural communities face significant challenges in attracting and retaining physicians due to financial constraints, professional isolation, and lack of resources;[2] and

Whereas, the ability to obtain care in rural America is complicated by scarce medical facilities, disproportionately lower health insurance coverage rates, and a higher proportion of Medicaid/CHIP clients than in urban areas;[3] and

Whereas, rural areas tend to have higher proportions of elderly residents, who typically require more care;[4] and

Whereas, reimbursement for health care services as well as low patient volume in rural areas may not be sufficient for a physician practice to be financially viable; and

Whereas, medical training is long and expensive, with significant student debt incurred; and

Whereas, physicians may choose practice opportunities which offer maximum opportunity to pay off student debt; and

Whereas, urban facilities and practices may offer higher salaries, more benefits, and better working conditions;[5] and

Whereas, our American Medical Association supports educational and recruiting strategies to encourage physicians choose and be prepared for rural practice, including recruitment of students from rural backgrounds;[6] and

Whereas, individuals from rural backgrounds may incur substantial student debt;[7] and

Whereas, our AMA supports Medicare bonus payments for physicians practicing in rural areas regardless of Health Professional Shortage Area (HPSA) status, low interest government business loans, and exemption from some business regulatory requirements in order to enhance recruitment and retention of physicians in rural areas;[8] therefore be it

RESOLVED, that our American Medical Association advocate for increased federal and state funding for loan forgiveness for physicians who commit to practice and reside in rural and underserved areas for a meaningful period of time (Directive to Take Action); and be it further

RESOLVED, that our AMA urge Congress and State legislatures to establish retention bonus programs for physicians who maintain practice in rural areas for extended periods, with increasing bonuses for longer commitments (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the expansion and sustainable funding of residency and graduate medical education slots in rural areas, as well as opportunities for exposure to rural health care such as through clinical rotations in rural areas, to increase the likelihood of physicians practicing in these communities after training. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/23/2024

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RELEVANT AMA POLICY

H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage

(1) In light of the data available from the current literature as well as ongoing studies being conducted by staff, our American Medical Association recommends that:
   a. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
   b. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
   c. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

d. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
e. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
f. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
g. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
h. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
i. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
j. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
k. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
l. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

(2) Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.
(3) Our AMA will:
a. work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and
b. work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.
(4) Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.
(5) Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

D-465.998 Addressing Payment and Delivery in Rural Hospitals

(1) Our American Medical Association will advocate that public and private payers take the following actions to ensure payment to rural hospitals is adequate and appropriate:
a. Create a capacity payment to support the minimum fixed costs of essential services, including surge capacity, regardless of volume.
b. Provide adequate service-based payments to cover the costs of services delivered in small communities.
c. Adequately compensate physicians for standby and on-call time to enable very small rural hospitals to deliver quality services in a timely manner.
d. Use only relevant quality measures for rural hospitals and set minimum volume thresholds for measures to ensure statistical reliability.
e. Hold rural hospitals harmless from financial penalties for quality metrics that cannot be assessed due to low statistical reliability.
f. Create voluntary monthly payments for primary care that would give physicians the flexibility to deliver services in the most effective manner with an expectation that some services will be provided via telehealth or telephone.
(2) Our AMA encourages transparency among rural hospitals regarding their costs and quality outcomes.
(3) Our AMA supports better coordination of care between rural hospitals and networks of providers where services are not able to be appropriately provided at a particular rural hospital.

(4) Our AMA encourages employers and rural residents to choose health plans that adequately and appropriately reimburse rural hospitals and physicians.

H-465.981 Enhancing Rural Physician Practices

(1) Our AMA supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status.
(2) Our AMA encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements.
(3) Our AMA will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result.
(4) Our AMA supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders.
(5) Our AMA will undertake a study of structural urbanism, federal payment polices, and the impact on rural workforce disparities.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-24)

Introduced by: Resident and Fellow Section, American Academy of Addiction Psychiatry

Subject: Clearing Federal Obstacles for Supervised Injection Sites

Referred to: Reference Committee B

Whereas, the Anti-Drug Abuse Act of 1986 (commonly known as the “crack house statute”) outlawed the operation of houses and buildings where crack cocaine and other drugs are made or used;[1] and

Whereas, the Anti-Drug Abuse Act led to an increased disparity in prison sentencing between Black and white populations;[2-4] and

Whereas, Supervised injection facilities (SIFs), also known as overdose prevention centers, have been linked to reduction in public injection, improperly-disposed syringes, and drug-related crime;[5-7] and

Whereas, SIFs have been estimated to result in significant net cost savings to communities based on reduction of transmissible diseases and wound infections;[8] and

Whereas, fentanyl overdose is the number one cause of death for Americans aged 18-45, and the rate of overdose deaths continues to rise;[9-10] and

Whereas, SIFs have a proven record of preventing fatal overdoses and increasing enrollment in detoxification services;[11-13] and

Whereas, the immediate success of two SIFs in New York City has demonstrated that SIFs in the United States can be an effective tool in the battle to curb overdose deaths;[14] and

Whereas, there is demonstrated interest from a number of states to support state-sanctioned SIFs;[15] and

Whereas, the legality of SIFs is directly threatened by the Anti-Drug Abuse Act, which has been used to shut down operations of some of these programs, and continues to be the major barrier to their implementation in the United States;[16-18] and

Whereas, our American Medical Association supports the development and implementation of pilot SIFs to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and healthcare costs related to injection drug use (AMA policy H-95.925); therefore be it

RESOLVED, that our American Medical Association advocate for federal policies that empower states to determine the legality of supervised injection facilities (SIFs). (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/2024

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RELEVANT AMA POLICY:

H-95.925 Pilot Implementation of Supervised Injection Facilities
Our AMA supports the development and implementation of pilot **supervised injection** facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to **injection** drug use. [Res. 513, A-17; Reaffirmation A-23]

H-95.978 Harmful Drug Use in the United States - Strategies for Prevention
Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.
(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development

of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.
(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol use.
(4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.
(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.
(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug use.
[BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21; Reaffirmed: Res. 523, A-23]

D-95.987 Prevention of Drug-Related Overdose
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
[Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22; Appended: Res. 221, A-23; Reaffirmation: A-23; Modified: Res. 505, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-24)

Introduced by: Post-Acute and Long-Term Care Medical Association

Subject: Expand Access to Skilled Nursing Facility Services for Patients with Opioid Use Disorder

Referred to: Reference Committee B

Whereas, opioid use disorder (OUD) in older adults is one of the fastest growing health problems that continues to go underrecognized and undertreated; and

Whereas, there is an increasing number of older adults with a history of OUD or on medications for OUD (Medication-Assisted Treatment [MAT] or MOUD; i.e., methadone, buprenorphine, and naltrexone) who are hospitalized and require discharge to skilled nursing facilities (SNFs) for skilled nursing and rehabilitation, but face disproportionate harms if they are unable to access SNF care; and

Whereas, there is a pervasive practice of screening patients for admission to SNFs (i.e., 80% of referrals being denied and 40% of patients being denied SNF admission) leading to longer hospital lengths of stay awaiting disposition, and/or discharge to self-care in the community despite being medically appropriate and referred for SNF level of care; and

Whereas, there are significant barriers and delays in many SNFs to obtain medications for the treatment of OUD; therefore be it

RESOLVED, that our American Medical Association advocate for legislative and regulatory action to ensure patients are not being denied appropriate admission to skilled nursing facilities based on practices of denying admission solely on the diagnosis of opioid use disorder or prescriptions for active medications for opioid use disorder (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for and support legislation and regulatory action to ensure adequate reimbursement of skilled nursing facilities that recognizes the complexity of care, treatment and resources required for opioid use disorder treatment (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for increased access to medications for opioid use disorder in long-term care pharmacies and address the barriers to access to methadone in long-term care for use in the treatment of opioid use disorder. (Directive to Take Action)

Fiscal Note: (Modest – between $1,000 - $5,000

Received: 9/24/2024

RELEVANT AMA POLICY

D-95.961 Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings
Our AMA: (1) will research current best practices and support pilot programs and other evidence-based efforts to expand and integrate primary care services for patients receiving methadone maintenance treatment; (2) supports further research to help define the population of patients who may be safely treated with methadone maintenance treatment via office-based treatment, including primary care; and (3) urges all payers, including health insurance companies, pharmacy benefit management companies, and state and federal agencies, to reduce prior authorization and other administrative burdens and to enhance the provision of primary care, counseling, and other medically necessary services for patients being treated with methadone maintenance treatment. [BOT Rep. 16, 1-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-24)

Introduced by: New Jersey

Subject: Time Sensitive Credentialing of New Providers with an Insurance Carrier

Referred to: Reference Committee B

Whereas, a health care provider is a physician or a non-physician health care practitioner, or group of health care practitioners, or a healthcare organization who are licensed, certified, or otherwise authorized by law to provide health care services; and

Whereas, a health care provider needs to be “credentialed” into an insurance carrier to create a financial relationship for reimbursement of services provided to patients insured by that insurance carrier (even though they have been licensed and board certified); and

Whereas, the requirements for the application process used by a carrier to credential a provider into the carrier’s network are individually created by the insurance carrier and the insurance carrier must provide a credentialing application to the provider for participation if the provider is part of an existing group or if the carrier has an open network, in order to get paid; and

Whereas, the application process in the current advanced technological era is quite simple, as the necessary segments are filled out correctly, they turn green if acceptable and the areas needing to be modified remain red or yellow, and they can be rectified within 24-48 hour so that the successfully completed application turns all green; and

Whereas, the ERISA plans need to be regulated Federally; and

Whereas, currently each carrier has “their own policies” and create unnecessary delays to the extent of several months, in some cases 8 to 9 months despite submitting all necessary supporting documents thus causing undue burden and roadblocks in providing essential medical care to their patients; and

Whereas, the carriers standard answer when enquired about the status of the applicant is” the application is in process”; therefore be it

RESOLVED, that our American Medical Association urge the US Department of Labor to establish uniform provider credentialing standards for Third Party Administrator’s (TPA's) serving ERISA Plans to include the following : that when a credentialing application is submitted, the insurance carrier must respond in writing within five business days whether the application is complete and acceptable, and if incomplete the carrier must send notice to the provider indicating what additional information is needed for completion of the process, and acknowledge the completion of a successfully completed application within ten business (Directive to Take Action); and be it further

RESOLVED, that our AMA urge the US Department of Labor to require Third Party Administrators to send a written notice to applicants within 45 days, regarding their credentialing decision and after 45 days, an applicant is deemed to have been automatically credentialled

and enrolled to be eligible for payment of services, even if the payer fails to acknowledge the applicant. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-24)

Introduced by: New York

Subject: Advocate to Continue Reimbursement for Telehealth / Telemedicine Visits Permanently

Referred to: Reference Committee B

Whereas, Medicare is set to end reimbursement for telehealth on 12/31/24; and

Whereas, the decision for a telehealth type visit should be made between a doctor and a patient and not determined by a third-party insurance payor; and

Whereas, “Telehealth offers patients and providers significant benefits as a lower cost, easier way to access quality care”[1]; and

Whereas, the COVID-19 health pandemic heightened awareness and dramatically increased the need for use of telehealth; and

Whereas, telehealth has been shown in surveys to benefit both physicians and patients and physicians would be able to maintain continuity of care to those patients who are unable to make in-person visits; and

Whereas, licensed health care professionals in the VA system can practice their profession “using telemedicine at any location in any state regardless of where the professional or patient is located if the covered health care professional is using telemedicine to provide VA [Department of Veterans Affairs (VA)] medical or health services”[2]; and

Whereas, physicians would be able to render care to those patients seeking their follow-up medical care and expert opinion without the need to travel to the physician;[3,4] and

Whereas, telehealth would benefit patients as it would increase patient access to a greater number of physicians particularly for the homebound, increase choice of patients for their physicians and has been shown to increase patient satisfaction;[3,4] and

Whereas, “The rise of telehealth during pandemic boosted mental health treatment rates”[5] in a society where “90% of US adults say the U.S. is experiencing a mental health crisis”;[6] and

Whereas, “An American Medical Association (AMA) survey released shows physicians have enthusiastically embraced telehealth and expect to use it even more in the future and “Nearly 85% of physician respondents indicated they are currently using telehealth to care for patients, and nearly 70% report their organization is motivated to continue using telehealth in their practice”;[3,4] therefore be it

RESOLVED, that our American Medical Association advocate for making telehealth reimbursement permanent for Medicare and for all health insurance providers. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/2024

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RELEVANT AMA POLICY

COVID-19 Emergency and Expanded Telemedicine Regulations - D-480.963

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

2)
In 2019, prior to the pandemic, the AMA developed the policy below on telehealth reimbursement and then reaffirmed it in 2022. However, the AMA does not request that coverage and reimbursement for telehealth be made **permanently or indefinitely.**

Reimbursement for Telehealth - D-480.965
Our AMA will work with third-party payers, the Centers for Medicare and Medicaid Services, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians."

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-24)

Introduced by: New York

Subject: MIPS Reform

Referred to: Reference Committee B

Whereas, MIPS is an administratively costly program that has failed as a strategy to improve the quality of care and has had many negative unintended consequences; and

Whereas, Based on 2019 data, before full program implementation, MIPS required a considerable investment in time and financial capital -- approximately 200 hours and $12,811 (IQR, $2,861-$17,715) annually per physician; thus, this is likely an underestimate of today's costs[1]; and

Whereas, a November 2023, JAMA study of 49,901 surgeons revealed that 78% of surgeons participating in MIPS in 2021 received quality scores qualifying them for a median positive payment adjustment of $1,341 (IQR, $210-$3120).[2] These adjustments do not compensate for the financial costs of participation and the significant diversion of physicians from patient care; and

Whereas, independently practicing physicians had significantly lower MIPS performance scores than physicians affiliated with better resourced health systems[3]; and

Whereas, physicians caring for more medically and socially vulnerable patients received significantly lower MIPS scores despite providing high-quality care, punishing them for factors outside of their control.[4] Thus, MIPS will serve to increase healthcare disparities by transferring resources from poorer patients to the most affluent; and

Whereas, a 2022 study demonstrated that the MIPS program is ineffective at measuring and incentivizing quality improvement[5]; and

Whereas, MIPS is inconsistent with physician professionalism, is perceived as manipulative and fails to harness what motivates physicians most – mastery, purpose and autonomy;[6] therefore be it

RESOLVED, that our American Medical Association advocate for the repeal of the Medicare Merit-Based Incentive Payment System (MIPS) and replacement with 1) a practicing physician-designed program that has far less administrative burdens and 2) only adopts measures that have been shown to measurably improve patient outcomes. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/2024

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-24)

Introduced by: New York

Subject: Medicare Coverage for Non-PAR Physicians

Referred to: Reference Committee B

Whereas, not all physicians participate in the Medicare program; and

Whereas, certain specialties as well as physicians in certain geographic regions have opted out of CMS insurance products due to reimbursement rates well below the level needed to provide adequate care; and

Whereas, traditional Medicare provides freedom of physician choice for its insured; and

Whereas, many non-governmental insurance products exist that provide out of network benefits albeit at some potential cost to the insured beyond the level of reimbursement; and

Whereas, certain services such as mental health care are critical to good health and covered under Medicare; and

Whereas, these services are difficult, if not impossible, to find within the participating provider panels; therefore be it

RESOLVED, that our American Medical Association support federal legislation that would provide Medicare enrollees with the ability to receive partial reimbursement towards the cost of receiving treatment from the physician of their choice, regardless of whether that physician participates in Medicare. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-24)

Introduced by: New York State

Subject: Rollback on Physician Performance Measures

Referred to: Reference Committee B

Whereas, there are increasing Initiatives from public and private payers that feature incentives purportedly aimed at “elevated performance standards” for physicians and facilitating public reporting; and

Whereas, this increased emphasis on “elevated performance standards” affects physicians’ pay, reputation, and job satisfaction, despite such measures being largely unproven; and

Whereas, the prioritization of such purported quality improvement measures places a financial and temporal strain on hospitals and administrators, and too often raises tensions between hospital administrators and physicians; and

Whereas, on average, physicians spend about 2.6 hours per week on quality improvement documentation, time that could be better utilized in patient care; and (NEJM)

Whereas, because of technological limitations, there is an omission of many aspects of quality that cannot be measured and claims data do not reliably capture many of the factors included in performance measurement, a problem compounded by variability in coding habits among physicians and institutions; and

Whereas, the reliability, validity, evidence, attribution, and meaningfulness of performance measures have been questioned; and (time out article)

Whereas, these largely unproven performance measures are a major driver of the systemic stressors that are resulting in moral injury and demoralization amongst physicians while also resulting in more patient dissatisfaction and destroying the patient-physician relationship; therefore be it

RESOLVED, that our American Medical Association will make public statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RESOLVED**,** that our AMA will seek legislation or regulation removing any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare (Directive to Take Action); and be it further

RESOLVED**,** that our AMA will include the following action on a national level, including but not limited to:

-AMA statements calling for a removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare; and legislation and regulation seeking the same, and

-AMA seeking legislation or regulation mandating the removal of any/all unproven outcomes measures and associated mandates placed on physicians, practices, licensed clinics, nursing homes, hospitals and other places of healthcare. (Directive to Take Action)

Fiscal Note: Moderate – between $5,000 - $10,000

Received: 9/24/2024

RELATED AMA POLICIES

Opposed Replacement of the Merit-Based Incentive Payment System with the Voluntary Value Program D-395.998
1. Our AMA will oppose the replacement of the Merit-Based Incentive Payment System (MIPS) with the Voluntary Value Program (VVP) as currently defined.
2. Our AMA will study the criticisms of the Merit-Based Incentive Payment System (MIPS) program as offered by proponents of the VVP to determine where improvement in the MIPS program needs to be made.
3. Our AMA will continue its advocacy efforts to improve the MIPS program, specifically requesting: (a) true EHR data transparency, as the free flow of information is vital to the development of meaningful outcome measures; (b) safe harbor protections for entities providing clinical data for use in the MIPS program; (c) continued infrastructure support for smaller practices that find participation particularly burdensome; (d) adequate recognition of and adjustments for socioeconomic and demographic factors that contribute to variation in patient outcomes as well as geographic variation; and (e) limiting public reporting of physician performance to those measures used for scoring in the MIPS program.
4. Our AMA will determine if population measures are appropriate and fair for measuring physician performance.
Policy Timeline
Res. 247, A-18 Reaffirmed: BOT Rep. 13, I-20

Merit-based Incentive Payment System (MIPS) Update H-385.905
Our AMA supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.
Policy Timeline
BOT Rep. 13, I-20 Reaffirmed: Res. 212, I-21

Reducing MIPS Reporting Burden D-395.999
Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System (**MIPS**) that have significant input from practicing physicians and reduce regulatory and paperwork burdens on physicians. In the interim, our AMA will work with CMS to shorten the yearly MIPS data reporting period from one-year to a minimum of 90-days (of the physician's choosing) within the calendar year.
Policy Timeline
Res. 236, A-18 Reaffirmation: A-19 Reaffirmed: BOT Rep. 13, I-20

MIPS and MACRA Exemption H-390.838
Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.
Policy Timeline
Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT

Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) D-390.950
1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.
Policy Timeline
Res. 242, A-16 Reaffirmed: BOT Rep. 13, I-20

Measurement of Drug Costs to Assess Resource Use Under MACRA H-385.911
1. Our AMA will work with Congress and the Centers for Medicare and Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System (**MIPS**) or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk, unless a Physician Focused Alternative Payment Model (incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory.
2. Our AMA will continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the **MIPS** payment adjustment as part of the Quality Payment Program (QPP).
Policy Timeline Res. 218, A-16Appended: Res. 225, I-17

Support for the Quadruple Aim H-405.955
1. Our AMA supports that the "Triple Aim"□ be expanded to the Quadruple Aim, adding the goal of improving the work-life balance of physicians and other health care providers.
2. Our AMA will advocate that addressing physician satisfaction count as a Clinical Practice Improvement Activity under the Merit-Based Incentive Payment System (**MIPS**).
Policy Timeline
Res. 104, A-16 Reaffirmation: A-22

Preserving Patient Access to Small Practices Under MACRA D-390.949
1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA **MIPS** exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.
2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.
Policy Timeline
Res. 243, A-16 Reaffirmation: I-17 Reaffirmation: A-18 Reaffirmed: BOT Rep. 13, I-20

Opposition to Mandatory Licensing Requirements for Qualified Clinical Data Registries H-180.943
1. Our AMA will oppose any Centers for Medicare and Medicaid Services (CMS) proposal that would require Qualified Clinical Data Registries (QCDR) measure owners, as a condition of measure approval for reporting in Merit-based Incentive Payment System (**MIPS**) and other Medicare quality payment programs, to enter into a free license agreement with CMS that would allow other QCDRs to use the owner's measures without a direct license with the measure owner.
2. Our AMA will oppose any CMS proposal that would require inclusion of CMS as a party in a QCDR measure licensing agreement between the QCDR measure owner and another.

3. Our AMA will support in situations where QCDR measures are shared between the original measure owner and another QCDR, that the latter QCDR:
A. must adhere to certain standards and terms set out by the QCDR measure owner on measure implementation and data capture, including data validity and reliability, plus fair remuneration for measure development and ongoing measure stewardship.
B. must have demonstrated clinical expertise in medicine, quality measure development and improvement by providing methods to ensure data quality, routine metric reporting, and quality improvement consultation.
Policy Timeline
Res. 232, I-18

Sequestration D-390.946
Our AMA will: (a) continue to prioritize and actively pursue vigorous and strategic advocacy to prevent sequester and other cuts in Medicare payments due to take effect on January 1, 2022; (b) seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs; (c) ensure Medicare physician payments are sufficient to safeguard beneficiary access to care; (d) work towards the elimination of budget neutrality requirements within Medicare Part B; (e) eliminate, replace, or supplement budget neutrality in **MIPS** with positive incentive payments; (f) advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system to address increasing costs of physician practices, and that continued budget neutrality is not an option; and (g) advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.
Policy Timeline
Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmed: CMS Rep. 02, A-23 Reaffirmed: Res. 214, A-23

Pay-for-Performance Principles and Guidelines H-450.947
1. The following *Principles for Pay-for-Performance and Guidelines for Pay-for-Performance* are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS H-450.947
Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:
. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based **quality** of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive **quality** improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of **quality** improvement across all participating physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care delivery system. The AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote **quality** patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based **quality** of care measures must be the primary measures used in any program.

1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care **quality** and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved **quality** patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure **quality** by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.

1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.
- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

Physician Participation

Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).

The **quality** of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet **quality** objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.
- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician **quality** performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."

Policy Timeline

BOT Rep. 5, A-05 Reaffirmation A-06 Reaffirmed: Res. 210, A-06 Reaffirmed in lieu of Res. 215, A-06 Reaffirmed in lieu of Res. 226, A-06 Reaffirmation I-06 Reaffirmation A-07 Reaffirmation A-09 Reaffirmed: BOT Rep. 18, A-09 Reaffirmed in lieu of Res. 808, I-10 Modified: BOT Rep. 8, I-11 Reaffirmed: Sub. Res. 226, I-13 Appended: BOT Rep. 1, I-14 Reaffirmed in lieu of Res. 203, I-15 Reaffirmed in lieu of Res. 216, I-15 Reaffirmation I-15 Reaffirmed: BOT Rep. 20, A-16 Reaffirmed in lieu of: Res. 712, A-17 Reaffirmation: A-18 Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-24)

Introduced by: New York

Subject: Mandated Economic Escalators in Insurance Contracts

Referred to: Reference Committee B

Whereas, our American Medical Association is committed to advocating for the best interests of its members and ensuring access to quality healthcare for all patients; and

Whereas, the ever-changing landscape of healthcare economics poses challenges to sustaining the financial viability of medical practices; and

Whereas, adequate payment for medical care provided through commercial insurance contracts are integral to the financial well-being of healthcare providers; and

Whereas, the US Congress has directed CMS to repeatedly lowered the conversion factor utilized in the Medicare Physician Fee Schedule (PFS) resulting in significant decline in payment rates under traditional Medicare; and

Whereas, most commercial insurance contracts are based on a multiple of Medicare Payment rate for a specified service resulting in a potential decline in commercial reimbursement rates over time; and

Whereas, healthcare providers face increased costs of operation due to inflation in various aspects of practice, including but not limited to personnel, supplies, and overhead expenses; and

Whereas, the absence of an economic escalator in insurance contracts fails to account for the economic realities faced by medical practices, thereby hindering their ability to provide quality care to patients; therefore be it

RESOLVED, that our American Medical Association advocates through legislation or regulation for the mandatory insertion of an economic escalator provision in all commercial insurance contracts to account for economic inflation or a decline in Medicare Physician Fee Schedule (PFS). (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-24)

Introduced by: Association for Clinical Oncology

Subject: Elimination of Medicare 14-Day Rule

Referred to: Reference Committee B

Whereas, our American Medical Association adopted D-330.903 at I-17, which asks our AMA "actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments"; and

Whereas, AMA advocacy on the CY 2018 Medicare Outpatient Prospective Payment System Rule was successful in getting complex molecular testing unbundled from outpatient diagnostic procedures – such as outpatient interventional radiology biopsies; and

Whereas, the Medicare 14-Day Laboratory Date of Service Rule (Medicare 14-Day Rule) provides billing requirements for diagnostic tests ordered for Medicare patients and determines whether the clinical laboratory performing the tests will directly bill Medicare or bill the hospital where the specimen was collected; and

Whereas, the Medicare 14-Day Rule was not changed for specimens collected during an inpatient encounter, with complex molecular tests ordered within 14 days of hospital discharge continuing to be bundled into inpatient Medicare payments; and

Whereas, performing complex molecular tests on inpatient samples parallel the criteria established for unbundling testing of outpatient samples: including it being medically appropriate to have been collected during the hospital inpatient encounter, the results of the test not guiding treatment during the hospital inpatient encounter, and the test being reasonable and medically necessary for the treatment of an illness; and

Whereas, the real-world effect of an inpatient Medicare 14-Day Rule is to routinely delay the initiation, until 14 days after discharge, of complex molecular tests on pathologic samples collected during an acute hospitalization, such as cytology from an inpatient thoracentesis for a new diagnosis of lung cancer; and

Whereas, diagnostic delay of pivotal molecular data due to the inpatient Medicare 14-Day Rule causes harm to patients, such as forcing an initial round of an inferior cytotoxic chemotherapy on newly diagnosed lung cancer patients while awaiting candidacy for a more efficacious targeted agent; therefore be it

RESOLVED, that our American Medical Association actively lobby the federal government to readdress and change laboratory date of service rules under Medicare, e.g. the Medicare 14-Day Laboratory Date of Service Rule (Medicare 14-Day Rule), such that complex laboratory services performed on pathologic specimens collected from an inpatient hospital procedure be

paid separately from inpatient bundled payments, consistent with Outpatient rules. (Directive to Take Action).

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/2024

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1. American Medical Association. Follow-Up on Implementation of Resolutions and Report Recommendations, AMA House of Delegates Interim Meeting - November 8-11, 2017. https://www.ama-assn.org/system/files/2018-11/i17-followup-status-report_0.pdf
2. Centers for Medicare & Medicaid Services. Laboratory Date of Service Policy. https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-schedule-clfs/date-service-policy
3. Foundation Medicine. 14-Day Rule Billing Requirements for Foundation Medicine Tests. https://www.foundationmedicine.com/sites/default/files/media/documents/2024-08/14%20Day%20Medicaid%20Rule_One%20Pager_LaboratoryDateOfService_June%202024_US-PF-2200092_R4.pdf

RELEVANT AMA POLICY

Elimination of Laboratory 14-Day Rules Under Medicare D-330.903
Our AMA will actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-24)

Introduced by: Association for Clinical Oncology, American Society of Hematology

Subject: Information Blocking Rule

Referred to: Reference Committee B

Whereas, the 21st Century Cures Act contained the Information Blocking Rule as a provision, requiring that patients be given immediate access to their medical records, including clinical notes, radiology and pathology reports and laboratory results; and

Whereas, since enforcement of the Information Blocking Rule began in April 2021, patients have increasingly received sensitive and distressing information and diagnoses from their patient portal first rather than from the treating physician, thereby causing undue distress, confusion and compromising the patient-physician relationship; and

Whereas, after elimination of a 36-hour embargo on release of radiology reports to patient portals to comply with the 21st Century Cures Act; and

Whereas, these reports were accessed first by the patient in 44% of cases compared to 18.2% of cases prior to the change, and the median time from report finalization to first patient access decreased from 45 hours during the embargo period to 5.5 hours following the change; and

Whereas, our American Medical Association supports revising the definition of harm exception to the Information Blocking Rule to include mental and emotional distress [D-315.972] but does not include an exception for harassment or potential harm of medical staff or others; and

Whereas, a short-term embargo of reports or results associated with sensitive information would give the treating physician the opportunity to act on new information and thereby reduce distress and confusion without restricting the patient's ultimate access to information; and

Whereas, the Information Blocking Rule does not allow patients to tailor their preferred way of receiving information, such as requesting that the ordering or treating physician review the report or results before its release to the portal; and

Whereas, the ordering physician no longer has the ability to review a report or result prior to release to the patient to verify its accuracy or add clinical context to the findings, thereby giving the patient the false impression that the information is absolute; therefore be it

RESOLVED, that our American Medical Association supports the use of short-term embargo of reports or results and individual tailoring of preferences for release of information as part of the harm exception to the Information Blocking Rule (New HOD Policy); and be it further

RESOLVED, that our AMA supports the requirement of review of report and result information by the ordering physician or physician surrogate prior to release of medical information to the patient (New HOD Policy); and be it further

RESOLVED, that our AMA supports expansion of the harm exception to the Information Blocking Rule to include harassment or potential harm of medical staff or others (New HOD Policy); and be it further

RESOLVED, that our AMA advocates for expansions to the harm exception to the Information Blocking Rule and for the requirement of review by the ordering physician or surrogate prior to the application of the Information Blocking Rule provisions. (Directive to Take Action).

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/2024

REFERENCES

1. Pollock JR, Petty SAB, Schmitz JJ, Varner J, Metcalfe AM, Tan N. Patient Access of Their Radiology Reports Before and After Implementation of 21st Century Cures Act Information-Blocking Provisions at a Large Multicampus Health System. AJR Am J Roentgenol. 2024 Jun;222(6):e2330343. doi: 10.2214/AJR.23.30343. Epub 2024 Mar 27. PMID: 38534191.

RELEVANT AMA POLICY

Redefining the Definition of Harm D-315.972
Our AMA will: (1) advocate to the Office for Civil Rights to revise the definition of harm to include mental and emotional distress. Such a revision would allow additional flexibility for clinicians under the Preventing Harm Exception, based on their professional judgement, to withhold sensitive information they believe could cause physical, mental or emotional harm to the patient; (2) advocate that the Office for Civil Rights assemble a commission of medical professionals to help the office review the definition of harm and provide scientific evidence demonstrating that mental and emotional health is intertwined with physical health; (3) continue to urge the Department of Health and Human Services (HHS)'s Office of the National Coordinator for Health Information Technology (ONC) and its Office of Inspector General (OIG) to leverage their enforcement discretion that would afford medical practices additional compliance flexibilities; and (4) urge the ONC to earnestly consult with relevant stakeholders about unintended or unforeseen consequences that may arise from the information blocking regulations.
Policy Timeline
Res. 206, A-21
UPDATE 2022: Our AMA has written to the Office for Civil Rights (OCR) and spoken to National Coordinator for Health Information Technology (ONC) about this issue multiple times. As of October, we have met with both OCR and ONC to clarify that emotional and psychological harm are encompassed in the "substantial harm" prong of HIPAA that should be better publicized to clinicians to help them comply with information blocking and HIPAA alike.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-24)

Introduced by: American College of Rheumatology

Subject: Medicare Payment Parity for Telemedicine Services

Referred to: Reference Committee B

Whereas, as a care delivery strategy, telemedicine holds huge potential to overcome certain limitations of our current health care system with its focus on fee-for-service environment; and

Whereas, considerable growth was seen in telemedicine delivery as the system adjusted to pandemic circumstances and the presence of telehealth flexibilities made available during the public health emergency declared by the federal government; and

Whereas, the rapid adoption of telemedicine during the public health emergency helped to combat the financial strain associated with a reduction of in-person visits for many practices during the pandemic; and

Whereas, from the onset of the public health emergency through the end of 2023, Medicare reimbursed for telemedicine services at the same rate as if the services were performed in person; and

Whereas, as of July 2024, 24 states require private payers to reimburse for telemedicine services at the same rate as if the services were provided in-person; and

Whereas, telemedicine visits are costly to set up and consume the same amount of resources as in-person visits; and

Whereas, providers are having to see a higher percentage of Medicare patients via telemedicine while experiencing workforce shortages, high inflation, higher costs for procuring drugs and medical supplies, and other economic burdens associated with running a medical practice; and

Whereas, payment parity for Medicare telemedicine services would provide resources for providers to cover these costs; therefore be it

RESOLVED, that our American Medical Association advocate for Medicare to reimburse providers for telemedicine-provided services at an equal rate as if the services were provided in-person. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 9/24/2024

RELEVANT AMA POLICY

Insurance Coverage Parity for Telemedicine Service D-480.969
Our AMA will: 1) advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers; and 2) develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies; and
3) work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.
Policy Timeline
Res. 233, A-16, Reaffirmed: CMS Rep. 1, I-19, Reaffirmed: CMS Rep. 7, A-21, Reaffirmed: Res. 239, A-22, Reaffirmed: CMS Rep. 2, A-22

Coverage of and Payment for Telemedicine H-480.946
Our American Medical Association believes that **telemedicine** services should be covered and paid for if they abide by the following principles:

a. A valid patient-physician relationship must be established before the provision of telemedicine services, through:
- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine.
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care.
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

a. Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
b. Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
c. Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
d. The delivery of telemedicine services must be consistent with state scope of practice laws.
e. Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
f. The standards and scope of telemedicine services should be consistent with related in-person services.
g. The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
h. The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
i. The patient's medical history must be collected as part of the provision of any telemedicine service.
j. The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.

k. The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
l. Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.

Policy Timeline

CMS Rep. 7, A-14 Reaffirmed: BOT Rep. 3, I-14 Reaffirmed in lieu of Res. 815, I-15 Reaffirmed: CME Rep. 06, A-16 Reaffirmed: CMS Rep. 06, I-16 Reaffirmed: Res. 111, A-17 Reaffirmation: A-18 Reaffirmed: CMS Rep. 1, I-19 Reaffirmed: CMS Rep. 8, A-21 Reaffirmed: Res. 239, A-22 Reaffirmed: CMS Rep. 2, A-22 Reaffirmed: Res. 213, A-23