DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2022 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-22)

Report of Reference Committee B
John Flores, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. BOT 09 – Council on Legislation Sunset Review of 2012 House Policies
2. BOT 17 – Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession
   213 – Resentencing for Individuals Convicted of Marijuana-Based Offenses
3. 219 – Due Process and Independent Contractors
4. 225 – Public Listing of Medical Directors for Nursing Facilities
5. 226 – Coverage for Clinical Trial Ancillary Costs

RECOMMENDED FOR ADOPTION AS AMENDED

6. 203 – Ban the Gay/Trans (LGBTQ+) Panic Defense
7. 208 – Prohibit Ghost Guns
8. 209 – Supporting Collection of Data on Medical Repatriation
9. 210 – Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits
10. 212 – Medication for Opioid Use Disorder in Physician Health Programs
11. 216 – Advocating for the Elimination of Hepatitis C Treatment Restrictions
12. 218 – Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas
    229 – Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas
13. 220 – Vital Nature of Board-Certified Physicians in Aerospace Medicine
14. 222 – To Study the Economic Impact of Mid-Level Provider Employment in the United States of America
15. 223 – National Drug Shortages of Lidocaine and Saline Preparations
16. 227 – Supporting Improvements to Patient Data Privacy
17. 228 – Expanded Child Tax Credit
    247– Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families
18. 230 – Advancing the Role of Outdoor Recreation in Public Health
19. 231 – Amending Policy H-155.955, "Increasing Accessibility to Incontinence Products to Include Diaper Tax Exemption"
20. 232 – Expansion of Epinephrine Entity Stocking Legislation
21. 233 – Support for Warning Labels on Firearm Ammunition Packaging
22. 236 – Out-of-Network Care
23. 245 – Definition and Encouragement of the Appropriate Use of the Word "Physician"

249 – Clarification of Healthcare Physician Identification: Consumer Truth & Transparency

24. 254 – Stakeholder Engagement in Medicare Administrative Contractor Policy Processes

RECOMMENDED FOR REFERRAL

25. 201 – The Impact of Midlevel Providers on Medical Education
26. 224 – HPSA and MUA Designation for SNFs
27. 237 – Prescription Drug Dispensing Policies

RECOMMENDED FOR REFERRAL FOR DECISION

28. 246 – Further Action to Respond to the Gun Violence Public Health Crisis

RECOMMENDED FOR NOT ADOPTION

29. 205 – Insurers and Vertical Integration
30. 207 – Physician Tax Fairness
31. 241 – Unmatched Graduate Physician Workforce

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

32. 202 – AMA Position on All Payer Database Creation
33. 215 – Transforming Professional Licensure to the 21st Century
34. 234 – Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities
35. 239 – Virtual Services When Patients Are Away From Their Medical Home
36. 250 – Opposition to Criminalization of Physicians' Medical Practice
37. 252 – The Criminalization of Health Care Decision Making and Practice

RECOMMENDED FOR ADOPTION IN LIEU OF

38. 211 – Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program
39. 217 – Preserving the Practice of Medicine
    251 – Physician Medical License Use in Clinical Supervision
40. 238 – COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians
41. 240 – Physician Payment Reform and Equity
    242 – Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System
    243 – Appropriate Physician Payment for Office-Based Services
    253 – Physician Payment Reform & Equity
42. 248 – Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non Physician Practitioners

Amendments

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

RECOMMENDED FOR ADOPTION

(1) BOT 9 COUNCIL ON LEGISLATION SUNSET REVIEW OF 2012 HOUSE POLICIES

RECOMMENDATION:

Recommendation in Board of Trustees Report 9 be adopted and the remainder of the report filed.

HOD ACTION: Board of Trustees Report 9 adopted and the remainder of the report filed.

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.

BOT Report 09 should be adopted and filed. The Sunset Report has been approved by the Council on Legislation and Board and vetted and reviewed by AMA staff to ensure appropriate policies are retained.

(2) BOT 17– EXPUNGEMENT, DESTRUCTION, AND SEALING OF CRIMINAL RECORDS FOR LEGAL OFFENSES RELATED TO CANNABIS USE OR POSSESSION
RESOLUTION 213 – RESENTENCING FOR INDIVIDUALS CONVICTED OF MARIJUANA-BASED OFFENSES

RECOMMENDATION:

Recommendations in Board of Trustees Report 17 be adopted in lieu of Resolution 213 and the remainder of the report filed.

HOD ACTION: Board of Trustees Report 17 adopted as amended by addition in clause 1 and the addition of a 5th clause in lieu of Resolution 213 and the remainder of report 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 or criminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis. (New HOD Policy)

5.That our American Medical Association (AMA) support ending conditions such as parole, probation, or other court-required supervision because of a cannabis-related offense for use or possession that would be legal or decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis. (New HOD Policy)

BOT 17

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)

Resolution 213

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 heard strong support for the issues raised in BOT 17. Testimony reflected the understanding that individuals should not suffer collateral consequences for past illegal acts concerning cannabis possession or use when nearly two-thirds of the nation has made those acts legal today. Your Reference Committee commends the Board for highlighting the public health consequences and inequities related to cannabis-related offenses for possession and use. Your Reference Committee agrees that fundamental fairness requires expungement of those past acts that now would be legal. As explained in the Board's report, expungement would foster increased opportunities for employment, housing, and other necessary social determinants of health.

Your Reference Committee also appreciates that the Board has separated the issues of expungement from the issues related to the health effects of cannabis use itself, and AMA policy that continues to oppose the legalization of cannabis. Your Reference Committee acknowledges that cannabis-related policy continues to evolve. Your Reference Committee appreciates that the Board has narrowly focused the report on expungement related to past acts relating to cannabis use and possession that now would be legal. Your Reference Committee heard testimony that supporting expungement of past acts that would still be illegal in certain states would be in conflict with AMA policy opposing legalization of cannabis. Your Reference Committee appreciates that there still are collateral consequences, but therein lays one of the many nuances of our AMA policy related to cannabis. States have more general expungement laws relating to many different

criminal acts. Your Reference Committee is pleased that our Board has focused its report on a tangible, actionable area to support public health and reduce health inequities.

Your Reference Committee heard from our Council on Legislation that a side-by-side analysis of BOT 17 and Resolution 213 shows that Resolution 213 raises substantively the same issues as contained in BOT 17. Moreover, testimony was given, that based on a side-by-side comparison of the recommendations in Resolution 213 and BOT 17, the Board's recommendations have the additional precision and detail that will allow our AMA to take the policy and clearly advocate in state legislatures and other appropriate venues. For these reasons, your Reference Committee recommends that Board of Trustees Report 17 be adopted in lieu of Resolution 213.

(3) RESOLUTION 219 – DUE PROCESS AND INDEPENDENT CONTRACTORS

RECOMMENDATION:

Resolution 219 be <u>adopted</u>.

HOD ACTION: Resolution 219 <u>adopted</u>.

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

Your Reference Committee heard unanimous testimony supporting the adoption of Resolution 219. Testimony emphasized that safeguarding physician autonomy is essential so that physicians may exercise their independent judgment and satisfy their ethical obligation to always act in the best interests of patients. However, testimony indicated that physicians have had their employment or contractor agreements terminated because they spoke up about issues negatively impacting their autonomy and patients, particularly during the COVID-19 pandemic. Your Reference Committee also heard that because of the prospect of retaliation, many physicians were reluctant to speak up. Testimony supported broadening AMA policy to ensure that independent contractor physicians, as well as employees, are protected from retaliation for raising concerns, and to protect physicians from retaliation by any entity employing or contracting with the physician. Therefore, your Reference Committee recommends adoption of Resolution 219.

(4) RESOLUTION 225 – PUBLIC LISTING OF MEDICAL DIRECTORS FOR NURSING FACILITIES

RECOMMENDATION:

Resolution 225 be <u>adopted</u>.

HOD ACTION: Resolution 225 <u>adopted</u>.

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 heard only testimony in support of Resolution 225 based on a need to have contact information for nursing facility medical directors readily available for attending physicians and families of patients in a nursing facility. Your Reference Committee heard from supporters of this resolution that it is often difficult for those caring for nursing facility patients to access the name and contact information for medical directors for the nursing facilities but that this information is important for continuity of care purposes, as well as for addressing quality issues in a timely fashion. Additionally, testimony stated the potential feasibly of this information being housed on existing federal webpages. Therefore, your Reference Committee recommends that Resolution 225 be adopted.

(5) RESOLUTION 226 – COVERAGE FOR CLINICAL TRIAL ANCILLARY COSTS

RECOMMENDATION:

Resolution 226 be <u>adopted</u>.

HOD ACTION: Resolution 226 <u>adopted</u>.

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 co-pays/coinsurance/ deductibles, ~~and~~ otherwise not covered clinical care, <u>and non-clinical ancillary costs</u> 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 heard unanimous support for Resolution 226. Your Reference Committee heard that clinical trials are key to advancing new standards of care that can improve survival and quality of life for people with cancer and other conditions. Testimony also stated that the inability of a clinical trial sponsor to defray participant's ancillary expenses (e.g., meals, transportation costs, childcare, lodging) prohibits many Medicare and Medicaid beneficiaries from participating in clinical trials since participation might otherwise be cost prohibitive. Testimony indicated that paying for ancillary services would increase diversity of clinical trial participants, and also promote health equity. Your Reference Committee also heard that pilot financial assistance programs that provide compensation for ancillary costs have demonstrated promise in improving clinical trial accrual and clinical outcomes. Finally, testimony noted that our AMA has already engaged in advocacy with respect to the Anti-Kickback Statute (AKS) and the Civil Monetary Penalties Law (CMP), through extensive correspondence to the U.S. Department of Health and Human Services that addressed health equity issues in relation to the AKS and CMP law. Therefore, your Reference Committee recommends that Resolution 226 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(6) RESOLUTION 203 – BAN THE GAY/TRANS (LGBTQ+) PANIC DEFENSE

RECOMMENDATION A:

That the first resolve of Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support ~~seek a~~ federal legislation ~~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 New HOD Policy); and be it further

RECOMMENDATION B:

That the second resolve of Resolution 203 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA develop ~~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 support of ~~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); and be it further

RECOMMENDATION C:

That Resolution 203 be amended by addition of a third resolved to read as follows:

RESOLVED, That our AMA reaffirm AMA policy H-65.965 – Support of Human Rights and Freedom.

RECOMMENDATION D:

Resolution 203 be adopted as amended.

HOD ACTION: Resolution 203 adopted as amended.

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 heard strong and impassioned testimony in support of Resolution 203. Your Reference Committee heard that the gay or trans panic defense strategy is a legal strategy that uses a victim's sexual orientation or gender identity/expression as an excuse for a defendant's violent reaction, seeking to legitimize and even to excuse violent and lethal behavior. Testimony stated that many murder sentences have been reduced, or defendants have been acquitted, by using the LGBTQ+ "panic" defense strategy such as in the Matthew Shepard case, and that this defense has only been banned in 11 states as of February 2, 2021. Your Reference Committee also heard that this is a medical, behavioral health, and equity issue, which is important for our AMA to act on in a timely fashion. Further testimony was heard in strong support for efforts to protect LGBTQ+ individuals from further violence and discrimination. Limited testimony was provided against adoption that noted that the "gay and trans panic defense" is not commonly employed and no state recognizes it as an affirmative defense as highlighted by a 2020 study that found the defense strategy was employed in only 104 cases across 35 states over a half century. Your Reference Committee also heard a recommendation to reaffirm existing AMA policy in support of human rights and freedom in lieu of adoption. Your Reference Committee agrees that this is an important equity issue, with those who testified overwhelmingly in support of adoption, but that minor amendments are needed. Additionally, testimony was offered that Policy H-65.965 Support of Human Rights and Freedom should be reaffirmed. Therefore, your Reference Committee recommends that Resolution 203 be adopted as amended.

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

(7) RESOLUTION 208 – PROHIBIT GHOST GUNS

RECOMMENDATION A:

Resolution 208 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

Resolution 208 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 208 be changed to read as follows:

REGULATION OF HOMEMADE FIREARMS

HOD ACTION: Resolution 208 adopted as amended with a change in title.

REGULATION OF HOMEMADE FIREARMS

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 heard mostly supportive testimony in favor of Resolution 208, with a few minor language modifications. Your Reference Committee heard that ghost guns should be treated just like other firearms and that they are a real problem, especially in cities such as New York. Testimony stated that homemade, difficult to trace firearms, are increasingly turning up at crime scenes. Further testimony was provided that the most important part of a gun is the lower receiver, the "chassis" of the weapon, the part housing vital components such as the hammer and trigger. Your Reference Committee also heard testimony that under federal law, the lower receiver is considered a firearm – while it is not clear whether other gun components require a background check for purchase and that dozens of companies sell what are known as "80%" lower receivers – ones that are 80% finished, lack a serial number, and can be used to make a homemade gun. Further testimony was presented that ghost guns provide an easy avenue for people banned from owning guns to obtain them and that according to the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) 30% of all weapons recovered by the bureau in California were homemade.

Your Reference Committee heard testimony that our AMA already has long-standing, strong, and clear policy that covers the goals of Resolution 208. Specifically, H-145.996, Firearm Availability, applies to waiting periods and background checks for all firearm purchasers, and advocates for legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. Testimony was also heard that our AMA has policy supporting a ban on the manufacture,

importation, or sale of 3-D printed firearms. Your Reference Committee heard testimony that these policies already cover ghost guns. Further testimony was provided that our AMA is actively working at both the state and federal levels on increasing regulation and background checks of all firearm purchasers, and that based on existing policy, our AMA submitted comments supporting a proposed rule issued by the Bureau of Alcohol, Tobacco, Firearms, and Explosives in the Department of Justice that would specifically regulate ghost guns. Testimony was provided that a final rule prohibiting the manufacture of ghost guns was released in April.

Your Reference Committee heard testimony that, if adopted, an amendment to the Resolution is needed to appropriately tailor the Resolution to firearms rather than all weapons. Your Reference Committee concluded that, considering the significant testimony in support of this Resolution, Resolution 208 should be adopted as amended, along with a change in the title. Accordingly, your Reference Committee recommends that Resolution 208 be adopted as amended.

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

RECOMMENDATION A:

Resolution 209 be amended by deletion of the first resolve:

~~**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**~~

RECOMMENDATION B:

Resolution 209 be adopted as amended.

HOD ACTION: Resolution 209 adopted as amended.

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 heard mixed testimony regarding Resolution 209. Your Reference Committee heard testimony that the concept of forced medical repatriation involves the involuntary transfer of a patient to a foreign country despite their health status, provoking an unwarranted intersection between immigration enforcement and the health care system. Testimony stated that, although it is unclear how widespread the issue of medical repatriation actually is, it does seem to disproportionately impact vulnerable immigrant patients. Testimony also stated that our AMA has advocated that every person should have access to essential health care and that Resolution 209 falls in line with this principle. However, your Reference Committee also heard that it is likely that the Department of Homeland Security (DHS), rather than the Department of Health and Human Services, would collect this data, or at the very least that DHS would be able to acquire this data. Testimony stated that once DHS had the information about

these patients they could, and likely would, use it to initiate deportation proceedings, going against the intent of the Resolution. Therefore, your Reference Committee recommends that Resolution 209 be adopted as amended.

(9) RESOLUTION 210 – REDUCING THE PREVALENCE OF SEXUAL ASSAULT BY TESTING SEXUAL ASSAULT EVIDENCE KITS

RECOMMENDATION A:

Part 5 of Resolution 210 be amended by addition and deletion to read as follows:

~~**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)**~~

5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 210 be adopted as amended.

HOD ACTION: Resolution 210 adopted as amended.

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 heard overwhelming and emotional testimony from sexual assault survivors in strong support of Resolution 210. Your Reference Committee commends the courage of those who testified and shared their personal experiences, highlighting the importance of this Resolution. Your Reference Committee heard that our AMA has extensive policy advocating for appropriate care and rights for victims of sexual assault. Testimony highlighted that our current AMA policy does not speak to the timely processing of sexual assault examination kits, which often provide important evidence to support prosecution of offenders. Testimony stated that adoption of Resolution 210 is a needed and an appropriate extension of current policy, but that amendments are needed to change "immediate" processing of exam kits to "timely," and to add patient consent for the processing of exam kits. Your Reference Committee agrees that the suggested amendments improve the Resolution, and, for clarity's sake, your Reference Committee recommends that Resolution 210 be adopted as amended.

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

RECOMMENDATION A:

Resolution 212 be amended by addition to read as follows:

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 Medical Boards (FSMB) and 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 FSMB and 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 FSMB and 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 FSMB and 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 FSMB and FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.

RECOMMENDATION B:

Resolution 212 be adopted as amended.

HOD ACTION: Resolution 212 adopted as amended.

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 heard supportive testimony regarding Resolution 212. Your Reference Committee agrees that physician health programs (PHPs) provide an essential resource to physicians. Your Reference Committee appreciates the support of AMA efforts from the Federation of State Physician Health Programs (FSPHP). Your Reference Committee wants to recognize any physicians that have been brave enough to come forward to participate in a PHP or a safe-haven program. Your Reference Committee strongly supports physicians and other health care professionals seeking care in a PHP or safe-haven type program to do so voluntarily and for there to be strong confidentiality protections for physicians who seek and receive care in a PHP or safe-haven type program. Testimony was offered concerning a potential amendment to Resolution 212 which requested expanding coverage to include independent physician experts who do not practice under a structure that allows safe harbor protections. Your Reference Committee did not accept this amendment because adequate protections would not be provided to physicians in this situation. Your Reference also heard about the important role that the Federation of State Medical Boards (FSMB) plays in supporting PHPs and confidentiality protections, and the need to acknowledge the role of FMSB in our AMA policy. Your Reference Committee further appreciates that the American Boards of Medical Specialties (ABMS) are working to develop policy on these issues. Your Reference Committee also understands that whether a physician seeks care in a PHP or safe-haven type program, confidentiality is essential. Your Reference Committee is pleased to hear of AMA advocacy wins to support these goals at the state and federal levels and believes that the partnership and support of the FSPHP, FSMB and other stakeholders will strengthen our AMA's efforts and support physicians' ability to receive evidence-based care when sought. As a result, your Reference Committee recommends that Resolution 212 be adopted as amended.

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

RECOMMENDATION A:

Resolution 216 be amended by addition and deletion to read as follows:

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:

Our AMA will: (1) encourage the adoption of ~~birth year-based~~ universal ~~hepatitis C~~ screening of all adults 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~~ payers;
(~~4~~5) support programs aimed at training physicians ~~providers~~ in the screening, treatment and management of patients infected with HCV;
(~~5~~6) 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;
(~~6~~7) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines;
(~~7~~8) 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.

RECOMMENDATION B:

Resolution 216 be adopted as amended.

HOD ACTION: Resolution 216 adopted as amended.

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;
(65) 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 heard overwhelmingly positive testimony on Resolution 216. Testimony was heard that the resolution would fill a gap in existing AMA policy on hepatitis C virus (HCV) prevention, screening, and treatment programs and is consistent with our AMA's equity policy and goals since it would encourage the allocation of targeted funding to increase HCV treatment for Indian Health Service patients insured by plans subject to HCV treatment restrictions and expand access to HCV treatment for American Indian/Alaska Native populations, who have disproportionately higher HCV incidence rates compared to non-Hispanic whites and the highest rates of HCV-related mortality of any racial/ethnic group.

Your Reference Committee also heard that Consensus guidelines from the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America recommend that nearly all people with acute or chronic HCV should receive treatment with direct-acting antivirals, which can cure over 95 percent of individuals with HCV, but that many state Medicaid programs, prisons and jails, and private insurers impose non-medically indicated restrictions on treatment, including fibrosis restrictions, sobriety restrictions, and limits on the type of clinician that can prescribe HCV treatment.

Your Reference Committee also heard an amendment offered by the US Public Health Service that recommends updating the language to conform with current Centers for Disease Control and Prevention (CDC) recommendations on universal screening for all adults for HCV. Your Reference Committee believes that clause 3 will allow the CDC to advocate for screening and treatment of patients with housing insecurity. Your Reference Committee, therefore, recommends that Resolution 216 be adopted as amended.

(12) RESOLUTION 218 – EXPEDITED IMMIGRANT GREEN CARD VISA FOR J-1 VISA WAIVER PHYSICIANS SERVING IN UNDERSERVED AREAS
RESOLUTION 229 – EXPEDITED IMMIGRANT GREEN CARD FOR J-1 VISA WAIVER PHYSICIANS SERVING IN UNDERSERVED AREAS

RECOMMENDATION A:

Resolution 218 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate ~~lobby US Congress and the US Administration~~ that ~~the J-1 visa waiver~~ 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 ~~obligation,~~ and be ~~exempted~~ from the per country limitation of H-1B visa to green card ~~visa~~ conversion.

RECOMMENDATION B:

Resolution 218 be adopted as amended in lieu of 229.

HOD ACTION: Resolution 218 adopted as amended in lieu of 229.

Resolution 218

RESOLVED, That our American Medical Association lobby US Congress and the US 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 per country limitation of H-1 to green card visa conversion. (Directive to Take Action)

Resolution 229

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 heard mixed testimony concerning Resolution 218. Your Reference Committee heard considerable testimony stating that our AMA should stand beside our IMG colleagues and support their right to remain and work in the United States, especially after they spend time serving our underserved communities. Multiple testimonies highlighted the much-needed work that international medical graduates provide to our country and our underserved communities and discussed the importance of international medical graduates, especially when considering the current and projected physician shortage. Testimony highlighted that our AMA is already supporting our IMG colleagues and their work within Congress and specifically that we are already doing the work requested in the mandate when it comes to the Conrad 30 legislation.

However, testimony stated that the Resolution needs to have technical edits made to ensure that our Resolution is legally correct. Your Reference Committee heard that as the Resolution currently reads it is asking for J-1 visa holders that complete service in an underserved area to be granted priority when obtaining green cards. J-1 visas are nonimmigrant visas meaning that one cannot be issued a green card when on J-1 visa status. Rather, the J-1 visa waiver allows individuals to forgo the home country return requirement and obtain an H-1B visa, which is an immigrant visa, in exchange for service in an underserved area. An H-1B visa can then, overtime, be converted to a green card. Additionally, your Reference Committee was informed that Resolution 218 and 229 are identical and as such only one should be adopted. Therefore, your Reference Committee recommends that Resolution 218 be adopted as amended in lieu of Resolution 229.

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

RECOMMENDATION A:

That the second resolve of Resolution 220 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ~~advocate for~~ compliance with international aerospace health care agreements, to include supporting the appropriate use of physicians and opposing inappropriate scope expansion by non-physicians, to protect ~~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)

RECOMMENDATION B:

Resolution 220 be adopted as amended.

HOD ACTION: Resolution 220 adopted as amended.

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 heard mixed testimony on Resolution 220. Your Reference Committee heard that with the spread of COVID-19 and the public health implications that come along with that, physicians are needed in the aerospace industry now more than ever. However, testimony also stated that our AMA has robust existing policy on the crux of Resolution 220, including policy on physician lead teams and scope of practice. Your Reference Committee heard that our policy includes clear guidelines for health care teams and principles guiding physician

supervision of non-physicians. Moreover, testimony stated that our AMA continues to zealously advocate for physician lead care and for the appropriate oversight and scope restrictions for mid-level providers. Your Refence Committee heard that scope of practice is a top legislative priority for our AMA as is evident by our robust and well-rounded campaign that includes comprehensive resources on the education and training of non-physicians, access to care, state laws charts, national and state-level patient surveys, social media cards, model op-eds, and model state legislation. Testimony highlighted that these resources are the foundation for our ongoing advocacy at the state and federal level to defend the practice of medicine and support physician-led care. Your Refence Committee heard that just this year our AMA has worked with more than 30 state medical associations to defeat laws that would have expanded the scope of practice of non-physicians. Your Refence Committee heard that our AMA has also followed numerous federal bills and, when needed, worked with state and specialty societies to amend, or defeat legislation. Testimony stated that our AMA continues to engage in its scope of practice work for all physicians, including aerospace physicians, and as such, the work that is being requested within this resolution is already within the purview of existing policy. However, testimony also stated that this is an important issue that needs to have attention brought to it and that advocacy, including letters, needs to be focused on the issues in aerospace medicine. Your Reference Committee also heard that focusing on supporting our aerospace medicine colleagues will provide our AMA with more flexibility which will allow our AMA to better assist our aerospace colleagues. Therefore, your Reference Committee recommends that Resolution 220 be adopted as amended.

(14) RESOLUTION 222 – TO STUDY THE ECONOMIC IMPACT OF MID-LEVEL PROVIDER EMPLOYMENT IN THE UNITED STATES OF AMERICA

RECOMMENDATION A:

The first resolve of Resolution 222 be amended by addition and deletion to read as follows:

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

RECOMMENDATION B:

The second resolve of Resolution 222 be deleted:

RESOLVED, That our AMA develop model state legislation that opposes enactment of legislation and supports 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).

RECOMMENDATION C:

Resolution 222 be adopted as amended.

HOD ACTION: Resolution 222 adopted as amended with a change of title.

TO STUDY THE COST AND QUALITY IMPACT OF NON-PHYSICIAN 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 heard overwhelmingly positive testimony in support of Resolution 222. Your Reference Committee received amendments to Resolution 222 which would allow our AMA to support a wider range of studies, including studies which address the cost or quality of care as well as studies conducted by a variety of authors such as those referenced in the resolution. The authors of the Resolution supported this friendly amendment. Testimony also stated that our AMA has existing model state legislation, An Act to Support Physician-Led Team-Based Health Care, as well as extensive policy supporting physician-led care and opposing inappropriate scope expansions that align with this Resolution, including (Independent Practice of Medicine by Advanced Practice Registered Nurses H-35.988, Scope of Practice Model Legislation D-35.996, Physician Assistants H-35.989, Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices D-35.979, AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982, Protecting Physician Led Health Care H-35.966, Physician Assistants and Nurse Practitioners H-160.947, Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950). Your Reference Committee also understands our AMA regularly works with state medical associations on state legislative language and other solutions, therefore, your Reference Committee does not think the second resolved is necessary as this is already found in existing policy, existing model legislation, and is being accomplished as part of our AMA's ongoing advocacy. Your Reference Committee, therefore, recommends Resolution 222 be adopted as amended.

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

RECOMMENDATION A:

The first resolve of Resolution 223 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with national specialty societies and other relevant stakeholders to advocate that ~~draft a letter to~~ the FDA ~~calling for~~ take direct and prompt actions to alleviate current national shortages of lidocaine, ~~and~~ normal saline preparations, and iodinated contrast media.

RECOMMENDATION B:

The second resolve of Resolution 223 be deleted:

~~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)~~

RECOMMENDATION C:

Resolution 223 be adopted as amended.

RECOMMENDATION C:

That the title of Resolution 223 be amended to read as follows:

NATIONAL SHORTAGES OF LIDOCAINE, SALINE PREPARATION, AND IODINATED CONTRAST MEDIA

HOD ACTION: Resolution 223 adopted as amended with a change in title.

NATIONAL SHORTAGES OF LIDOCAINE, SALINE PREPARATION, AND IODINATED CONTRAST MEDIA

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 heard supportive testimony for this resolution. Your Reference Committee overwhelmingly heard that shortages in the supply of saline and lidocaine have clear, adverse effects on patient care. Your Reference Committee also appreciates testimony that highlighted the similar shortage of iodinated contrast media and the need for immediate attention of this shortage as well. Your Reference Committee heard how our AMA has worked closely with many specialty and state society partners to better understand and mitigate drug shortages when possible. Your Reference Committee thanks the Council on Science, Medicine and Public Health (CSAPH) for reminding the Reference Committee that there will be a CSAPH report on drug shortages, including saline and lidocaine, to the House at the Interim Meeting. Your Reference Committee questions whether there is a benefit for amending the language in H-100.956, National Drug Shortages, to reflect "less purchasing power" compared to a practice's "purchasing history." Your Reference Committee also appreciates testimony about the wide range of drug shortages, but points to H-100.956, which provides our AMA with strong policy to address the wide range of drug shortages. In recognition of testimony urging a broader advocacy on this matter your Reference Committee recommends an amendment that would extend our AMA advocacy beyond writing a letter and allow for a more holistic approach. Your Reference Committee, therefore, recommends that our AMA amend our policy specific to the limited number of medications delineated in testimony today. Your Reference Committee therefore recommends that Resolution 223 be adopted as amended.

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

RECOMMENDATION A:

Resolution 227 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~support legislation to~~ strengthen patient data privacy protections by ~~making health information collected or stored~~ advocating for legislation that reflects the AMA's Privacy Principles ~~on smartphones and similar consumer devices subject to the same privacy protections as standard medical records~~ with particular focus on mobile health apps and other digital health tools. (New HOD Policy)

RECOMMENDATION B:

Resolution 227 be <u>adopted as amended</u>.

HOD ACTION: Resolution 227 <u>adopted as amended</u>.

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 heard mixed testimony regarding Resolution 227. Your Reference Committee heard testimony that data collected through smartphones, connected consumer devices, and cloud-based applications are not currently protected under Health Insurance Portability and Accountability Act (HIPAA) because software and technology companies and vendors are not classified as covered entities. Testimony stated that federal legislation has been introduced to expand the health data protections to include this type of device-collected information. Your Reference Committee also heard that our AMA has strong policy supporting the protection of patient data. Testimony highlighted that HIPAA is a permissive law and provides covered entities the ability to access, exchange, and use patients' medical information for broad purposes, i.e., treatment, payment, and operations. Your Reference Committee also heard that in late 2019, our AMA, developed a set of data privacy principles that apply to entities other than those already considered covered entities under HIPAA. Testimony further stated that our AMA's Privacy Principles (link provided, content not included in the printed version because it is four pages long) provide individuals with rights and protections from discrimination and shift the responsibility for privacy from individuals to data holders other than HIPAA-covered entities. Your Reference Committee heard that extending HIPAA protections for protected health information to non-HIPAA covered technology companies and vendors could create a gap in needed privacy policies. Your Reference Committee also heard that our AMA has advocated to incorporate our Privacy Principles in several regulatory policies, including an Office for Civil Rights HIPAA proposed rule and multiple CMS' Quality Payment Program proposed rules, and we are aware that Congressional Committees are incorporating certain principles in legislative language. Therefore, your Reference Committee recommends that Resolution 227 be adopted as amended.

(17) RESOLUTION 228 – EXPANDED CHILD TAX CREDIT
RESOLUTION 247– RECOGNIZING CHILD POVERTY AND THE RACIAL WEALTH GAP AS PUBLIC HEALTH ISSUES AND EXTENDING THE CHILD TAX CREDIT FOR LOW-INCOME FAMILIES

RECOMMENDATION A:

That the third resolve of Resolution 247 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA advocate for fully refundable, expanded child tax credit ~~payments~~ and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for ~~low-income U.S. residents~~ <u>families in need.</u>

RECOMMENDATION B:

Resolution 247 be adopted as amended in lieu of Resolution 228.

HOD ACTION: Resolution 247 adopted as amended in lieu of Resolution 228.

Resolution 228

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)

Resolution 247

RESOLVED, That our AMA recognize child poverty as a public health issue and a crucial social determinant of health across the life course; and be it further

RESOLVED, That our AMA recognize that the disproportionate concentration of child poverty and generational wealth gaps experienced by Black, American Indian or Alaska Native, and Hispanic families are a consequence of structural racism and a barrier to achieving racial health equity; and be it further

RESOLVED, That our AMA advocate for fully refundable expanded child tax credit payments and other evidence-based cash assistance programs to alleviate child poverty, ameliorate the racial wealth gap, and advance health equity for low-income U.S. residents.

Your Reference Committee heard mixed testimony regarding Resolutions 228 and 247. Your Reference Committee heard that rates of child poverty in the United States grew from 14.4% in 2019 to 16.1% in 2020, with a disproportionate impact among Black, Indigenous, and Latinx families, which widened the racial wealth gap. Testimony also stated that child poverty negatively impacts children's physical, mental, and emotional health and development, and this effect continues into adulthood. Your Reference Committee heard that direct assistance to families in the form of tax credits paid on a regular basis boosts the academic and economic performance of children over time. However, testimony also stated that any reference to specific federal legislation substantially limits our AMA's ability to be nimble and flexible in its work to advocate for a permanent tax credit in whatever legislative form or policy opportunity arises in the future. Therefore, your Reference Committee recommends that Resolution 247 be adopted as amended in lieu of 228.

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

RECOMMENDATION A:

That the first resolve of Resolution 230 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~encourages federal, state and local governments to~~ ~~create~~ support the creation and maintenance of ~~new and maintain~~ existing public lands and outdoor spaces for the purposes of outdoor recreation~~;~~ ~~(Directive to Take Action)~~ ~~and be it further~~ and support continued research on the clinical uses of outdoor recreation therapy. (New AMA Policy)

RECOMMENDATION B:

That the second resolve of Resolution 230 be deleted:

~~**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 Act) (New AMA Policy)**~~

RECOMMENDATION C:

Resolution 230 be adopted as amended.

HOD ACTION: Resolution 230 adopted as amended.

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 heard mostly positive testimony regarding Resolution 230. Your Reference Committee heard that outdoor recreation has been shown to have a positive impact on physical, mental, and social health and can result in savings related to chronic disease. Testimony also noted that, considering its proven health benefits, outdoor recreation is now being considered as a potential clinical tool via park prescriptions and outdoor organization referrals. However, your Reference Committee heard that public spaces available for outdoor recreation are increasingly threatened by decreased public availability, and that spending has remained stagnant or fallen in the National Parks and state parks, with billions of dollars in maintenance backlogs even as visits have risen. Testimony was also heard that decreased spending on recreation spaces is an equity issue, disproportionately affecting lower socioeconomic and

minority communities that already have lower quality public spaces for recreation, decreased accessibility, and increased rates of space loss, despite these groups disproportionately benefiting from outdoor recreation. Your Reference Committee also heard that adoption of Resolution 230 would fill a gap in AMA policy by providing specific policy on outdoor recreation and the health benefits of such activity. Limited testimony was heard against adoption, based on the realities and difficulties of implementing the resolution and the complexities of land and natural resources policy. Your Reference Committee also was presented with an amendment that recommended broadening the language from specific directives to supportive policy in order for our AMA advocacy to be as effective as possible. Testimony also stated that broadening the asks in the Resolution to be supportive policy rather than directives would provide our AMA staff with more flexibility to engage with, and support, other organizations that may already have specific experience with these issues and may have existing advocacy campaigns. Your Reference Committee, therefore, recommends adoption of Resolution 230 as amended.

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

RECOMMENDATION A:

Resolution 231 be amended by addition and deletion to read as follows:

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~~,~~ for children and adults, including the removal of sales tax ~~on child and adult diapers, including single-use and reusable diapers, and the inclusion of child diapers as qualified~~ and ensuring eligibility of these products as medical expenses for Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Flexible Spending Accounts (FSAs). (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 231 be adopted as amended.

HOD ACTION: Resolution 231 adopted as amended.

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 heard overwhelmingly supportive testimony in favor Resolution 231. Your Reference Committee heard that AMA policy, H-155.955, Increasing Accessibility to Incontinence Products, supports increased access to affordable incontinence products but is not specific about how to increase such access. Testimony further highlighted that AMA policy H-270.953, Tax Exemptions for Feminine Hygiene Products, recognizes access to feminine hygiene products as a public health issue and supports the removal of sales tax on all feminine hygiene products. Testimony also was heard that stated that a lack of affordable access to diapers can result in diapers not being changed in a timely manner, resulting in health issues, such as increased risk of urinary tract infections and diaper dermatitis and creating an environment for the creation of pressure ulcers. Your Reference Committee heard that access to affordable incontinence products is an equity issue, disproportionately impacting vulnerable patient groups such as infants/toddlers, the elderly, adults with physical disabilities, and adults with intellectual disabilities, as well as low-income individuals. Testimony was also heard that adopting Resolution 231 would be consistent with, and a logical extension of, existing AMA policy. Your Reference Committee heard recommendations on a few minor amendments, which your Reference Committee believes improve the original resolution. Therefore, your Reference Committee recommends that Resolution 231 be adopted, as amended.

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

RECOMMENDATION A:

Resolution 232 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support the adoption of state laws that ~~authorize entities with emergency food allergy guidelines and staff trained in recognizing and responding to a food allergy emergencies to have~~ allow state-authorized entities to permit the storage of auto-injectable epinephrine for use in case of anaphylaxis~~an emergency~~. (Directive to Take Action)

RECOMMENDATION B:

Resolution 232 be adopted as amended.

HOD ACTION: Resolution 232 adopted as amended.

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 heard generally supportive testimony for Resolution 232. Increased access to epinephrine in the event of a food allergy emergency will help save lives. Testimony highlighted that recognizing the signs and indications of an anaphylactic reaction is important so as to know when to administer epinephrine. Your Reference Committee heard that existing AMA policy already provides a guide to amend the resolution to focus on education and training. Testimony stated that businesses or others who want to have epinephrine on their premises in

the event of a food allergy should be able to do so—as long as they have education or other protocols in place to ensure its safe storage and administration. Current AMA Policy H-440.884, Food Allergic Reactions in Schools and Airplanes, provides a model on which to amend this resolution. Your Reference Committee, therefore, recommends that Resolution 232 be adopted as amended.

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

RECOMMENDATION A:

Resolution 233 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support ~~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~~ research on the effectiveness of warning labels on packaging for firearm ammunition, 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.

RECOMMENDATION B:

Resolution 233 be adopted as amended.

HOD ACTION: Resolution 233 adopted.

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 heard mostly positive testimony regarding Resolution 233. Your Reference Committee heard that text-based warning labels have been shown to be, and may be, effective in reducing harmful health behaviors such as consumption of high-sugar or nutritionally poor foods, consumption of alcohol, and misuse of medications. Moreover, testimony was heard that there is a large body of evidence that graphic warning labels on tobacco packaging consistently reduce tobacco use, are more effective at changing behaviors and cognitive patterns than text-only warnings and are equally effective for many diverse population subgroups. Your Reference Committee also heard that given the public health crisis of gun violence, innovative solutions are needed, and warning labels on ammunition is such a solution.

However, your Reference Committee also heard that our AMA already has strong, clear, and well-developed policies on firearm safety, including policy that specifically addresses storage of ammunition, as well as policy on the importance of education for the public about safe storage, especially in households with children. Further testimony stated that there is no pending federal

legislation to date that calls for graphic warning labels or text-based messaging on ammunition packaging and there is no evidence to support ammunition warning labels as a means to reduce or prevent firearm injuries or deaths. Your Reference Committee acknowledges the strong testimony in support of adoption of Resolution 233, but also recognizes that without evidence on the specific effectiveness of warning labels on packaging for firearm ammunition, it will be difficult for our AMA staff to implement the directive to advocate for legislation requiring such labeling. Therefore, your Reference Committee believes that our AMA should support research of such labeling as a first step. Your Reference Committee, therefore, recommends that Resolution 233 be adopted as amended.

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

RECOMMENDATION A:

Resolution 236 be amended by addition and deletion to read as follows:

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~~ allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians ~~providers~~.

RECOMMENDATION B:

Resolution 236 be adopted as amended.

HOD ACTION: Resolution 236 adopted as amended.

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 heard testimony in support of Resolution 236. Testimony noted that current AMA policy does not fully reflect the comprehensive solution to surprise billing in terms of a backstop for payment disputes with an Independent Resolution Process. Testimony also stated that our AMA and the Federation have successfully advocated for federal and state legislative proposals. Your Reference Committee also heard support for an amendment to the resolution

that removes reference to “mediation,” instead keeping the focus on an independent dispute resolution process for physicians who are not satisfied with the initial payment from an insurer. Your reference committee agrees that mediation is not the appropriate tool to resolve out-of-network billing disputes. Testimony also stated that the amended language would more accurately reflect principles agreed to by most members of the Federation during debate over the language of the No Surprises Act and the advocacy that continues in the states on surprise billing. Additionally, your Reference Committee received a friendly amendment to replace “permitted” with “allowed” in the Resolution. Therefore, your Reference Committee recommends that 236 be adopted as amended.

(23) RESOLUTION 245 – DEFINITION AND ENCOURAGEMENT OF THE APPROPRIATE USE OF THE WORD "PHYSICIAN"
RESOLUTION 249 – CLARIFICATION OF HEALTHCARE PHYSICIAN IDENTIFICATION: CONSUMER TRUTH & TRANSPARENCY

RECOMMENDATION A:

That the second resolve of Resolution 249 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for “Truth & Transparency” legislation that would combat medical title misappropriation; that such legislation would require non-physician healthcare practitioners to clearly and accurately state their level of training, credentials, and ~~licensing~~ board licensure~~, and practice qualifications~~ in all professional interactions with patients including hospital and other health care facility identifications, as well as in advertising and marketing materials; and that such legislation would prohibit non-physician healthcare practitioners from using any identifying terms (i.e. ~~doctor~~, -ologist) that can mislead the public (Directive to Take Action).

RECOMMENDATION B:

Resolution 249 be adopted as amended in lieu of Resolution 245.

HOD ACTION: Resolution 249 adopted as amended in lieu of Resolution 245.

Resolution 245

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)

Resolution 249

RESOLVED, That our American Medical Association will advocate for legislation that would establish clear legal definitions for use of words or terms “physician,” “surgeon,” “medical doctor,” “doctor of osteopathy,” “M.D.” , “D.O.,” or any other allopathic or osteopathic medical specialist (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate “Truth & Transparency” legislation that would combat medical title misappropriation; that such legislation would require non-physician healthcare practitioners to clearly and accurately state their level of training, credentials, licensing board, and practice qualifications in all professional interactions with patients including hospital and other health care facility identifications, as well as in advertising and marketing materials; and that such legislation would prohibit non-physician healthcare practitioners from using any identifying terms (i.e. doctor, -ologist) that can mislead the public (Directive to Take Action).

Your Reference Committee heard testimony generally supportive of Resolutions 245 and 249. Your Reference Committee heard that our AMA has extensive policy supporting truth in advertising laws and opposing misappropriation of medical specialties titles. Testimony also stated that our AMA has model truth in advertising legislation and a TIA campaign. Your Reference Committee understands that our advocacy team works regularly with state medical associations to support state Truth in Advertising legislation, including legislation that opposes misappropriation of medical specialty titles. Several amendments were offered to Resolution 249, including a recommendation from the Council on Legislation, to delete the term “practice qualifications” as this is a subjective term that will be difficult for the non-physician to convey to patients accurately and succinctly in each encounter, as well as removal of the term “doctor” as this term is already widely used by non-physicians, such as dentists, pharmacists, optometrists, and chiropractors. Your Reference Committee supports these amendments and, therefore, your Reference Committee recommends that Resolution 249 be adopted as amended in lieu of Resolution 245.

(24) RESOLUTION 254 – STAKEHOLDER ENGAGEMENT IN MEDICARE ADMINISTRATIVE CONTRACTOR POLICY PROCESSES

RECOMMENDATION A:

That the second resolve of Resolution 254 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid Services (CMS) to improve the instructions to MACs regarding development of local coverage policies in such a manner as to prevent ~~ensure no~~ LCAs that could have the effect of restricting coverage or access from being adopted ~~are issued by MACs~~ without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process~~, through the modernization requirement of the 21st Century Cures Act~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

That the third resolve of Resolution 254 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with specialty and state medical societies and other interested stakeholders to identify ~~advocate to CMS that the agency immediately invalidate any~~ LCAs that ~~are identified as~~ potentially restrict~~ing~~ coverage or access and that were issued without the MACs providing opportunities for stakeholder input, public data, decision criteria, and evidentiary review~~, or that were issues without an associated LCD and the required stakeholder processes,~~ and advocate that CMS require MACs to revise the policies by ~~restart those processes~~ taking any such proposed changes through an appropriate ~~CLDs and associated requirements for~~ stakeholder engagement, public data, and evidentiary review (Directive to Take Action)~~; and be it further~~

RECOMMENDATION C:

That the fourth resolve of Resolution 254 be deleted:

~~**RESOLVED, That our AMA advocate that Congress and the Department of Health and Human Services consider clarifying language that reinstates a role for local Carrier Advisory Committees in review processes going forward, addressing unintended outcomes of changes in the 21st Century Cures Act that allowed local CACs to be left without a voice or purpose (Directive to Take Action).**~~

RECOMMENDATION D:

Resolution 254 be adopted as amended.

HOD ACTION: Resolution 254 adopted as amended.

RESOLVED, That our American Medical Association opposes Medicare Administrative Contractors (MACs) using Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes (New HOD Policy); and be it further

RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid Services (CMS) to ensure no LCAs that could have the effect of restricting coverage or access are issued by MACs without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input process, through the modernization requirement of the 21st Century Cures Act (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to CMS that the agency immediately invalidate any LCAs that are identified as potentially restricting coverage or access and that were issued without the MACs providing public data, decision criteria, and evidentiary review, or that were issues without an associated LCD and the required stakeholder processes, and that CMS require MACs to restart those processes taking any such proposed changes through CLDs and associated requirements for stakeholder engagement, public data, and evidentiary review (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that Congress and the Department of Health and Human Services consider clarifying language that reinstates a role for local Carrier Advisory Committees in review processes going forward, addressing unintended outcomes of changes in the 21st Century Cures Act that allowed local CACs to be left without a voice or purpose (Directive to Take Action).

Your Reference Committee heard testimony primarily in favor of adopting Resolution 254. While testimony was in favor of adopting the first resolved, an amendment was offered that modifies the second and third resolved and deletes the fourth resolved. Testimony was received that expressed concern that it is not feasible to expect the Centers for Medicare & Medicaid Services to identify the problematic local policies on its own and get them revised. Instead, testimony was heard that our AMA should work with medical societies and others to identify the policies that need to be revised. Testimony also was heard that it would be problematic to refer to the 21st Century Cures Act as the source of the problem because that could imply that these changes cannot be made without action by Congress, which is not the case. Local Coverage Articles were typically published by a local Medicare Administrative Contractor to provide coding/billing guidelines or other provider education that was complementary to an existing National Coverage Decision or Local Coverage Decision. Additional testimony was heard in support of the offered amendment. Therefore, your Reference Committee recommends that Resolution 254 be adopted as amended.

RECOMMENDED FOR REFERRAL

(25) RESOLUTION – 201 THE IMPACT OF MIDLEVEL PROVIDERS ON MEDICAL EDUCATION

RECOMMENDATION:

Resolution 201 be referred.

HOD ACTION: Resolution 201 referred.

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 heard mixed testimony regarding Resolution 201. Your Reference Committee heard testimony from multiple specialties, including primary care, and multiple Councils, but no clear consensus emerged. Testimony provided recommendations ranging from not adopt to support and received multiple amendments. Testimony highlighted that our AMA has extensive policy on scope of practice, including support for physician-led team-based care, as well as policy that medical education should prepare students to practice in physician-led teams, and that physician-led interprofessional education should be incorporated into medical education and residency programs. Your Reference Committee also heard support for interprofessional collaboration and the role of non-physicians as important members of the care team. General support was heard for further studies about scope of practice, but also testimony was provided that our AMA has extensive information and existing resources outlining the differences in post graduate education and training of nonphysicians. Moreover, your Reference Committee heard that the directives in Resolution 201 are not feasible and may not be possible to complete. As an example, our AMA does not have authority over post-graduate clinical training or continuing education requirements for non-physicians. These requirements are set by the individual profession's accrediting bodies and other regulatory bodies and are likely not to follow AMA directives. Therefore, your Reference Committee recommends that Resolution 201 be referred.

(26) RESOLUTION 224 – HPSA AND MUA DESIGNATION FOR SNFS

RECOMMENDATION:

Resolution 224 be referred.

HOD ACTION: Resolution 224 referred.

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 heard mixed testimony on Resolution 224. Your Reference Committee heard that Health Professional Shortage Areas (HPSAs) and medically underserved areas (MUAs) are areas, population groups, and facilities designated by the United States Department of Health and Human Services as having met criteria indicating a significant need for additional primary health care resources, such that limited resources can be prioritized and directed to those areas to assist in addressing that need. Testimony also stated that due to a rapidly aging population, lack of commensurate increase in medical school and residency positions, early retirement of healthcare professionals from burnout and effects of the pandemic, and a lack of direct incentives to practice in senior living communities, there is an acute shortage of healthcare professionals including Physicians, nurses, and clinical practitioners in skilled nursing facilities. However, your Reference Committee also heard that our AMA has ample policy that supports legislation to address the need to enhance resources for physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold. Testimony also stated that our AMA policy includes clear instruction for our AMA to support such legislation, encourage federal and state governments to provide financial assistance to assist physicians with shortage area practices, support 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, and support legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders, and undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities. In addition, your Reference Committee heard that our AMA continues to advocate, as a top legislative priority, to provide HPSAs and MUAs the resources needed to help bolster physician practices in these areas evidenced by our AMA providing exhaustive comments to CMS and written testimony to our Congressional leaders. Due to the conflicting testimony provided, your Reference Committee recommends that Resolution 224 be referred.

(27) RESOLUTION 237 – PRESCRIPTION DRUG DISPENSING POLICIES

RECOMMENDATION:

Resolution 237 be referred.

HOD ACTION: Resolution 237 referred.

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 heard testimony in support of physicians communicating clearly on a prescription. Your Reference Committee also heard clear support for improving medication adherence for patients with a chronic condition, including supporting having multiple 30-day prescriptions converted into a 90-day prescription when clinically appropriate. Your Reference Committee appreciates that there are some prescriptions, such as trial medications, that would not benefit the patient if the prescription were converted into a 90-day prescription. Your Reference Committee agrees with the Council on Legislation that the prescribing physician should take care and clearly write on the prescription, “dispense as written” or “no refills” if the physician does not want the pharmacist to take matters into his or her own hands. Testimony emphasized that our AMA has longstanding and extensive policies supporting individualized patient care decisions. This includes our AMA supporting patients with chronic conditions being able to receive a 90-day prescription when clinically appropriate. Your Reference Committee, however, also agrees with testimony that directions such as “dispense as written” may not stop a pharmacist or pharmacy benefit manager (PBM) from inappropriately extending a 30-day prescription to 90 days, which could create patient safety concerns. Testimony highlighted that some harms could be accidental overdose or treatment failure, but there also was testimony that such harms could result from many different types of medications and not just opioids or prescription medication. Your Reference Committee notes that our colleagues from the U.S. Public Health Service provided pro- and con- testimony to different parts of the resolution, underscoring the nuances that would benefit from further study. Your Reference Committee, therefore, recommends that Resolution 237 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(28) 246 – FURTHER ACTION TO RESPOND TO THE GUN VIOLENCE PUBLIC HEALTH CRISIS

RECOMMENDATION:

Resolution 246 be referred for decision.

HOD ACTION: Resolution 246 referred for report back at the 2022 Interim Meeting.

RESOLVED, Our AMA convene a task force for the purposes of working with advocacy groups and other relevant stakeholders to advocate for federal, state, and local efforts to end the gun violence public health crisis; identifying and supporting evidence-based community interventions to prevent gun injury, trauma, and death; monitoring federal, state, and local legislation, regulation, and litigation relating to gun violence; and reporting annually to the House of Delegates on the AMA's efforts to reduce gun violence.

Your Reference Committee heard mixed testimony on Resolution 246. Your Reference Committee heard that gun violence is a major public health crisis in the US that only continues to worsen every year, with the Centers for Disease Control and Prevention (CDC) most recently reporting 45,222 gun deaths in 2020. This report on gun deaths was the highest on record at the time, a 14% increase from 2019, a 25% increase from 2015, and a 43% increase from 2010. Your Reference Committee heard further testimony that the CDC reported that gun-related injuries were one of the five leading causes of death for people aged 1-44 in the US in 2020, and a May 2022 a letter in The New England Journal of Medicine suggested that gun-related injuries may have surpassed motor vehicle crashes becoming the leading cause of death for children and young adults aged 1-19. Testimony also stated that 246 mass shootings took place in the first five months of 2022 according to the Gun Violence Archive, and that 27 school shootings took place in this same period according to Education Week, compared to 34 school shootings in all of 2021. Your Reference Committee further heard that given this rash of firearm violence, AMA advocacy could benefit from unified efforts to collaborate and partner with stakeholders to bolster our efforts and navigate the difficult US landscape on gun violence. Your Reference Committee heard support for the creation of an AMA task force to develop actionable recommendations for our AMA to be a leader in responding to the gun violence crisis.

However, your Reference Committee heard testimony against adoption of this resolution. Testimony stated that preventing firearm violence is already an advocacy priority for our AMA, and our AMA is already engaged in advocacy activities similar to what is called for in this resolution, such as most recently working with other medical specialties, including the American Academy of Pediatrics, to advocate to Congress for increased funding on research to prevent firearm violence. Your Reference Committee also heard that our AMA Advocacy staff is already monitoring state and federal legislation and regulation, as well as litigation, related to firearm violence, and our AMA is engaged in litigation on firearms, including cases pending in the Supreme Court this term. Moreover, testimony stated that our AMA recently sent a letter to the House Judiciary Committee in support of H.R. 7910, the "Protecting Our Kids Act," which includes provisions to increase the purchasing age for semi-automatic rifles from 18 to 21 and close the ghost-gun loophole. In addition, testimony highlighted that our AMA has issued several press statements in recent weeks reiterating that gun violence is a public health crisis and needs real-world, common-sense federal actions. Your Reference Committee also heard that creating an

AMA task force is not necessary, since our AMA is already engaged in the activities that would be done by a task force.

Your Reference Committee agrees that our AMA is already engaged in the advocacy, litigation, and coalition activities that Resolution 246 calls for, and believes that creating a task force would take time. Given the mixed testimony presented, your Reference Committee believes that our Board of Trustees is in the best position to weigh the competing factors regarding whether an AMA task force on preventing firearm violence should be created and can act in a timely manner to decide on how the AMA can best continue its advocacy and initiatives on preventing firearm violence. Therefore, your Reference Committee recommends that Resolution 246 be referred to the Board of Trustees for decision.

RECOMMENDED FOR NOT ADOPTION

(29) RESOLUTION 205 – INSURERS AND VERTICAL INTEGRATION

RECOMMENDATION:

Resolution 205 not be adopted.

HOD ACTION: Resolution 205 not adopted.

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 heard mixed testimony concerning Resolution 205. Those in favor pointed out that health payers vertically integrating with other entities in the health care supply chain may result in competitive harm to patients and physicians, pointing to the CVS-Aetna merger. Testimony against adoption indicated that adopting Resolution 205 would result in our AMA having to take the position that every proposed vertical merger is bad, regardless of the entities involved-which might include AMA member organizations. Strong testimony highlighted that requiring our AMA to pursue legislation and regulation that would ban all proposed payer vertical mergers in effect requires our AMA to advocate against all such mergers, even if they are small and pose no threat to competition, have procompetitive effects, or might even be sought by AMA group constituents or AMA members. Further, our AMA is a nationally recognized leader when it comes to challenging anti-competitive mergers involving payers, both horizontal and vertical mergers. Testimony highlighted that the last two mergers that our AMA has taken on have been proposed vertical mergers involving payers. Moreover, your Reference Committee heard that our AMA was very aggressive in opposing the proposed CVS-Aetna merger, being one of only a very few organizations invited by a federal judge to provide testimony in federal court against a proposed settlement agreement between the U.S. Department of Justice (DOJ) and CVS that allowed the merger to proceed. More recently, our AMA has asked the DOJ to closely scrutinize the proposed Optum-Change Healthcare merger, and in April 2022, our AMA sent a letter to both the Federal Trade Commission and the DOJ urging both agencies to modernize enforcement of the antitrust laws regarding mergers. Your Reference Committee heard that our AMA will continue to closely monitor all proposed payer mergers and will challenge any such mergers that might hurt patients or physicians. Therefore, your Reference Committee recommends that Resolution 205 not be adopted.

(30) RESOLUTION 207 – PHYSICIAN TAX FAIRNESS

RECOMMENDATION:

Resolution 207 not be adopted.

HOD ACTION: Resolution 207 not adopted.

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 heard limited testimony regarding Resolution 207. One comment was received that Resolution 207 would benefit physicians. However, opposing testimony commented

that the purpose of the tax law change for pass-through entities was to provide relief for small businesses that rely on capital investment to generate their income (rather than their own professional expertise). Other professionals, such as attorneys and CPAs, are treated the same way. Rather than being harmed by the tax provision for pass-through entities, physicians and other professionals simply do not benefit from it. Your Reference Committee also heard that, depending on their circumstances, physicians may realize a net benefit from the tax law change because of reductions in most of the individual tax brackets and other business tax provisions. Therefore, your Reference Committee recommends that Resolution 207 not be adopted.

(31) RESOLUTION 241 – UNMATCHED GRADUATE PHYSICIAN WORKFORCE

RECOMMENDATION:

Resolution 241 not be adopted.

HOD ACTION: Resolution 241 not adopted.

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 heard mixed testimony on Resolution 241. Your Reference Committee heard that some young physicians are not able to match and are stuck with medical school debt and no professional pathway forward. However, testimony also noted that a very small percentage of physicians never match. Furthermore, your Reference Committee heard that our AMA has existing policy that is opposed to assistant physicians and would need to be changed in order to support this resolution. Testimony also noted that the first resolved clause assumes that physicians at these underserved communities have the time and resources to supervise these physicians that were unable to match. Furthermore, testimony noted that there could be equity issues sending those that did not match to communities that are most in need and potentially those with the least economic mobility. These communities deserve care from the most qualified individuals. Your Reference Committee heard that, with regard to the second resolved, our AMA is working to increase the number of GME positions, so that medical school graduates can receive appropriate training. However, testimony stated that if our AMA begins to advocate for funding for these individuals that did not match it will weaken our current advocacy for additional slots. Testimony highlighted that it is likely that more funding will not be appropriated for these unmatched physicians to be trained and so, if anything, money will be taken from the

existing pot and potentially away from our current funding for GME slots for residents that matched. Your Reference Committee also heard that technically a request for Section status can be made via a resolution. However, testimony noted that every Section established thus far has been through the Council on Long Range Planning and Development (CLRPD) route. Additionally, testimony highlighted that the proposed Section will still need to prove that it has met the threshold for creating a section including issues of concern, consistency, appropriateness, representation threshold, stability, and accessibility. Testimony stated that this request would be more appropriately handled by an application to CLRPD. Your Reference Committee also heard that the fourth resolved aligns with AMA Policy H-160.949 which opposes special licensing pathways for physicians. Therefore, your Reference Committee recommends that Resolution 241 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

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

RECOMMENDATION:

That AMA Policy H-225.964 be reaffirmed in lieu of Resolution 202.

HOD ACTION: AMA Policy H-225.964 reaffirmed in lieu of Resolution 202.

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 heard mixed testimony on Resolution 202. Your Reference Committee heard testimony in support of the resolution suggesting the inclusion of data in claims databases on direct payments to employed physicians should be required to establish more accurate payment benchmarks. However, testimony questioned both the feasibility of collecting this data, and the risk of doing so in a public (or publicly accessible) database, including privacy, accuracy, and antitrust concerns. Your Reference Committee shares such concerns. Additional testimony called for reaffirmation of existing policy, H-225.964 – Hospital Employed/Contracted Physicians Reimbursement, that requires hospitals to provide payment information at the time of contracting, offering a more feasible way for physicians to access such information and incorporate it into their contracting negotiations. Therefore, your Reference Committee recommends reaffirmation of H-225.964 in lieu of Resolution 202.

H-225.964 – Hospital Employed/Contracted Physicians Reimbursement

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians.

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

RECOMMENDATION:

That AMA Policies D-275.994, D-275.996, and D-480.960 be reaffirmed in lieu of Resolution 215.

HOD ACTION: AMA Policies D-275.994, D-275.996, and D-480.960 reaffirmed in lieu of Resolution 215.

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 heard testimony expressing concern that the current licensure system has failed to utilize existing technological advancements, is slow and outdated, and results in a long wait for states to approve physician licenses. Testimony stated that these negative aspects of the current licensure system have in turn negatively impacted a physician's ability to care for patients, including through telehealth. However, your Reference Committee also heard that our AMA has extensive policy, model state telehealth legislation, and has already worked with the Federation of State Medical Boards (FSMB), which has a number of viable solutions to address the concerns raised in Resolution 215. Your Reference Committee heard directly from the FSMB, which outlined many programs they have in place utilizing the most up to date technology, including digital certification, to streamline the licensure process and aid states in primary source verification, as well as updated policy which includes some narrow exceptions to licensure for care provided via telehealth across state lines. Testimony also stated that our AMA has been working with FSMB to expedite and facilitate multi-state licensure through the Interstate Medical Licensure Compact, which now includes 36 states plus DC and Guam, and has processed more than 32,000 licenses with an average processing time of 18 days and more than half the applications taking 7 days or less. Finally, your Reference Committee heard that our AMA has existing policy supporting limited exceptions to licensure for care provided via telehealth across state lines, such as physician-to-physician consultations, and for physicians providing ongoing or follow-up care by a physician to an existing patient, when that patient is temporarily out of state. Given the ongoing collaboration with FSMB and existing AMA policy addressing the issues outlined in Resolution 215, your Reference Committee recommends that existing policies D-275.994, D-275.996, and D-480.960 be reaffirmed in lieu of Resolution 215.

D-275.994 – Facilitating Credentialing for State Licensure

Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4)

supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission.

D-275.996 – Creation of AMA Data Bank on Interstate Practice of Medicine

Our AMA will: (1) continue to study interstate practice of medicine issues as they relate to the quality of care available to patients; (2) explore the provision of information on physician licensure, including telemedicine, to members and others through the internet and other media; and (3) continue to make information on state legal parameters on the practice of medicine, including telemedicine, available for members and others.

D-480.960 – Licensure and Telehealth

1. Our AMA will work with the Federation of State Medical Boards, state medical associations and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient in the state without penalty if the following conditions are met:
(a) The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.
(b) There is a pre-existing and ongoing physician-patient relationship.
(c) The physician has had an in-person visit(s) with the patient.
(d) The telehealth services are incident to an existing care plan or one that is being modified.
(e) The physician has verified that the telehealth services are covered under the physician's medical liability insurance policy that satisfies applicable state legal requirements.
(f) Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules.

2. It is the policy of the AMA that a state with a patient compensation fund should consider the impact on the fund of telehealth use by out-of-state physicians providing continuity of care to existing patients in the fund's state. Physicians and patients should be made aware that a state's patient compensation fund may not be applicable when care using interstate telehealth is provided.

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

RECOMMENDATION:

That AMA Policies H-350.955, D-255.980, D-255.991, H-60.906, H-65.960, and H-80.993 be reaffirmed in lieu of Resolution 234.

HOD ACTION: AMA Policies H-350.955, D-255.980, D-255.991, H-60.906, H-65.960, and H-80.993 reaffirmed in lieu of Resolution 234.

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 of 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 heard mixed testimony in favor of Resolution 234. Your Reference Committee heard that our AMA already has existing policy on most of the issues raised in the Resolution and is already engaged in most of the advocacy requested by the Resolution. Your Reference Committee heard that our AMA has already done advocacy championing the use of alternatives to detention for immigrants. Alternatives to detention include things like releasing immigrants on recognizance, community support, bonding, or formal monitoring programs. Your Reference Committee heard that our AMA also supports alternatives to detention. Testimony also stated that our AMA adopted policy on alternatives to detention at our 2021 June Meeting and that our AMA has sent a letter to the Administration on this topic and submitted comments supporting the increased use of release programs within Department of Homeland Security (DHS). Moreover, testimony highlighted that during the beginning of the pandemic our AMA wrote multiple letters to the Administration asking for extensions of physician visas that were valid prior to a national crisis but could not be renewed due to DHS shutting down/slowing down considerably in their review of visas. Testimony also stated that our AMA has been opposing the utilization of 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. Your Reference Committee also heard that our AMA has policies, and has written comment letters, concerning allowing immigrants into the U.S. in line with best health practices and has offered alternatives like quarantining before individuals are allowed into the U.S. rather than providing no alternatives to immigration. Therefore, your Reference Committee recommends that existing AMA Policies H-350.955, D-255.980, D-255.991, H-60.906, H-65.960, and H-80.993 be reaffirmed in lieu of Resolution 234.

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

1. Our AMA 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.

D-255.991 – Visa Complications for IMGs in GME

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.

H-60.906 – Opposing the Detention of Migrant Children

Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children “without unnecessary delay” when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the “least restrictive setting” possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.

H-65.960 – Health, In All Its Dimensions, Is a Basic Right

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

H-80.993 – Ending Money Bail to Decrease Burden on Lower Income Communities

Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

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

RECOMMENDATION:

That AMA Policies H-480.969, H-480,946, D-480.963, and D-480.969 be reaffirmed in lieu of Resolution 239.

HOD ACTION: AMA Policies H-480.969, H-480,946, D-480.963, and D-480.969 reaffirmed in lieu of Resolution 239.

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 heard limited testimony regarding Resolution 239. Your Reference Committee heard generally supportive testimony of allowing physicians to provide ongoing care to patients across state lines via telehealth. Testimony also stated that Medicare regulations currently do not impact a physician's ability to provide care via telehealth across state lines. Rather, this is an issue related to licensure. Your Reference Committee heard that our AMA has ample policy supporting Medicare coverage and payment of telehealth and has been aggressively advocating for Medicare to permanently extend waivers lifting originating site and geographic restrictions. Testimony also stated that our AMA has extensive policy on licensure and telehealth, including policy that physicians must be licensed in the state where the patient is located and policy supporting limited exceptions to licensure for continuity of care such as when a physician provides episodic or follow-up care to an existing patient located in another state. Together these policies address the concerns in Resolution 239. Therefore, your Reference Committee recommends that existing AMA Policies H-480.969, H-480,946, D-480.963, and D-480.969 be reaffirmed in lieu of Resolution 239.

H-480.969 –The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:
(a) exemption from such a licensure requirement for physician-to-physician consultations;
(b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient;
(c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified; and
(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

H-480.946 – Coverage of and Payment for Telemedicine

1. Our AMA 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; or
- 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; or

- 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.
b) 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.
c) 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.
d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
e) The delivery of telemedicine services must be consistent with state scope of practice laws.
f) 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.
g) The standards and scope of telemedicine services should be consistent with related in-person services.
h) 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.
i) 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.
j) The patient's medical history must be collected as part of the provision of any telemedicine service.
k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
l) 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.
m) 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.

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

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.

D-480.969 – Insurance Coverage Parity for Telemedicine Service

1. Our AMA will 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.

2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.

3. Our AMA will 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.

(36) RESOLUTION 250 – OPPOSITION TO CRIMINALIZATION OF PHYSICIANS' MEDICAL PRACTICE

RECOMMENDATION:

That AMA Policies D-125.997, H-270.959, H-160.954, and H-160.946 be <u>reaffirmed in lieu</u> of Resolution 250.

HOD ACTION: AMA Policies D-125.997, H-270.959, H-160.954, and H-160.946 reaffirmed in lieu of Resolution 250.

RESOLVED, That our American Medical Association affirms that government and other third-party interference in evidence-based medical care compromises the physician-patient relationship and may undermine the provision of quality healthcare (Directive to Take Action); and be it further

RESOLVED, That our AMA opposes any government regulation or legislative action which would criminalize physicians for providing evidence-based medical care within the accepted standard of care according to the scope of a physician's training and professional judgment (New HOD Policy).

Your Reference Committee received testimony stating that government and third-party interference with medical practice hurts the patient-physician relationship and quality of care. Your Reference Committee also heard testimony expressing concern that a recent criminal prosecution of a nurse for a medication error, resulting in a patient death, may signal a trend in which physicians may be subject to criminal liability for medical errors or other medical liability allegations, and that our AMA needs to vigorously challenge any attempts by the government to criminalize any aspect of medical practice. At the same time, testimony indicated that our AMA already has strong policy in place mandating that our AMA oppose any governmental or third-party interference with the practice of medicine. Similarly, our AMA has policy mandating our AMA oppose any attempts to impose criminal liability on physicians with respect to any health care decisions, errors in medical decision-making, and medical records documentation. Testimony also indicated that our AMA has recently expanded its model bill prohibiting the criminalization of health care decisions to provide the maximum possible protection from any criminal allegations stemming from medical liability allegations. Therefore, your Reference Committee recommends that existing AMA policies D-125.997, H-270.959, H-160.954, and H-160.946 be reaffirmed in lieu of Resolution 250.

D-125.997– Interference in the Practice of Medicine

Our AMA shall initiate action by whatever means to bring a halt to the interference in medical practice by pharmacy benefit managers and others.

H-270.959 – AMA Stance on the Interference of the Government in the Practice of Medicine

1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.

2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.

C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.

H-160.954 – Criminalization of Medical Judgment

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

H-160.946 –The Criminalization of Health Care Decision Making

The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

(37) RESOLUTION 252 – THE CRIMINALIZATION OF HEALTH CARE DECISION MAKING AND PRACTICE

RECOMMENDATION:

That AMA policies H-160.954 and H-160.946 be <u>reaffirmed in lieu</u> of Resolution 252.

HOD ACTION: AMA policies H-160.954 and H-160.946 <u>reaffirmed in lieu</u> of Resolution 252

RESOLVED, That Policy H-160.946, "The Criminalization of Health Care Decision Making" be amended by addition and deletion with a change in title to read as follows:

The Criminalization of Health Care Decision Making <u>and Practice</u> H-160.946

That our~~The~~ AMA: <u>(1)</u> opposes the attempted criminalization of health care decision-making<u>,</u> <u>practice, malpractice, and medical errors, including medication errors related to electronic medical record or other system errors,</u> ~~especially~~ as ~~represented by the current trend toward criminalization of malpractice;~~ it interferes with appropriate decision making and is a disservice to the American public; ~~and~~<u>(2) actively update and promote</u> ~~will develop~~ model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making <u>and practice</u>, including cases involving allegations of medical malpractice <u>and medical errors</u>~~,~~<u>;</u> and <u>(3)</u> implement an appropriate action plan for all components of the Federation to

educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making, practice, malpractice, and medical errors. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA study the increasing criminalization of health care decision-making, practice, malpractice, and medical errors with report back on our advocacy to oppose this trend; and be it further

RESOLVED, That our AMA study the ramifications of trying all health care decision-making, practice, malpractice, and medical error cases in health courts instead of criminal courts; and be it further

RESOLVED, That our AMA reaffirm policies H-120.921, H-160.954, H-375.984, H-375.997, and H-435.950 (Reaffirm HOD Policy); and be it further

Your Reference Committee heard testimony supporting adoption of Resolution 252, and testimony favoring reaffirmation. The testimony in favor of adoption pointed to the recent criminal conviction of a nurse, based on a medical error she herself reported, and wanted to ensure that our AMA oppose any attempt to criminalize medical errors or anything else that might expose a physician to medical liability. Supportive testimony also called for a study on increasing criminalization of the medical practice setting, and a second study regarding the ramifications of litigating all medical liability cases in health courts instead of criminal courts. However, testimony supporting reaffirmation pointed out that AMA policy already opposes any attempts to criminalize health care decision-making, errors in medical decision-making, and errors in medical records documentation. Testimony also indicated that a study regarding criminalization at this point was premature based on only one prosecution, and a study about litigating cases in health courts as opposed to criminal courts was likely to yield little information, given that at this time there are no medical liability health courts. Finally, your Reference Committee heard that our AMA is making significant revisions to a model bill that was created in response to AMA policy calling for model legislation prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice. These revisions significantly expand the bill's protections and remedies. Your Reference Committee, therefore, recommends that existing AMA policies H-160.954 and H-160.946 be reaffirmed in lieu of Resolution 252.

H-160.954 – Criminalization of Medical Judgment

(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law.

(2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

H-160.946 –The Criminalization of Health Care Decision Making

The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the

Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

RECOMMENDED FOR ADOPTION IN LIEU OF

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

RECOMMENDATION:

Alternative Resolution 211 be adopted in lieu of Resolution 211 to read as follows:

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 and the Centers for Medicare & Medicaid Services (CMS) to delay implementation of ~~the effective date~~ and advance modifications to ~~of~~ the Medicare Appropriate Use Criteria (AUC) Program ~~until the Centers for Medicare & Medicaid Services (CMS) can~~ in such a manner that exempts care mandated by EMTALA, adequately addresses technical and workflow challenges that add to clinician's administrative burden and practice expenses, ~~with its implementation and any interaction between~~ maximizes alignment with the Quality Payment Program (QPP), and ~~the use of~~ creates provider flexibility for the consultation of physician-developed, evidence-based and transparent AUC or advanced diagnostic imaging ~~appropriate use criteria~~guidelines using a mechanism best suited for their practice, specialty and workflow. (Modify Current HOD Policy)

HOD ACTION: Alternate Resolution 211 adopted in lieu of Resolution 211.

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 heard overwhelming testimony in support of Alternative Resolution 211. Your Reference Committee heard that eight years after the bipartisan enactment of Protecting Access to Medicare Act (PAMA), CMS continues to face challenges in completing the

rulemaking and implementation of the AUC program. This delay fuels ongoing concerns about the complexity of the law, associated costs, and regulatory burden sustained by physicians and other health care providers to meet the program requirements. Testimony also stated that the AUC program, if ever fully implemented, would apply to every clinician who orders or furnishes an advanced diagnostic imaging test, unless a statutory or hardship exemption applies. Further, testimony highlighted that practitioners whose ordering patterns are considered outliers will be subject to prior authorization — at a time when physicians are working to advance policies that reduce the administrative burdens associated with these types of utilization management policies. Your Reference Committee also heard concerns that a CMS analysis of CY2020 claims concluded that only 9 to 10 percent of all claims subject to the AUC program reported sufficient information to be considered compliant with the provisions within PAMA. However, there was testimony in opposition to fully repealing the AUC program due to concerns that it would be replaced with additional prior authorization requirements. This conflicting testimony favored adopting Alternative Resolution 211 to provide our AMA with the flexibility needed to achieve the best outcome for physicians. With respect to critiques that the imaging AUC policy conflicts with the QPP, your Reference Committee heard that consultation of imaging AUC already qualifies as a Merit-Based Incentive Payment System (MIPS) high-weight improvement activity. The concerns about the CMS claims analysis were also tempered by the reality that CMS did not mandate consultation during the education and testing period. Furthermore, testimony stated that CMS has attempted to address all major concerns surrounding challenges with claims-based reports of imaging AUC information. Your Reference Committee also heard concerns that full repeal of the imaging AUC policy would prompt federal lawmakers to revisit policies mandating prior authorization for all advanced diagnostic imaging services within Medicare. Testimony highlighted the absence of policies advocating for prior authorization for advanced diagnostic imaging services within annual Presidential budgets following the passage of the PAMA AUC policy. Your Reference Committee also heard that Congress has multiple health care priorities to consider before the end of 2022, thus making it unlikely that federal lawmakers will attempt to repeal a portion of the complicated PAMA statute. Therefore, your Reference Committee recommends that Alternative Resolution 211 be adopted in lieu of Resolution 211.

(39) RESOLUTION 217 – PRESERVING THE PRACTICE OF MEDICINE
RESOLUTION 251 – PHYSICIAN MEDICAL LICENSE USE IN CLINICAL SUPERVISION

RECOMMENDATION A:

Resolution 217 be <u>amended by addition of a new resolve clause</u> to read as follows:

<u>RESOLVED, That our AMA support whistleblower protections for physicians who report unsafe care provided by non-physicians to the appropriate regulatory board.</u>

RECOMMENDATION B:

That resolves 2–6 of Resolution 217 be referred for decision.

RECOMMENDATION C:

That resolves 1-3 of Resolution 251 be referred for decision.

RECOMMENDATION D:

Resolution 217 be adopted as amended in lieu of 251.

HOD ACTION: Resolution 217 adopted as amended in lieu of 251.
Resolves 2–6 of Resolution 217 referred for decision.
Resolves 1-3 of Resolution 251 referred for decision.

Resolution 217

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 effectiveness, and access to necessary medical care, and to publish the findings in a peer-reviewed medical journal. (Directive to Take Action)

Resolution 251

RESOLVED, That our American Medical Association work with relevant regulatory agencies to ensure physicians receive written notification when their license is being used to document "supervision" of non-physician practitioners (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose mandatory physician supervision of non-physician practitioners as a condition for physician employment (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the right of physicians to deny participation in "supervision" of any non-physician practitioner with whom they have concerns for patient safety and/or clinical care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that physicians be able to report unsafe care provided by non-physician practitioners to the appropriate regulatory board with whistleblower protections for the physician and their employment (Directive to Take Action).

Your Reference Committee heard extensive testimony in support of Resolutions 217 and 251. Your Reference Committee heard that scope of practice is a top legislative priority for our AMA and that we have extensive resources supporting our advocacy at the state and federal level to protect patient access to physician-led care and defend the practice of medicine. Strong testimony stated support for policy opposing mandates from employers to supervise non-physician providers as a condition for physician employment and in physician employment contracts. General support was also heard for whistleblower protections of physicians who report unsafe care of non-physicians to the appropriate regulatory board. Your Reference Committee heard supportive testimony of the need for studies to support our scope campaign, particularly studies comparing the cost and quality of care provided by physicians to non-physicians. Testimony also stated that, while our AMA is supportive of conducting studies or surveys to support our scope campaign, these types of studies are expensive and time-intensive and must be considered as part of our broader scope agenda to ensure they will have the greatest impact. Your Reference Committee understands the concerns raised by the authors of Resolutions 217 and 251 and also recognizes the need for such studies to be focused, aligned, and in coordination with other activities in our AMA's scope of practice campaign. Your Reference Committee also agrees expediency is necessary. Therefore, Your Reference Committee recommends adoption of Resolution 217 in lieu of 251 and referral of Resolution 217's second through sixth resolves and referral of Resolution 251's first through third resolves.

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

RECOMMENDATION:

Alternative Resolution 238 be <u>adopted</u> in lieu of Resolution 238 to read as follows:

RESOLVED, That our American Medical Association <u>advocate at the federal level for</u> ~~support~~ debt-relief or <u>loan</u> forgiveness for <u>independent</u> physician practices facing COVID-related financial jeopardy.

HOD ACTION: Alternate Resolution 238 <u>adopted as amended in lieu</u> of Resolution 238.

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 heard mixed testimony on Resolution 238. 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 testified that forgiveness of EIDL loans 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. However, your Reference Committee heard testimony that it is unclear whether Resolution 238 is based upon up-to-date information on the EIDL loan program, and it appears to conflate the EIDL program with other COVID-19 relief programs as well as ask for retroactive forgiveness for loans received under the EIDL program even though the program makes clear that these loans need to be repaid. Your Reference Committee also heard that our AMA worked vigorously and successfully with Congress and the Administration during the height of the pandemic to protect the viability of physician practices and continues to advocate for repayment extensions and other relief related to the Provider Relief Fund. Finally, testimony stated that the limit on the practice size of five or fewer physicians and loan amount of $150,000 appear arbitrary and heard that an alternative resolution would apply more broadly to physicians facing COVID-related financial jeopardy. Your Reference Committee agrees that broadening the language would provide more flexibility to our AMA staff in advocating for implementation of the resolution. Therefore, your Reference Committee recommends that Alternative Resolution 238 be adopted in lieu of Resolution 238.

(41) RESOLUTION 240 – PHYSICIAN PAYMENT REFORM & EQUITY (PPR & E)
RESOLUTION 242 – PUBLIC AWARENESS AND ADVOCACY CAMPAIGN TO REFORM THE MEDICARE PHYSICIAN PAYMENT SYSTEM
RESOLUTION 243 – APPROPRIATE PHYSICIAN PAYMENT FOR OFFICE-BASED SERVICES
RESOLUTION 253 – PHYSICIAN PAYMENT REFORM & EQUITY

RECOMMENDATION:

Alternative Resolution 240 be adopted in lieu of Resolutions 240, 242, 243, and 253 to read as follows:

RESOLVED, That our AMA develop a comprehensive advocacy campaign to achieve enactment of reforms to the Medicare physician payment system consistent with AMA policy and in accord with the principles (Characteristics of a Rational Medicare Payment System) endorsed by over 120 state and medical specialty Federation of Medicine members.

RESOLVED, That our AMA reaffirm AMA Policy H-390-849, Physician Payment Reform, which states, among other things, that our AMA will advocate for the development and adoption of physician payment reforms that are designed with input from the physician community, not require budget neutrality within Medicare Part B, and be based on payment rates that are sufficient to cover the full cost of sustainable medical practice.

RESOLVED, That our AMA reaffirm AMA Policy D-390.946, Sequestration, which states, among other things, that our AMA will continue to seek positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs, ensure Medicare physician payments are sufficient to safeguard beneficiary access to care, work towards the elimination of budget neutrality requirements within Medicare Part B, 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 advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services.

HOD ACTION: Alternative Resolution 240 adopted in lieu of Resolutions 240, 242, 243, and 253

Resolution 240

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)

Resolution 242

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)

Resolution 243

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)

Resolution 253

RESOLVED, That our American Medical Association define Physician Payment Reform and Equity (PPR & E) as "improvement in physician payment be 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" (New HOD Policy); and be it further

RESOLVED, That our AMA place Physician Payment Reform & Equity as the advocacy priority of our organization (Directive to Take Action); and be it further

RESOLVED, That our AMA use multiple resources, 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 practices (Directive to Take Action); and be it further

RESOLVED, That 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 Physician Payment Reform & Equity and report back to the HOD at each subsequent Annual meeting regarding their progress on meeting the goals of Physician Payment Reform & Equity (PPR&E) until PPR&E is accomplished (Directive to Take Action).

Your Reference Committee received mixed testimony on Resolutions 240, 242, 243, and 253. In general, testimony was heard in strong support of the goals of these resolutions. Several commented that our AMA already has extensive policy on the physician payment reforms called for in all of these resolutions, including advocating for positive inflation-adjusted annual physician payment updates that keep pace with rising practice costs, Medicare physician payments sufficient to safeguard beneficiary access to care, allowing the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services, development and adoption of physician payment reforms that are designed with input from the physician community, and eliminating budget neutrality requirements within Medicare Part B. Some testimony argued in favor of the type of additional action called for in Resolutions 240, 242, and 253. Additional testimony noted that physicians are tired of having to fight each year to avoid payment cuts, and that a permanent solution is needed. Other testimony was opposed to these Resolutions and argued that they would be counterproductive and not achieve its intended goals. Testimony also raised concerns of the substantial fiscal notes for Resolutions 240, 242, and 253. Testimony was also heard that our AMA is already leading an effort with Federation members to reshape the Medicare payment system as called for in these resolutions. Just two weeks ago (May 25), over 120 state and specialty Federation members—including most of the cosponsors of Resolutions 242 and 243—endorsed a set of principles (Characteristics of a Rational Medicare Payment System) developed in collaboration with Federation organizations. These principles include establishing a rational Medicare physician payment system that provides financial stability through positive annual payment updates that reflect inflation in practice costs, and eliminating, replacing, or revising budget neutrality requirements. Your Reference Committee also heard testimony that our AMA advocacy is already working to build awareness of the problems with the current system with Congress and the Administration. Furthermore, last Friday (June 10) our AMA launched the Recovery Plan for America's Physicians—#FightingforDocs—which is a comprehensive campaign designed to increase visibility on the Medicare Payment Reform principles broadly endorsed by Federation members, as well as other top AMA priorities. Your Reference Committee also heard testimony in strong agreement that our AMA should continue to build awareness of the problems with the Medicare physician payment system, but that the specific strategy, tactics, and financing are in the purview of the Board. On this point, a member of the Board of Trustees, as well as some others who testified, indicated support for referring these resolutions to the Board for decision. Testimony from some others opposed referral and called for the House of Delegates to make a point by adopting these resolutions. Your Reference Committee also received

testimony in support of adopting an alternative resolution that captures the essence of these resolutions while leaving the strategy and tactics to the Board. Your Reference Committee agrees with this approach and recommends that Alternative Resolution 240 be adopted in lieu of Resolutions 240, 242, 243, and 253.

(42) RESOLUTION 248 – PROMOTING PROPER OVERSIGHT AND REIMBURSEMENT FOR SPECIALTY PHYSICIAN EXTENDERS AND NON PHYSICIAN PRACTITIONERS

RECOMMENDATION:

Alternative Resolution 248 be <u>adopted in lieu</u> of Resolution 248 to read as follows:

PROMOTING PROPER OVERSIGHT OF NON-PHYSICIAN PRACTITIONERS

RESOLVED, That our AMA support state medical board oversight of non-physician practitioners who are practicing without physician supervision, collaboration, or direction.

HOD ACTION: Resolution 248 <u>referred</u>.

RESOLVED, That our AMA work with state medical boards to improve oversight and coordination of the work done with physician extenders and non-physician practitioners (Directive to Take Action); and be it further

RESOLVED, That our AMA adopt the position that Boards of Medical Examiners or its equivalent in each state should have oversight of cases involving specialty care as boards with oversight over physician extenders and non-physician practitioners do not have the training to oversee specialty care (New HOD Policy); and be it further

RESOLVED, That our AMA adopt the position that in each state the Board of Medical Examiners or its equivalent should have oversight over physician extenders and non-physician practitioners if billing independently or in independent practice as their respective oversights boards do not have experience providing accurate oversight for specialty care (New HOD Policy).

Your Reference Committee heard that the AMA has existing policy on point regarding physician supervision of non-physicians, state medical board oversight of physician led teams, and medical board oversight of physician agreements with non-physicians. Your Reference Committee heard concerns with the language of the second Resolved clause and agrees the intent is unclear. Your Reference Committee also heard that while the third Resolved is overly broad, the general objective is supported by existing AMA policy. Your Reference Committee received alternative language that seeks to achieve the goal of the third Resolved and adds to existing AMA policy. Based on this testimony, your Reference Committee recommends Alternative Resolution 248 be adopted in lieu of Resolution 248.

Mister Speaker, this concludes the report of Reference Committee B. I would like to thank Christine Kim, MD, Dale Mandel, MD, Edward Tuohy, MD, Joshua Lesko, MD, Michelle Knopp, MD, Richard Geline, MD, and all those who testified before the Committee.

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