Preliminary Summary of Online Member Forum Comments

John Flores, MD, Chair

Pursuant to Policy D-600.956, adopted at the November 2021 Special Meeting, commentary submitted to the online member forums will be used to generate a preliminary document to inform the discussion at the in-person reference committee hearings.

The following items of business are under consideration by Reference Committee B:

2. BOT 17 – Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession
3. 201 – The Impact of Midlevel Providers on Medical Education
4. 202 – AMA Position on All Payer Database Creation
5. 203 – Ban the Gay/Trans (LGBTQ+) Panic Defense
6. 204 – Insurance Claims Data
7. 205 – Insurers and Vertical Integration
8. 206 – Medicare Advantage Plan Mandates
9. 207 – Physician Tax Fairness
10. 208 – Prohibit Ghost Guns
11. 209 – Supporting Collection of Data on Medical Repatriation
12. 210 – Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
13. 211 – Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program
14. 212 – Medication for Opioid Use Disorder in Physician Health Programs
15. 213 – Resentencing for Individuals Convicted of Marijuana-Based Offenses
16. 214 – Eliminating Unfunded or Unproven Mandates and Regulations
17. 215 – Transforming Professional Licensure to the 21st Century
18. 216 – Advocating for the Elimination of Hepatitis C Treatment Restrictions
19. 217 – Preserving the Practice of Medicine
20. 218 – Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas
21. 219 – Due Process and Independent Contractors
22. 220 – Vital Nature of Board-Certified Physicians in Aerospace Medicine
23. 221 – Strategies to Mitigate Racial and Ethnic Disparities in Maternal and Fetal Morbidity and Mortality at the Grassroots Level
24. 222 – To Study the Economic Impact of Mid-Level Provider Employment in the United States of America
25. 223 – National Drug Shortages of Lidocaine and Saline Preparations
26. 224 – HPSA and MUA Designation for SNFs
27. 225 – Public Listing of Medical Directors for Nursing Facilities
28. 226 – Coverage for Clinical Trial Ancillary Costs
29. 227 – Supporting Improvements to Patient Data Privacy
30. 228 – Expanded Child Tax Credit
31. 229 – Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas
32. 230 – Advancing the Role of Outdoor Recreation in Public Health
33. 231 – Amending Policy H-155.955, "Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption"
34. 232 – Expansion of Epinephrine Entity Stocking Legislation
35. 233 – Support for Warning Labels on Firearm Ammunition Packaging
37. 235 – Improving the Veterans Health Administration Referrals for Veterans for Care Outside the VA System
38. 236 – Out-of-Network Care
39. 237 – Prescription Drug Dispensing Policies
40. 238 – COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians
41. 239 – Virtual Services When Patients Are Away From Their Medical Home
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(1) BOT 9 COUNCIL ON LEGISLATION SUNSET REVIEW OF 2012

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

Your Reference Committee reviewed online testimony regarding this Report. One comment was received from the Board of Trustees. Your Reference Committee notes that the comment was supportive of the Report and recommended that the policies listed in the appendix of Board of Trustees Report 9 be acted upon in the manner indicated in the report and that the remainder of the report be filed.

(2) BOT 17 EXPUNGEMENT, DESTRUCTION, AND SEALING OF CRIMINAL RECORDS FOR LEGAL OFFENSES RELATED TO CANNABIS USE OR POSSESSION

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

1. That our American Medical Association (AMA) support automatic expungement, sealing, and similar efforts regarding an arrest or conviction for a cannabis-related offense for use or possession that would be legal under subsequent state legalization of adult use or medicinal cannabis. (New HOD Policy)

2. That our AMA support automatic expungement, sealing, and similar efforts regarding an arrest or conviction of a cannabis-related offense for use or possession for a minor upon the minor reaching the age of majority. (New HOD Policy)

3. That our AMA inquire to the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, Federation of State Medical Boards, and other relevant medical education and licensing authorities, as to the effects of disclosure of a cannabis related offense on a medical school, residency, or licensing application. (Directive to Take Action)

4. That AMA Policy D-95.960, “Public Health Impacts of Cannabis Legalization” be rescinded since this report fulfills the directive contained in the policy. (Rescind HOD Policy)

Your Reference Committee reviewed online testimony regarding this Report. One comment was received from the Board of Trustees. The comment noted the increased number of states that have legalized cannabis for adult and medical use. The comment also highlighted that most of the arrests for possession and use of cannabis were disproportionally of Black and Brown individuals, and young people and young adults, resulting in significant long-term consequences. The Board of Trustees commented that the recommendations made in Board of Trustees Report 17 aligned with our AMA policy on numerous fronts. Overall, the Board was supportive of the Report and recommended that it be adopted.
RESOLUTION – 201 THE IMPACT OF MIDLEVEL PROVIDERS ON MEDICAL EDUCATION

RESOLVED, That our American Medical Association study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated, and standardized education they receive (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for nurse practitioners and physician assistants prior to working within a specialty or subspecialty field (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for nurse practitioners and physician assistants in order to maintain licensure to practice. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Mixed testimony was received for Resolution 201. However, your Reference Committee notes that the spirit of the Resolution is supported throughout all the comments and all commentors agreed that it is important to protect the physician lead health care team and ensure proper training for residents. Your Reference Committee observed that testimony differed on which resolved clauses should be supported. Most of the testimony did not support the Resolution in whole. The Council on Medical Education recommended adoption of the recommendations in CME Report 5, “Education, Training, and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training”, presented at A-22, in lieu of adopting the first, third, and fourth resolved clauses. Other commentors offered amendments to the Resolution.

(4) RESOLUTION 202 – AMA POSITION ON ALL PAYER DATABASE CREATION

RESOLVED, That our American Medical Association advocate that any All Payer Database should also provide true payments that hospitals are making to their employed physicians, not just the amount of payment that the insurer is making on the physician’s behalf to the hospital. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. No online forum comments were received for Resolution 202.
(5) RESOLUTION 203 – BAN THE GAY/TRANS (LGBTQ+) PANIC DEFENSE

RESOLVED, That our American Medical Association seek a federal law banning the use of the so-called “gay/trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual assault cases (Directive to Take Action); and be it further

RESOLVED, That our AMA publish an issue brief and talking points on the topic of so called “gay/trans (LGBTQ+) panic” defense, that can be used by our AMA in seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called “gay/trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Resolution 203 had supportive testimony. Your Reference Committee notes that all commentors agreed that the LGBTQ+ panic defense should be outlawed. However, one commentor stated that other organizations, such as the UCLA Williams Institute, the LGBTQ+ Bar, and the American Bar Association, have a greater knowledge and background on this issue and have already created issue briefs and talking points on this topic. The commentor also argued that our AMA is better equipped to support these efforts rather than take the lead and offered amendments to Resolution 203 in line with these points.

(6) RESOLUTION 204 – INSURANCE CLAIMS DATA

RESOLVED, That our American Medical Association seek legislation and regulation to promote open sharing of de-identified health insurance claims data. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 204, which was supportive of the Resolution. Your Reference Committee notes that the testimony argued that insurance claims data is an important resource for public health and physician practice information, and that this Resolution would help make medical research more equitable and accessible.

(7) RESOLUTION 205 – INSURERS AND VERTICAL INTEGRATION

RESOLVED, That our American Medical Association seek legislation and regulation to prevent health payers (except non-profit HMO’s) from owning or operating other entities in the health care supply chain. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. No online forum comments were received for Resolution 205.

(8) RESOLUTION 206 – MEDICARE ADVANTAGE PLAN MANDATES

RESOLVED, That our American Medical Association advocate for federal legislation to ensure that no person should be mandated to change from traditional Medicare to Medicare Advantage plans. (Directive to Take Action)
Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee notes that the comments received are supportive of Resolution 206. The comments noted that patients should not be forced to choose Medicare Advantage Plans over other health care plans. One friendly amendment was offered in the comments.

(9) RESOLUTION 207 – PHYSICIAN TAX FAIRNESS

RESOLVED, That our American Medical Association lobby that physicians be excluded from being considered a specified service business as defined by the Internal Revenue Service. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. No online forum comments were received for Resolution 207.

(10) RESOLUTION 208 – PROHIBIT GHOST GUNS

RESOLVED, That our American Medical Association support state and federal legislation and regulation that would subject homemade weapons to the same regulations and licensing requirements as traditional weapons. (New HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee notes that mixed testimony was received for Resolution 208. The majority of the testimony was supportive of the resolution and the testimony highlighted the need to reduce the epidemic of gun violence in our country. Some testimony stated that though this Resolution is not a solution to all our gun violence issues, ensuring that homemade weapons are outlawed or at least have serial numbers is important. Additional testimony argued that information provided in the whereas clauses was not accurate, and that the Resolution conflates guns with weapons.

(11) RESOLUTION 209 – SUPPORTING COLLECTION OF DATA ON MEDICAL REPATRIATION

RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it further

RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 209. Your Reference Committee notes that the comment was supportive of the Resolution. The comment argued that the health of the patient and the medical decision of the physician should be the controlling factors when discharging a patient and not the patient’s immigration status.
(12) RESOLUTION 210 – REDUCING THE PREVALENCE OF
SEXUAL ASSAULT BY TESTING SEXUAL ASSAULT EVIDENCE
KITS

RESOLVED, That our American Medical Association amend Policy H-80.999, “Sexual Assault Survivors,” by addition to read as follows:

H-80.999 – SEXUAL ASSAULT SURVIVORS

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitations (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor’s Bill of Rights Act of 2016.

4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.

5. Our AMA will advocate at the state and federal level for (a) the immediate processing of all “backlogged” and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits. (Modify Current HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee notes that the comments received are supportive of Resolution 210. The comments highlighted the magnitude of the backlog of the thousands of untested sexual assault kits. The commentors argued that the Resolution should be passed to reinforce the importance of testing the backlog of kits to help catch perpetrators, protect victims, and to ensure that the statute of limitations does not pass before testing takes place.

(13) RESOLUTION 211 – REPEAL OR MODIFICATION OF THE
MEDICARE APPROPRIATE USE CRITERIA (AUC) PROGRAM

RESOLVED, That our American Medical Association Policy H-320.940, “Medicare’s Appropriate Use Criteria Program,” be amended by addition and deletion to read as follows:

Our AMA will continue to advocate to Congress for delay the effective date either the full repeal of the Medicare Appropriate Use Criteria (AUC) Program or legislative modifications to the
program in such a manner that until the Centers for Medicare & Medicaid Services (CMS) can adequately addresses technical and workflow challenges, with its implementation and any interaction between maximizes alignment with the Quality Payment Program (QPP), and the use of advanced diagnostic imaging appropriate use criteria, creates provider flexibility for the consultation of AUC or advanced diagnostic imaging guidelines using a mechanism best suited for their practice, specialty and workflow. (Modify Current HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee notes that the comments received are supportive of Resolution 211. The comments stated that current AMA policy only permits our AMA to support efforts to delay the effective date of Medicare’s Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging and argued that delay is no longer appropriate but rather, that a legislative solution is needed address to the problems surrounding AUC.

(14) RESOLUTION 212 – MEDICATION FOR OPIOID USE DISORDER IN PHYSICIAN HEALTH PROGRAMS

RESOLVED, That our American Medical Association reaffirm policy H-95.913, “Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA modify policy D-405.990, “Educating Physicians About Physician Health Programs and Advocating for Standards,” by addition to read as follows:

Our AMA will:

(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;

(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;

(3) in conjunction with the FSPHP, develop model state legislation and/or legislative guidelines addressing the design and implementation of physician health programs including, but not limited to, the allowance for safe-haven or non-reporting of physicians to a licensing board, and/or acceptance of Physician Health Program compliance as an alternative to disciplinary action when public safety is not at risk, and especially for any physicians who voluntarily self-report their physical, mental, and substance use disorders and engage with a Physician Health Program and who successfully complete the terms of participation;

(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;

(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member
PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and

(6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options. (Modify Current HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that mixed comments were received regarding Resolution 212. Your Reference Committee notes that the spirit of the Resolution, to support and safeguard physicians that seek treatment for substance use disorders, was generally supported. However, some comments argued that Resolution 212 is redundant with existing policy and that our AMA is already working on the issues presented in Resolution 212. Comments also noted that referral may be preferable to passage of Resolution 212.

(15) RESOLUTION 213 – RESENTENCING FOR INDIVIDUALS CONVICTED OF MARIJUANA-BASED OFFENSES

RESOLVED, That our American Medical Association adopt policy supporting the expungement, destruction, or sealing of criminal records for marijuana offenses that would now be considered legal (New HOD Policy); and be it further

RESOLVED, That our AMA adopt policy supporting the elimination of violations or other penalties for persons under parole, probation, pre-trial, or other state or local criminal supervision for a marijuana offense that would now be considered legal. (New HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that the comments received were supportive of Resolution 213. The comments stated that individuals should not have to continue to be punished for marijuana-based offenses in states that have now legalized marijuana. The comments also noted the long-term negative implications of marijuana sentences. Your Reference Committee also saw comments that highlighted the fact that that Board of Trustees Report 17 covers the same topics as Resolution 213.

(16) RESOLUTION 214 – ELIMINATING UNFUNDED OR UNPROVEN MANDATES AND REGULATIONS

RESOLVED, That our American Medical Association advocate for policies that allow for physician judgment and documented medical decision-making to supersede government regulation—including the utilization of Augmented Intelligence—in instances of disputes in patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for policies that require “proof of concept,” in the form of independently demonstrated quality improvement, prior to the implementation of any government, insurance company or other third party mandate or regulation on patient care and the physician-patient relationship (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for policies requiring government, insurance company or other third party entities to fully fund any mandates or regulations imposed on patient care and the physician-patient relationship. (Directive to Take Action)
Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that the comments received were supportive of Resolution 214. Your Reference Committee notes that the comments stated that the administrative burden placed on physicians today leads to many delays in care, stress on patients, burnout in physicians, and ultimately a much more inefficient and costly health care system with unfunded and unproven mandates being a large contributor to these inefficiencies.

(17) RESOLUTION 215 – TRANSFORMING PROFESSIONAL LICENSURE TO THE 21ST CENTURY

RESOLVED, That our American Medical Association address the issue of state licensure in a comprehensive manner including studying the best mechanisms to ensure interstate licensure for practitioners practicing in multiple states, optimizing state licensure practices to allow for seamless telemedicine practice across state lines, and addressing long delays in practitioners obtaining state licensures which lead to delays in medical care (Directive to Take Action); and be it further

RESOLVED, That our AMA research the feasibility of convening a meeting of appropriate stakeholders, including but not limited to state medical boards, medical specialty societies, state medical societies, payers, organizations representing non-physician medical professionals, Centers for Medicare and Medicaid Services-approved accrediting agencies, and patients to develop recommendations to modernize the state medical licensure system including creating mechanisms for multi-state licensure, streamlining the process of obtaining medical licensure, and facilitate practice across state lines (Directive to Take Action); and be it further

RESOLVED, That our AMA report back on these recommendations by the 2022 Interim Meeting. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that the comments received were supportive of Resolution 215 with amendments. The comments all noted that amendments to Resolution 215 are needed. Some commentors argued that the third resolved clause should be removed because there would not be an appropriate amount of time to study this issue, while others stated that the work requested by the first resolved clause is already ongoing, meaning that the first resolved is either not needed or needs to have its language amended. An additional commentor believed that it may be necessary to study this issue.

(18) RESOLUTION 216 – ADVOCATING FOR THE ELIMINATION OF HEPATITIS C TREATMENT RESTRICTION

RESOLVED, That our American Medical Association amend policy H-440.845, “Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment,) by addition to read as follows:

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment, H-440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC, Indian Health Service (IHS), and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support
hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) advocate, in collaboration with state and specialty medical societies, as well as patient advocacy groups, for the elimination of sobriety requirements, fibrosis restrictions, and prescriber restrictions for coverage of HCV treatment by public and private payors; (54) support programs aimed at training providers in the treatment and management of patients infected with HCV; (66) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies, and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment;

(76) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines; (87) encourage equitable reimbursement for those providing treatment; (9) encourage the allocation of targeted funding to increase HCV treatment for IHS patients insured by plans subject to HCV treatment restrictions. (Modify Current HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 216, which was supportive of the Resolution. Your Reference Committee observed that the comment noted that 2.4 million Americans are currently living with a Hepatitis C Virus (HCV) infection with a disproportionate amount of those infected being American Indian/Alaskan Natives. The comment also stated that many Medicaid programs, prisons, and private insurers have implemented restrictions on who can receive treatment to the detriment of many, especially those in vulnerable groups in our society.

(19)  RESOLUTION 217 – PRESERVING THE PRACTICE OF MEDICINE

RESOLVED, That our American Medical Association oppose mandates from employers to supervise non-physician providers as a condition for physician employment and in physician employment contracts (New HOD Policy); and be it further

RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to “supervise” non-physician providers (Directive to Take Action); and be it further

RESOLVED, That our AMA conduct a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in fields which are not a core part of those physicians’ completed residencies and fellowships (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact scope-of-practice advocacy by physicians has had on physician employment and termination (Directive to Take Action); and be it further

RESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care, and study the utility of a physician-reported database to track and report institutions that replace physicians with non-physician providers in order to aid patients in seeking physician-led medical care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to commission an independent study comparing medical care provided by physician-led health care teams vs. care provided by
unsupervised non-physician providers, which reports on the quality of health outcomes, cost\neffectiveness, and access to necessary medical care, and to publish the findings in a peer-\nreviewed medical journal. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference\nCommittee observed that mixed comments were received regarding Resolution 217. One\ncomment stated that Resolution 217 should be referred so that the topics mentioned can be\nstudied and the language offered in the Resolution can be improved. The commentor argued that\nthe first two resolved clauses sound like physicians do not want to supervise non-physician\nproviders. However, other commentors believed that Resolution 217 is worded clearly and does\nnot need to be referred. One commentor argued that physician-led care teams provide less costly\nand more effective care and that a study of the cost effectiveness of physicians, that is not lead\nby insurance companies, is needed.

(20) RESOLUTION 218 – EXPEDITED IMMIGRANT GREEN CARD\nVISA FOR J-1 VISA WAIVER PHYSICIANS SERVING IN\nUNDERSERVED AREAS

RESOLVED, That our American Medical Association lobby US Congress and the US\nAdministration that the J-1 visa waiver physicians serving in underserved areas be given highest\npriority in visa conversion to green cards upon completion of their service commitment obligation\nand be exempted from per country limitation of H-1 to green card visa conversion. (Directive to\nTake Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference\nCommittee observed that the comments received are supportive of Resolution 218. Multiple\ncommentors highlighted the much-needed work that international medical graduates provide to\nour country and our underserved communities and discussed the importance of international\nmedical graduates, especially when considering the current and projected physician shortage.\nOne commentor noted that our AMA has policy on clearing the backlog of conversion from H-1B\nstatus to permanent resident status however, the comment argued that none of our policies\naddress this issue for J-1 visa holders. Your Reference Committee notes that another commentor\was supportive of Resolution 218 but offered amendments to broaden the Resolution to all non-\nimmigrant visas.

(21) RESOLUTION 219 – DUE PROCESS AND INDEPENDENT\nCONTRACTORS

RESOLVED, That our American Medical Association develop a model state legislative template\nand principles for federal legislation in order to protect physicians from corporate, workplace,\nand/or employer retaliation when reporting safety, harassment, or fraud concerns at the places of\nwork (licensed health care institution) or in the government, which includes independent and third-\nparty contractors providing patient services at said facilities. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference\nCommittee observed that the comments received were supportive of Resolution 219. One\ncommentor noted the importance of due process protections from retaliation by a corporation,\nworkplace, or employer when physicians report concerns regarding safety, harassment, or fraud.\nCommentors also argued that a legislative template for states will increase the potency of our\nAMA advocacy and allow for flexibility and an opportunity to compare and contrast existing laws,
while providing guidance to state medical societies and specialty societies that are interested in
pursuing a state legislative initiative to address due process concerns.

(22) RESOLUTION 220 – VITAL NATURE OF BOARD-CERTIFIED
PHYSICIANS IN AEROSPACE MEDICINE

RESOLVED, That our American Medical Association recognize the unique contributions and
advanced qualifications of aerospace medicine professionals, and specifically oppose any and all
efforts to remove, reduce or replace aerospace medicine physician leadership in civilian,
corporate or government aerospace medicine programs and aircrew healthcare support teams;
(Directive to Take Action) and be it further

RESOLVED, That our AMA advocate for compliance with international agreements, to include
advocating against other mid-level provider scope of practice expansions that threaten the safety,
health, and well-being of aircrew, patients, support personnel and the flying public. (Directive to
Take Action)

Your Reference Committee reviewed online testimony regarding this item. No online forum
comments were received for Resolution 220.

(23) RESOLUTION 221 – STRATEGIES TO MITIGATE RACIAL AND
ETHNIC DISPARITIES IN MATERNAL AND FETAL MORBIDITY
AND MORTALITY AT THE GRASSROOTS LEVEL

RESOLVED, That our American Medical Association advocate for institutional and departmental
policies that promote awareness and transparency in defining the criteria for identifying and
mitigating gaps in health equity in Maternal Fetal outcome measures affecting racial and minority
U.S. population (Directive to Take Action); and be it further

RESOLVED, That our AMA engage with relevant stakeholders to initiate a similar awareness
campaign for public health education and health prevention at the grassroots level in the
communities, and advocate Medicaid and affordable insurance coverage for ancillary support
services. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference
Committee observed that the comments received are supportive of Resolution 221. One
commentor noted the need to address the high rates of maternal mortality and morbidity in the
United States especially for African Americans. Commentors stated that Resolution 221 builds off
our existing AMA policy by integrating our current state and federal advocacy at local levels. Some
commentors believed that this Resolution would help to promote awareness of the need for more
transparent policies that identify and mitigate racial reproductive health disparities at institutional
and departmental levels.
(24) RESOLUTION 222 – TO STUDY THE ECONOMIC IMPACT OF MID-LEVEL PROVIDER EMPLOYMENT IN THE UNITED STATES OF AMERICA

RESOLVED, That our American Medical Association encourage and support studies sponsored by relevant state and federal agencies to determine the economic impact of mid-level unsupervised practice on American consumers (Directive to Take Action); and further be it

RESOLVED, That our AMA develop model state legislation that opposes enactment of legislation and reversal of such legislation, if present, that would authorize the independent practice of medicine by any individual who is not a physician. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. No online forum comments were received for Resolution 222.

(25) RESOLUTION 223 – NATIONAL DRUG SHORTAGES OF LIDOCAINE AND SALINE PREPARATION

RESOLVED, That our American Medical Association work with national specialty societies and other relevant stakeholders to draft a letter to the FDA calling for direct and prompt actions to alleviate current national shortages of lidocaine and normal saline preparations (Directive to Take Action); and be it further

RESOLVED, That our AMA amend existing HOD policy H-100.956 on National Drug Shortages by addition and deletion to read as follows:

“8. Our AMA supports the view that wholesalers should routinely institute a transparent allocation-based system for distribution of drugs in short supply that does not discriminate against small, independent or new medical practices or those with less purchasing power that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer’s purchase history.” (Modify Current HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. One comment was received by the author for Resolution 223, which advocated for Resolution 223 to be amended to include iohexol and iodixanol intravenous contrast shortages and to draft a letter to the FDA calling for direct and prompt actions to alleviate current national shortages of lidocaine, normal saline preparations, and iodinated contrast media. The commentor noted that in addition to the national shortages of lidocaine and normal saline preparations, the Food and Drug Administration (FDA) has reported shortages of iohexol and iodixanol intravenous contrast media. Your Reference Committee notes that the comment stated that these shortages point to the need to improve the resilience of the supply chain so that urgently needed care for patients is not interrupted.
1. **RESOLUTION 224 – HPSA AND MUA DESIGNATION FOR SNFS**

   RESOLVED, That our American Medical Association advocate for legislative action directing the United States Department of Health and Human Services to designate all skilled nursing facilities, irrespective of their geographic location, as health professional shortage areas and/or medically underserved areas to facilitate recruitment and retention of health professionals using the usual and customary support made available for such designations. (Directive to Take Action)

   Your Reference Committee reviewed online testimony regarding this item. No online forum comments were received for Resolution 224.

2. **RESOLUTION 225 – PUBLIC LISTING OF MEDICAL DIRECTORS FOR NURSING FACILITIES**

   RESOLVED, That our American Medical Association advocate for the Centers for Medicare & Medicaid Services to promote health care transparency and consumer access to quality health care by hosting a public listing of medical directors of all nursing facilities (NFs) in the country. (Directive to Take Action)

   Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 225, which was supportive of the Resolution. The comment noted that the Resolution fills a gap in our AMA policy by emphasizing the need to ensure compliance with relevant regulations and addresses a public need. The comment also noted that it is important for nursing home residents, families, and public health entities to be able to readily identify the medical director who is responsible for coordinating medical care in the facility and implementing resident care policies including infection control and antibiotic stewardship. Further, the commentor stated that CMS has no compliance mechanisms or public records to promote accountability, transparency, and facilitate adequate regulatory oversight.

3. **RESOLUTION 226 – COVERAGE FOR CLINICAL TRIAL ANCILLARY COSTS**

   RESOLVED, that our AMA amend Policy H-460.965, Viability of Clinical Research Coverages and Reimbursement, as follows “...(11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover copays/coinsurance/ deductibles, and otherwise not covered clinical care, and non-clinical ancillary costs in the context of nationally approved clinical trials (Modify Current HOD Policy); and be it further

   RESOLVED, That our AMA actively advocate for federal and state legislation that would allow coverage of non-clinical ancillary costs by sponsors of clinical trials. (Directive to Take Action)

   Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 226, which was supportive of Resolution 226. The commentor noted that many patients, particularly underrepresented minorities, lower-income patients, and rural patients, encounter prohibitive ancillary costs, such as transportation, lodging, meals, and childcare which precludes their ability to participate in trials. The commentor also stated that
federal legislation exists in Congress addressing this issue, but current AMA policy does not allow for our support of this legislation.

(29) RESOLUTION 227 – SUPPORTING IMPROVEMENTS TO PATIENT DATA PRIVACY

RESOLVED, That our American Medical Association support legislation to strengthen patient data privacy protections by making health information collected or stored on smartphones and similar consumer devices subject to the same privacy protections as standard medical records. (New HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that mixed comments were received regarding Resolution 227. One comment noted that our AMA has strong policy promoting the protection of patient data and information but stated that our policy needs to be updated to remain current with the use of technology and mobile devices. However, another comment argued that Resolution 227 should be referred, stating that additional mandates could be burdensome for small practices and preclude the ability for small practices to access data on mobile devices.

(30) RESOLUTION 228 – EXPANDED CHILD TAX CREDIT

RESOLVED, That our American Medical Association actively support the American Families Plan of 2021 and/or similar policies that aim to institute a permanent, expanded child tax credit at the federal level. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that mixed comments were received regarding Resolution 228. A couple of comments were supportive of the Resolution and noted that expanding the child tax credit would help to lift children out of poverty which is in line with our existing AMA policy. One comment argued that Resolution 228 should be amended so that our policy is not tied to specific legislation such as the American Families Plan of 2021. The comment noted that supporting the American Families Plan of 2021, which is an expansive piece of legislation, would require extensive debate and analysis before our AMA could endorse the legislation. A different comment opposed Resolution 228 because it calls for a permanent expansion, would be very expensive and does not explain how it would be funded, and does not define the term “children”.

(31) RESOLUTION 229 – EXPEDITED IMMIGRANT GREEN CARD FOR J-1 VISA WAIVER PHYSICIANS SERVING IN UNDERSERVED AREAS

RESOLVED, That our American Medical Association lobby U.S. Congress and the U.S. Administration that the J-1 visa waiver physicians serving in underserved areas be given highest priority in visa conversion to green cards upon completion of their service commitment obligation and be exempted from the per country limitation of H-1B to green card visa conversion. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that the comments received were supportive of Resolution 229. One comment noted that international medical graduate physicians are a crucial part of the medical workforce and are essential to ensuring access to care for many Americans, especially those in low-income and rural communities. The comment stated that due to an inefficient immigration
system, our country makes it difficult for these physicians to obtain legal immigration status due to long waiting periods and limitations on visa conversion to green cards, depending on country of origin, and that this Resolution would help to address these issues. Another comment argued that this Resolution would not only improve available quality care in underserved communities, but also directly support trainees in their ability to secure future positions.

(32) RESOLUTION 230 – ADVANCING THE ROLE OF OUTDOOR RECREATION IN PUBLIC HEALTH

RESOLVED, That our AMA encourages federal, state and local governments to create new and maintain existing public lands and outdoor spaces for the purposes of outdoor recreation; (Directive to Take Action) and be it further

RESOLVED, That our AMA work with the Centers for Disease Control and Prevention, National Institute of Environmental Health Science, National Recreation and Park Association, and other relevant stakeholders to encourage continued research on the clinical uses of outdoor recreation therapy. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 230 from the author, which was supportive of the Resolution. The commentor noted the positive impacts of outdoor recreation including increased mental, physical, and social health and decreased risk factors linked to morbidity. The commentor also stated that decreased funding for outdoor spaces have disproportionately adverse impacts on low-socioeconomic and minoritized communities. Your Reference Committee notes that the comment argued that this Resolution is important and relevant due to its connection to holistic health and climate change.

(33) RESOLUTION 231 – AMENDING POLICY H-155.955: INCREASING ACCESSIBILITY TO INCONTINENCE PRODUCTS TO INCLUDE DIAPER TAX EXEMPTION

RESOLVED, That our AMA amend Policy H-155.955, “Increasing Accessibility to Incontinence Products,” by addition and deletion as follows:

Increasing Accessibility to Incontinence Products H-155.955
Our AMA supports increased access to affordable incontinence products, the removal of sales tax on child and adult diapers, including single-use and reusable diapers, and the inclusion of child diapers as qualified medical expenses for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). (Modify Current HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that mixed comments were received regarding Resolution 231. One comment argued that Resolution 231 should be amended to include incontinence products for adults since adult incontinence is a medical diagnosis. Additional testimony supported the Resolution and highlighted the fact that both children and adults utilize diapers and incontinence products and emphasized that there is significant overlap between the patients that use these products and vulnerable patient groups. The comment stated that despite this, in many circumstances the cost of these products is prohibitive and can put children at risk for UTIs, diaper dermatitis, and other diseases. The testimony also argued that the Resolution would improve our
current AMA policy, which supports access to affordable incontinence products but provides no clear mechanisms to achieve increased accessibility.

(34) RESOLUTION 232 – EXPANSION OF EPINEPHRINE ENTITY STOCKING LEGISLATION

RESOLVED, That our AMA support the adoption of laws that allow state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of an emergency. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 232 from the author, which was supportive of the Resolution. The commentor stated that timely epinephrine access is vital to treat anaphylaxis and to prevent hospitalization and death. The testimony argued that the benefits of epinephrine availability greatly outweigh the minimal risks associated with accidental epinephrine injection and stated that our AMA already has policy supporting the presence of emergency epinephrine in schools and flights. The comment also argued that due to our existing policy our AMA should expand our advocacy in this area to include allowing state-defined entities to permit auto-injectable epinephrine storage for emergency use.

(35) RESOLUTION 233 – SUPPORT FOR WARNING LABELS ON FIREARM AMMUNITION PACKAGING

RESOLVED, That our AMA supports legislation requiring that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a legible, boxed warning that includes, at a minimum, (a) text-based statistics and/or graphic picture-based warning labels related to the risks, harms, and mortality associated with firearm ownership and use, and (b) explicit recommendations that ammunition be stored securely and separately from firearms. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that the comments received were supportive of Resolution 233. One comment noted that firearm violence is a public health crisis that continues to grow in severity and stated that improper storage of ammunition can result in firearm violence, disproportionately affecting people with mental illness and children. The comment also argued that the action proposed in this Resolution provides physicians with support in educating the public on risks and in risk mitigation of firearm ownership. The testimony further argued that the use of warning labels on ammunition packaging allows for public health education surrounding these risks beyond the physician’s office and provides flexibility for these warning labels to be updated in accordance with a growing body of evidence. Another comment stated that in our AMA statement on the Uvalde shooting, our AMA offered our policy compendium as a reference for strategies to reduce firearm injury and death and argued that our AMA should continue to add robust policy to this collection.

(36) RESOLUTION 234 – UPDATING POLICY ON IMMIGRATION LAWS, RULES, LEGISLATION, AND HEALTH DISPARITIES

RESOLVED, That our AMA, in order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic:
(1) opposes the slowing or halting of the release of individuals and families that are currently part of the immigration process; and

(2) opposes continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; and

(3) supports the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and

(4) opposes utilizing public health concerns to deny or significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution; (New HOD Policy) and be it further

RESOLVED, That our AMA support discontinuation of the use of non-medically necessary dental and bone forensics to assess an immigrant’s age. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that mixed comments were received regarding Resolution 234. One comment stated that a resolved clause should be added to require vaccinations, unless medically contradicted, and testing for COVID-19 for all immigrants. Additional testimony noted the unique hardships experienced by immigrants, asylees, refugees, and migrant workers during the COVID-19 pandemic including a delay in immigration services and a lack of access to testing and health care services. Your Reference Committee notes that comments argued that this Resolution fills gaps in our existing AMA policy.

(37) RESOLUTION 235 – IMPROVING THE VETERANS HEALTH ADMINISTRATION REFERRALS FOR VETERANS FOR CARE OUTSIDE THE VA SYSTEM

RESOLVED, That our American Medical Association advocate for reform of the veterans’ health administration to provide timely and complete payment for veterans’ care received outside the VA system and accurate and efficient management of travel reimbursement for that care. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 235, which was supportive of the Resolution. The comment argued that the Resolution builds on existing AMA policy by asking that Travel Expenses for Veterans be paid when Veterans are seeking care outside their living area.

(38) RESOLUTION 236 – OUT-OF-NETWORK CARE

RESOLVED, That our American Medical Association amend, by substitution, AMA Policy H-285.904, “Out-of-Network Care,” item H, to read as follows:

H. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g. the Gould Criteria) are not accounted for within a 18 minimum coverage standard.
H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted in all circumstances as an option or alternative to come to payment resolution between insurers and providers. (Modify Current HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 236, which was supportive of the Resolution. The comment argued that the Resolution is designed to modify our existing policy to be in line with what our AMA has already been advocating, and permit Mediation or Independent Dispute Resolution (IDR) in all circumstance.

RESOLUTION 237 – PRESCRIPTION DRUG DISPENSING POLICIES

RESOLVED, That our American Medical Association work with pharmacy benefit managers to eliminate financial incentives for patients to receive a supply of medication greater than prescribed (Directive to Take Action); and be it further

RESOLVED, That our AMA create model state legislation that would restrict dispensing medication quantities greater than prescribed (Directive to Take Action); and be it further

RESOLVED, That our AMA support any legislation that would remove financial barriers favoring dispensing quantities of medication greater than prescribed. (New HOD Policy)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that the comments received are supportive of Resolution 237. The comments generally argued that a prescription’s duration should be determined by the physician and patient. Testimony varied on whether the Resolution should apply to all prescriptions or only those for controlled substances. One comment noted that if a patient has remaining pills that the physician is not aware of, there is an increased risk of accidental overdose, waste of medication, and increased costs. Another commentor argued that that this Resolution pertains to patients dispensed an oversupply of controlled substances, and in a time of depression or despair use these drugs to commit suicide. Additional testimony stated that this Resolution should not be limited to controlled substances. The commentor argued that the decision regarding duration of prescription therapy should be a decision between the patient and their physician(s), not a decision made by any part of the pharmaceutical industry.

RESOLUTION 238 – COVID-19 ECONOMIC INJURY DISASTER LOAN (EIDL) FORGIVENESS FOR PHYSICIAN GROUPS OF FIVE OR FEWER PHYSICIANS

RESOLVED, That our American Medical Association advocate for Economic Injury Disaster Loan (EIDL) forgiveness for physician groups of five or fewer physicians for loans of less than $150,000 granted by the Small Business Administration by whatever mechanism is available, with no stipulations based on productivity or profit/loss reports to receive this forgiveness. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that the comments received are supportive of the Resolution. Testimony noted that small medical practices were hit hard financially during the COVID-19 pandemic and that many of these practices are still struggling to stay afloat. One commentor argued that forgiveness of Economic Injury Disaster Loans (EIDL) would greatly help these small practices
and negate the expense of creating a new federal program to identify deserving recipients. Additional testimony noted that financial assistance was provided to multiple other sectors of the economy during the pandemic and argued that small physician practices should be provided with additional relief due to the increased financial burdens they had to undertake during and after the pandemic. This commentor also proposed an amendment to Resolution 238 to include physician practice loan amounts of $150,000 or less.

(41) RESOLUTION 239 – VIRTUAL SERVICES WHEN PATIENTS ARE AWAY FROM THEIR MEDICAL HOME

RESOLVED, That our American Medical Association support Medicare coverage of virtual continuity of care follow-up services for patients within the physician’s established medical home when the patient has an established relationship with the provider and such care is not prohibited by the state in which the patient is geographically situated at the time of service (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate with the Centers for Medicare and Medicaid Services (CMS), and Congress if necessary, to cover virtual continuity follow-up care services provided by a patient’s established medical home or usual source of care, as if they were in person, even if the patient is temporarily located outside of the region or state of their medical home. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. One comment was received for Resolution 239, which was supportive of Resolution 239. The comment noted that patients that travel extensively and winter and summer in different locations would be benefited by this Resolution due to the ability to see the same physician regardless of location. The commentor also noted that virtual care improves patients experience and outcomes and should be reimbursed at regular insurance rates.

(42) RESOLUTION 240 – PHYSICIAN PAYMENT REFORM & EQUITY (PPR & E)

RESOLVED, That our American Medical Association define Physician Payment Reform and Equity (PPR & E) as “improvement in physician payment by Medicare and other third-party payers so that physician reimbursement covers current office practice expenses at rates that are fair and equitable, and that said equity include annual updates in payment rates” (Directive to Take Action); and be it further

RESOLVED, That our AMA place PPR & E as the single highest advocacy priority of our organization (Directive to Take Action); and be it further

RESOLVED, That our AMA use every resource at its disposal (including but not limited to elective, legislative, regulatory, and lobbying efforts) to advocate for an immediate increase in Medicare physician payments to help cover the expense of office practice (Directive to Take Action); and be it further

RESOLVED, That in addition to an immediate increase in Medicare physician payments, our AMA advocate for a statutory annual update in such payments that would equal or exceed the Medicare
Economic Index or the Consumer Price Index, whichever is most advantageous in covering the continuously inflating costs of running an office practice (Directive to Take Action); and be it further

RESOLVED, That our AMA establish a Task Force appointed by the Board of Trustees to outline a specific set of steps that are needed to accomplish the goals of PPR & E and report back to the HOD at the 2022 Interim Meeting regarding that plan (Directive to Take Action); and be it further

RESOLVED, That our AMA Board of Trustees report back to the HOD at each subsequent meeting regarding their progress on meeting the goals of PPR & E, until PPR & E is accomplished. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that mixed testimony was received regarding Resolution 240. Some commentors noted that Resolutions 240, 242, and 243 address the same issue and should be combined. Additional testimony stated that Resolutions 240 and 243 should be referred for report so that recommendations can be added to the RVS Update Committee (RUC) to help address disparities in the relative valuation of procedural care versus office-based care. However, other testimony expressed disagreement that the RUC could address disparities when the RUC’s role is to make recommendations to the Centers for Medicare and Medicaid Services (CMS) regarding work value units and direct practice expense inputs in accordance with the statutorily and regulatorily required methods. Major components of the fee schedule, such as indirect practice expense, is not an area that the RUC can comment upon on a procedure-by-procedure basis but rather testimony argued that Medicare’s payment system is the problem. Additional testimony highlighted the urgency of this Resolution due to the lack of financial viability of small practices owing to poor Medicare and commercial insurance reimbursements. Other testimony argued that Payment Reform & Equity (PPR & E) is a prescription for our AMA to produce a plan of action, share the plan with our HOD, and work that plan until PPR & E is accomplished so that independent practices can receive fair compensation. Comments also noted the failure of the physician fee schedule to keep up with payments made to hospitals, practice expenses, and general inflation. Further testimony argued that both primary and specialty physicians should be receiving pay increases and that physicians should stop dividing themselves based on practice area. Your Reference Committee also notes that an amendment was offered to include Medicaid payment reform and equity in this Resolution.

(43) RESOLUTION 241 – UNMATCHED GRADUATE PHYSICIAN WORKFORCE

RESOLVED, That our American Medical Association work with state societies to support these unmatched graduate physicians through their legislators and regulators to allow these physicians to work in underserved areas, in primary care, only in collaboration with a licensed physician (Directive to Take Action); and be it further

RESOLVED, That our AMA work with appropriate parties and the Centers for Medicare and Medicaid Services to reimburse for services rendered by these graduating physicians working in their collaborative practices as do private insurers and state Medicaid programs (Directive to Take Action); and be it further

RESOLVED, That the AMA allow these graduating physicians, working in collaboration with a licensed physician, to become members of an AMA subgroup (Directive to Take Action); and be it further
RESOLVED, That our AMA oppose any effort by these graduating physicians working in collaboration with licensed physicians, to become independent licensed physicians without satisfactorily completing formal residency training. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that mixed testimony was received regarding Resolution 241. Some testimony stated that unmatched graduates should be utilized within the health care system since their academic and clinical training is greater than many non-physician team members and supports a study to evaluate how to best support medical students that do not match. Additional testimony noted that opening additional PGY1 slots would be beneficial for unmatched medical graduates so that they can gain experience in a wide variety of fields, continue training, and hopefully match in the future. Also, there was some testimony from the Council on Medical Education in opposition to Resolution 241 due to the inequity that could occur by placing lesser trained physicians in underserved communities, the fact that these positions would be unregulated and have an increased chance of abuse in the workplace, and the fact that there is already existing policy that opposes alternative pathways for physicians to obtain licensure. Your Reference Committee notes that additional testimony asks that Resolution 241 be referred for study due to the potential for abuse of unmatched physicians.

RESOLUTION 242 – PUBLIC AWARENESS AND ADVOCACY CAMPAIGN TO REFORM THE MEDICARE PHYSICIAN PAYMENT SYSTEM

RESOLVED, That our American Medical Association immediately launch and sustain a well-funded comprehensive public awareness and advocacy campaign, that includes paid advertising, social and earned media, and patient and physician grassroots, to prevent/mitigate future Medicare payment cuts and lay the groundwork to pass federal legislation that reforms the current Medicare physician payment system by incorporating annual inflation updates, eliminating/replacing or revising budget neutrality requirements, offering a variety of payment models and incentives to promote value-based care and safeguarding access to high-quality care by advancing health equity and reducing disparities. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that mixed testimony was received regarding Resolution 242. The majority of the comments acknowledged that our AMA has extensive policy on this topic. Some testimony argued that additional action is needed on physician payment reform to stabilize reimbursement to allow physician offices to cover the costs of running their practices, which increase each year while payments do not. Additionally, testimony noted that physicians are tired of having to fight each year to avoid payment cuts, and that a permanent solution is needed. However, other testimony was opposed to the Resolution and argued that the Resolution would be counterproductive and not achieve its intended goals. The testimony noted that many across the United States are struggling to make ends meet and that spending millions of dollars on a campaign will not convince the public that physicians are placing patients’ needs ahead of our own. Additionally, this testimony stated that unless the House of Medicine can openly discuss and resolve the value of primary versus specialty care, our AMA will be unable to create a united approach to equitable and affordable care.
(45) RESOLUTION 243 – APPROPRIATE PHYSICIAN PAYMENT
FOR OFFICE-BASED SERVICES

RESOLVED, That our American Medical Association advocate for improvement in physician payment by Medicare and other third-party payers so that physician reimbursement covers current office practice expenses at rates that are fair and equitable, and that said equity include annual updates in payment rates to account for increased costs of running a medical practice. (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that mixed testimony was received regarding Resolution 243. Some comments noted that adequate reimbursement for office-based services has been a long-standing problem. Additional testimony stated that Resolutions 240 and 243 cover the same material and should be combined and referred for report to include recommendations to the RVS Update Committee (RUC) for addressing disparities in the relative valuation of procedural care versus value-based services. However, some testimony disagreed with the fact that the RUC could address disparities when the RUC’s role is to make recommendations to the Centers for Medicare and Medicaid Services (CMS) regarding work value units and direct practice expense inputs in accordance with the statutorily and regulatorily required methods. Major components of the fee schedule such as indirect practice expense is not an area that the RUC can comment upon on a procedure-by-procedure basis, but testimony argued that Medicare’s payment system is the problem. Additional testimony stated that, based on our existing AMA policy, our AMA should advocate for inflation-based updates to cover our rising costs of maintaining our practices especially since hospitals and Medicare skilled nursing facilities have had significantly larger payment increases over the past 20 years when compared to physicians. Additional testimony argued that both primary and specialty physicians should be receiving pay increases and that physicians should stop dividing themselves based on practice area. Your Reference Committee also notes that an amendment was offered to include Medicaid payment reform and equity.

(46) RESOLUTION 244 – PROHIBIT REVERSAL OF PRIOR AUTHORIZATION

RESOLVED, That once the physician’s office has received prior authorization for testing, a procedure, or a medication, the insurance company should not be permitted to refuse payment for that test or procedure or medication unless the patient is no longer insured by that company at the time the test or procedure is done or the medication is given; and be it further

RESOLVED, That a health insuring corporation or utilization review organization that authorizes a proposed admission, treatment, or health care service by a participating provider based upon the complete and accurate submission of all necessary information relative to an eligible enrollee should not retroactively deny this authorization if the provider renders the health care service in good faith and pursuant to the authorization and all of the terms and conditions of the provider’s contract with the health insuring corporation, and be it further

RESOLVED, That our American Medical Association seek federal legislation/rules to prohibit denial of payment by a Medicare Advantage plan for a previously prior approved medication, procedure, or test unless the patient is no longer insured by that company at the time of service (Directive to Take Action); and be it further

RESOLVED, That our AMA redistribute its model legislation on retrospective denial of payment to all state societies, especially those who have not already passed such legislation. (Directive to Take Action)
Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that the comments received are supportive of Resolution 244. One commentor noted that this Resolution builds on our existing AMA policies. Another commentor stated that physicians are very frustrated with the prior authorization process and argued that the only reason that insurance companies should deny payment is if the patient is no longer insured by that company at the time of the procedure or when the medication is distributed. Your Reference Committee also noted that the testimony argued that this Resolution should be adopted because the prior authorization process is time consuming, often delays patient care, and is unfair to the physician’s office and the patient.

(47) RESOLUTION 245 – DEFINITION AND ENCOURAGEMENT OF THE APPROPRIATE USE OF THE WORD "PHYSICIAN"

RESOLVED, That our American Medical Association independently, or in coordination with any other appropriate medical organizations that have similar policy regarding the use of the term “physician,” develop and implement a sustained and wide-reaching public relations campaign to utilize the term “physician” and discontinue use of the term “provider.” (Directive to Take Action)

Your Reference Committee reviewed online testimony regarding this item. Your Reference Committee observed that the comments received are supportive of Resolution 245. Some testimony highlighted the additional education and sacrifices that individuals must undertake to become physicians and the importance of ensuring that patients know when they are, and are not, being treated by physicians. Other testimony stated that the Resolution fails to address the usurpation of non-physicians describing themselves as physicians and their ability to bill the Centers for Medicare and Medicaid Services (CMS). Your Reference Committee observed that additional testimony stated that addressing current CMS billing practices is not needed, rather our efforts should be focused on stopping other non-physicians from gaining the ability to bill CMS as physicians.