

## Reference Committee B

### **BOT Report(s)**

- 09 Council on Legislation Sunset Review of 2013 House Policies
- 11 HPSA and MUA Designation For SNFs
- 12 Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners

### **Resolution(s)**

- 201 Pharmacists Prescribing for Urinary Tract Infections
- 202 Support for Mental Health Courts
- 203 Drug Policy Reform
- 204 Supporting Harm Reduction
- 205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness
- 206 Tribal Public Health Authority
- 207 Ground Ambulance Services and Surprise Billing
- 208 Medicaid Managed Care for Indian Health Care Providers
- 209 Purchased and Referred Care Expansion
- 210 The Health Care Related Effects of Recent Changes to the US Mexico Border
- 211 Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-cost Rape Test Kits
- 212 Marijuana Product Safety
- 213 Telemedicine Services and Health Equity
- 214 Advocacy and Action for a Sustainable Medical Care System
- 215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud
- 216 Improved Foster Care Services for Children
- 217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools
- 218 Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners
- 219 Repealing the Ban on Physician-Owned Hospitals
- 220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations
- 221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool
- 222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA)
- 223 Protecting Access to Gender Affirming Care
- 224 Advocacy Against Obesity-Related Bias by Insurance Providers
- 225\* Regulation of “Cool/Non-Menthol” Tobacco Products
- 226\* Vision Qualifications for Driver’s License
- 227\* Reimbursement for Postpartum Depression Prevention
- 228\* Reducing Stigma for Treatment of Substance Use Disorder
- 229\* Firearm Regulation for Persons Charged with or Convicted of a Violent Offense
- 230\* Address Disproportionate Sentencing for Drug Offenses
- 231\* Equitable Interpreter Services and Fair Reimbursement
- 232\* Supervised Injection Facilities (SIFs) Allowed by Federal Law
- 233\* Dobbs - EMTALA Medical Emergency
- 234\* Medicare Physician Fee Schedule Updates and Grassroots Campaign

*\*Contained in the Handbook Addendum*

## Reference Committee B

### Resolution(s)

- 235\* EMS as an Essential Service
- 236\* AMA Support for Nutrition Research
- 237\* Prohibiting Covenants Not-To-Compete in Physician Contracts
- 238\* Eliminate Mandatory Medicare Budget Cuts
- 239\* Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians
- 240\* Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication
- 241\* Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents
- 242\* Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure
- 243\* Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony
- 244\* Recidivism
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- 246\* Modification of CMS Interpretation of Stark Law
- 247\* Assessing the Potentially Dangerous Intersection Between AI and Misinformation
- 248\* Supervised Consumption Sites
- 249\* Restrictions on Social Media Promotion of Drugs
- 250\* Medicare Budget Neutrality
- 251\* Federal Government Oversight of Augmented Intelligence
- 252\* Strengthening Patient Privacy
- 253\* Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)
- 254\* Eliminating the Party Statement Exception in Quality Assurance Proceedings
- 255\* Correctional Medicine
- 256\* Regulating Misleading AI Generated Advice to Patients

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-A-23

Subject: Council on Legislation Sunset Review of 2013 House Policies

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee B

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1 Policy G-600.110, "Sunset Mechanism for AMA Policy," calls for the decennial review of  
2 American Medical Association (AMA) policies to ensure that our AMA's policy database is  
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for  
4 review and specifying the procedures to follow:  
5

6 1. As the House of Delegates (HOD) adopts policies, a maximum ten-year time horizon shall  
7 exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain  
8 it. Any action of our AMA HOD that reaffirms or amends an existing policy position shall  
9 reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.  
10

11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the  
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of  
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall  
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been  
15 asked to review policies shall develop and submit a report to the HOD identifying policies that  
16 are scheduled to sunset; (d) For each policy under review, the reviewing council can  
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain  
18 part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each  
19 recommendation that it makes to retain a policy in any fashion, the reviewing council shall  
20 provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way  
21 for the HOD to handle the sunset reports.  
22

23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier  
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current  
25 policy, or has been accomplished.  
26

27 4. The AMA councils and the HOD should conform to the following guidelines for sunset:  
28 (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been  
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is  
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA HOD  
31 Reference Manual: Procedures, Policies and Practices.  
32

33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.  
34

35 6. Sunset policies will be retained in the AMA historical archives.

## 1 RECOMMENDATION

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

**APPENDIX – Recommended Actions**

<b>Policy Number</b>	<b>Title</b>	<b>Text</b>	<b>Recommendation</b>
D-100.970	Drug Enforcement Administration Licensure Fees	Our AMA will work through appropriate channels to freeze Drug Enforcement Administration (DEA) licensure fees for physicians.  (Res. 219, I-13)	Retain – this policy remains relevant.
D-120.948	FDA Recommendation on Scheduling of Hydrocodone Combination Products	Our AMA will issue a public statement to the US Food and Drug Administration urging the FDA to maintain hydrocodone combination products as Schedule III of the Controlled Substances Act.  (Res. 518, A-13)	Sunset this policy.  This policy has been completed. See: <a href="https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fda-rescheduling-letter-22march2013.pdf">https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fda-rescheduling-letter-22march2013.pdf</a> and <a href="https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fdea-coalition-comment-letter-28april2014.pdf">https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fdea-coalition-comment-letter-28april2014.pdf</a>
D-145.997	Physicians and the Public Health Issues of Gun Safety	Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.  (Res. 410, A-13)	Sunset this policy.  The Surgeon General issued a report on suicide in 2021, “ <a href="#">The Surgeon General’s Call to Action to Implement the National Strategy for Suicide Prevention.</a> ” There have been more recent calls on the Surgeon General to develop a report on reducing firearm-related injuries and deaths and our AMA

Policy Number	Title	Text	Recommendation
			has more recent policies supporting government funding for research into preventing firearm injuries and deaths ( <a href="#">Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975</a> )
D-150.976	Hazards of Energy Beverages - Their Abuse and Regulation	<p>1. Our AMA will seek necessary regulatory action through the US Food and Drug Administration to regulate potentially hazardous energy beverages (like Red Bull (TM), Rockstar (TM), Monster (TM), Full Throttle (TM)).</p> <p>2. Our AMA will seek federal regulation to implement warning labels about the side effects of the contents of energy drinks, particularly when combined with alcohol.</p> <p>3. Our AMA supports a ban on the marketing of "high stimulant/caffeine drinks" to children/adolescents under the age of 18.</p> <p>(Res. 909, I-11; Appended: Res. 409, A-13)</p>	Retain – this policy remains relevant.
D-175.986	Physician Prosecution	<p>Our American Medical Association will consider and take action at the national level on Medicaid fraud prosecutions and related issues.</p> <p>(Res. 212, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
D-190.973	The SAFE Act	<p>Our AMA will seek immediately an opinion and guidance from Health and Human Services Office of Civil Rights regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in light of the conflicting standards set forth by the State SAFE Act and federal HIPAA regulations.</p> <p>(Res. 228, A-13)</p>	<p>Sunset this policy.</p> <p>Clarification regarding how physicians in New York State should handle concerns regarding safety and privacy of patients' protected health information in compliance with standards set forth by the State SAFE Act and with federal HIPAA regulations is provided by the New York State Office</p>

Policy Number	Title	Text	Recommendation
			<p>of NICS Appeals &amp; SAFE Act, set forth in FAQs and guidance documents available at: <a href="https://nics.ny.gov/safe-act.html">https://nics.ny.gov/safe-act.html</a></p> <p>Among the above-referenced FAQs is the following information:</p> <p>Q: Are such reports in compliance with HIPAA?</p> <p>A: Under HIPAA, because these informational disclosures are required by law, they can be made without the patient's consent. HIPAA permits disclosures of protected health information without the authorization or consent of the individual to the extent that such disclosure is required by law and the disclosure complies with the requirements of that law.</p>
D-190.982	HIPAA Extension	<p>Our AMA will: <del>(1) support necessary legislative and/or regulatory changes to mandate that health plans continue to accept non-standard electronic claims from physicians during a reasonable transition period following October 16, 2003, when the HIPAA transaction rule takes effect, and</del> (2) take steps to assure that Medicare continues to support free software for filing claims to Medicare and that payers continue to accept paper claims from physicians who choose to submit claims on paper.</p> <p>(Res. 224, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	<p>Retain this policy in part.</p> <p>Delete clause (1). It is no longer relevant as the transition period following October 16, 2003, when the HIPAA transaction rule took effect, has passed.</p>
D-190.983	Protection of Health Care Providers from Unintended Legal	Our AMA will: (1) take appropriate legislative, regulatory, and/or legal action to assure that the unanticipated negative consequences of the Health	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Consequences of HIPAA	<p>Insurance Portability and Accountability Act privacy regulations, affecting the patient/doctor relationship and exposing health care providers to legal action, are corrected; and (2) initiate necessary legislative, regulatory, and/or legal action to assure that HIPAA violations that are not malicious in intent and are not directly related to any alleged act of medical negligence may not be attached to such litigation.</p> <p>(Res. 204, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	
D-330.913	Direct-to-Consumer Advertising of Durable Medical Equipment and Medical Supplies	<p>1. Our AMA will pursue legislation or regulation as appropriate to require that direct-to-consumer advertising and any other media for durable medical equipment (DME) and other medical supplies: (a) include a disclaimer statement to the effect that eligibility for and coverage of the illustrated product is subject to specific criteria and that only a physician can determine if a patient meets those criteria; (b) list the actual criteria (or a summary thereof) from the appropriate source, such as the applicable Certificate of Medical Necessity, DME Information Form (DIF), “Dear Physician Letter” from DME Contractor Medical Directors, Local Coverage Determination or associated policy article; and (c) refrain from statements to the effect that only a physician order or signature is required to obtain the desired items.</p> <p>2. Our AMA recommends that DME companies stop coercive acts which inappropriately influence physicians to sign these prescriptions for their patients.</p> <p>(BOT Rep. 14, A-13)</p>	<p>Sunset this policy.</p> <p>Our AMA has responded to opportunities to testify on direct-to-consumer (DTC) issues that affect the membership. While this reference is to “examining the drug supply chain,” the effect of DTC on the patient-physician is on the record. See: <a href="https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-1-23-Dr-Harmon-Response-to-Pharmaceutical-Distribution-Chain.pdf">https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-1-23-Dr-Harmon-Response-to-Pharmaceutical-Distribution-Chain.pdf</a>.</p> <p>In addition, other AMA policy reaffirmed at the I-22 HOD Meeting covers many of the nuances on this issue: See: <a href="#">Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988</a>.</p>

<b>Policy Number</b>	<b>Title</b>	<b>Text</b>	<b>Recommendation</b>
D-35.984	Physician Supervision of Invasive Procedures and the Provision of Fluoroscopy	<p>1. Our AMA will (a) advocate that interventional chronic pain management including those techniques employing radiation (e.g., fluoroscopy or CT) is within the practice of medicine and should be performed only by physicians, and (b) develop appropriate model state legislation with interested state and medical specialty societies that reflects this policy.</p> <p>2. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies to develop principles to guide advocacy efforts aimed at addressing the appropriate level of supervision, education, training and provision of other invasive procedures by non-physicians including those employing radiologic imaging and report back to our House of Delegates.</p> <p>(BOT Rep. 10, I-11; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.
D-35.990	Limiting the Scope of Practice of Specialist Assistants in Radiology	<p>Our AMA supports the efforts of the American College of Radiology and will work with the Scope of Practice Partnership and interested Federation partners to obtain regulation or legislation which would preclude a Specialist Assistant in Radiology or other non-physician practitioner from rendering an official report of any image produced by any diagnostic imaging technique.</p> <p>(Res. 219, A-06; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.
D-35.996	Scope of Practice Model Legislation	<p>Our AMA Advocacy Resource Center will continue to work with state and specialty societies to draft model legislation that deals with non-physician independent practitioners scope of practice, reflecting the goal of ensuring that non-physician scope of practice is determined by training, experience, and demonstrated competence; and our AMA will distribute to state medical and specialty societies the model legislation</p>	<p>Sunset this policy.</p> <p>This policy has been accomplished. Model legislation has been approved by the Council on Legislation and Board of Trustees and distributed to state and specialty medical societies. Our AMA continues to work</p>



Policy Number	Title	Text	Recommendation
		as a framework to deal with questions regarding non-physician independent practitioners' scope of practice.  (Res. 923, I-03; Reaffirmed: BOT Rep. 28, A-13)	with state and specialty medical societies on this legislation as part of our extensive scope of practice advocacy activities and policy.
D-360.993	Recognition of the "Nurse as Agent" of the Prescriber in Long Term Care Settings	Our AMA will urge the US Drug Enforcement Administration to amend its regulations to recognize nursing staff as agents of the prescriber/physician in long term care facilities.  (Res. 222, A-09; Reaffirmation A-13)	Sunset this policy.  This has been accomplished. See: <a href="https://fpnpc.enpnetwork.com/nurse-practitioner-news/2092-dea-announces-policy-change-recognizing-long-term-care-nurses-as-agents-of-the-prescriber">https://fpnpc.enpnetwork.com/nurse-practitioner-news/2092-dea-announces-policy-change-recognizing-long-term-care-nurses-as-agents-of-the-prescriber</a> .
D-390.955	Flexibility in Medicare Opt-Out and New Safe Harbor	1. Our AMA will seek regulation or legislation to amend the Medicare law to allow physicians to opt out of the Medicare program without a requirement to reaffirm that opt-out. 2. Our AMA will seek legislation and work with the Centers for Medicare & Medicaid Services, as appropriate, to allow for a safe-harbor period for a physician to continue to remain opted out of the Medicare program, without penalty or possibility of recoupment, in those circumstances where the physician has mistakenly not been reaffirming an intention to be opted out.  (Res. 234, A-13)	Retain – this policy remains relevant.
D-390.971	Medicare Reimbursement for Anesthesiologists	Our AMA will continue its advocacy to replace the flawed SGR payment formula, resulting in increases to the Medicare conversion factors and payments to all physicians.  (BOT Action in response to referred for decision Res. 718, I-05; Reaffirmed in lieu of Res. 207, A-13)	Sunset this policy.  The sustainable growth rate (SGR) payment formula was replaced by the Medicare Access and CHIP Reauthorization Act of 2015, which repealed the SGR formula and put in place a new payment system for physicians participating in Medicare.
D-40.993	Inequity in Military Pay for Physicians	Our AMA will work, as appropriate, with other interested organizations, to support immediate reintroduction of a	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		bill based on H.R. 5353 (107th Congress) in this Congress.  (BOT Action in response to referred for decision Res. 901, I-03; Reaffirmed: BOT Rep. 28, A-13)	
D-435.988	Family Protection Act	Our AMA will develop a strategy for promoting bankruptcy reform that is consistent with our AMA's efforts to promote medical liability reform.  (BOT Rep. 9, I-03; Modified: BOT Rep. 28, A-13)	Retain – this policy remains relevant.
D-478.981	Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities	Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits.  (Res. 827, I-10; Reaffirmation I-13)	Sunset this policy.  There has been on-going work in this area across the Department of Health and Human Services, including the Centers for Medicare & Medicaid Services, Office of national Coordinator, Office of Civil Rights, among other federal agencies and research entities. Our AMA consistently comments on this matter as regulations propose changes to HIT standards, existing rules relating to privacy, and interoperability of protected health information. In addition, our AMA has other policy on point: <a href="#">EHR Interoperability D-478.972</a> , <a href="#">Health Information Technology D-478.994</a> , <a href="#">Information Technology Standards and Costs D-478.996</a> , <a href="#">National Health Information Technology D-478.995</a>
H-100.979	Repeal of Federal Regulations	The AMA urges the Drug Enforcement Administration to develop an alternative system for identifying partially filled	Retain – this policy remains relevant.

<b>Policy Number</b>	<b>Title</b>	<b>Text</b>	<b>Recommendation</b>
		<p>prescriptions for Schedule II drugs that does not reveal diagnostic information.</p> <p>(Sub. Res. 511, A-92; Reaffirmed: BOT Rep. 28, A-03; Modified: CSAPH Rep. 1, A-13)</p>	
H-120.969	Dispensing Controlled Substances to Long Term Care Patients	<p>The AMA will work with the Drug Enforcement Administration to amend the Code of Federal Regulations to allow for pharmacy service providers to use appropriately authenticated medication orders from patients' charts in place of an original prescription for controlled substances for long term care patients.</p> <p>(Res. 204, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: Res. 209, A-11; Reaffirmation A-13)</p>	Retain – this policy remains relevant.
H-15.961	Safety for Passengers in the Back of Pickup Trucks	<p>The AMA supports legislation that would prohibit passengers from riding in the cargo bed of a pickup truck.</p> <p>(Res. 409, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain – this policy remains relevant.
H-15.966	Preventing Underride Motor Vehicle Crash Injury	<p>The AMA supports a federal action, regulatory or legislative as appropriate, that would require rear and side impact guards on all new tractor trailers.</p> <p>(Res. 426, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CSAPH Rep. 1, A-13)</p>	Retain – this policy remains relevant.
H-150.932	Reform the US Farm Bill to Improve US Public Health and Food Sustainability	<p>Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders.</p> <p>(Res. 215, A-13)</p>	Retain – this policy remains relevant.
H-160.931	Health Literacy	<p>Our AMA:</p> <p>(1) recognizes that limited patient literacy is a barrier to effective medical</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>diagnosis and treatment;</p> <p>(2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;</p> <p>(3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;</p> <p>(4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;</p> <p>(5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;</p> <p>(6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;</p> <p>(7) encourages the allocation of federal and private funds for research on health literacy;</p> <p>(8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;</p> <p>(9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and</p> <p>(10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.</p>	

Policy Number	Title	Text	Recommendation
		(CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13)	
H-160.950	Guidelines for Integrated Practice of Physician and Nurse Practitioner	<p>Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners:</p> <p>(1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.</p> <p>(2) The physician is responsible for managing the health care of patients in all practice settings.</p> <p>(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.</p> <p>(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.</p> <p>(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.</p> <p>(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.</p> <p>(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.</p> <p>(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.</p> <p>(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.</p> <p>(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.</p> <p>(CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-180.970	Expanded State/Federal Regulation Oversight of Multiple Employer Welfare Arrangements	<p>The AMA supports appropriate federal and state initiatives to regulate and oversee health care plans provided through multiple employer welfare arrangements.</p> <p>(Sub. Res. 204, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-180.998	Regulation of Insurance Carriers and Health Plans	<p>Our AMA believes that organizations financing health care services (e.g., insurance companies, Blue Cross, Blue Shield, HMOs, health and welfare trusts) should be certified at the state level on the basis of financial soundness, and plans should be routinely monitored by the same agency to guard against misrepresentation of costs or benefits. All carriers in a given regulatory jurisdiction should be subject to the same standards.</p> <p>(BOT Rep. A, NCCMC Rec. 7, A-78; Reaffirmed: CLRPD Rep. C, A-89;</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		Reaffirmed: Sunset Report, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)	
H-190.969	Delay in Payments Due to Disputes in Coordination of Benefits	<p>Our AMA:</p> <p>(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;</p> <p>(2) includes the "birthday rule" and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;</p> <p>(3) urges state medical associations to advocate for the inclusion of the "employer first rule" and "birthday rule" in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;</p> <p>(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;</p> <p>(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;</p> <p>(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.</p> <p>(CMS Rep. 8, I-98; Reaffirmation I-04; Reaffirmed in lieu of Res. 729, A-13)</p>	
H-260.973	Cost and Benefits of CLIA '88 and Other Health Regulations	<p>The AMA demands from the government any proven evidence, research, study or any data concerning CLIA '88: (a) showing that this law was actually necessary, and (b) indicating in a quantitative way how any potential benefits of this law outweigh this addition to the already overburdened cost of health care.</p> <p>(Res. 245, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-260.975	Repeal of CLIA	<p>The AMA (1) will work through appropriate regulatory, legislative or judicial channels for changes in CLIA '88 or elimination of those portions of the CLIA '88 regulations that do not improve patient care; and (2) will continue to work to achieve changes that markedly reduce or eliminate the obstacles experienced by physicians under CLIA '88, with the understanding that should this not be successful, the Association shall move to seek legislative repeal of CLIA '88.</p> <p>(Sub. Res. 237, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-260.977	Commission on Office Laboratory Accreditation	<p>The AMA, with state medical and national medical specialty societies, will (1) take immediate action to cause CMS to publish the “deeming” regulations under CLIA '88;</p> <p>(2) take immediate action to assure that applications for deemed status under</p>	Retain – this policy remains relevant.



<b>Policy Number</b>	<b>Title</b>	<b>Text</b>	<b>Recommendation</b>
		<p>CLIA '88 are processed expeditiously and that potential accrediting organizations capable of complying with the regulations are granted deemed status as quickly as possible;</p> <p>(3) take immediate action to cause CMS to delay sending bills for laboratory certification fees until at least 60 days have passed from the time that at least one alternative private sector accrediting body has been granted deemed status; and</p> <p>(4) publicize information about the Commission on Office Laboratory Accreditation (COLA) and encourage that all physicians seek clinical laboratory accreditation through COLA in lieu of federal or other government certification.</p> <p>(Sub. Res. 264, A-92; Reaffirmation I-99; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	
H-270.954	Regulatory Modernization	<p>Our AMA will work with regulatory bodies at the national level to identify outdated regulations and modernize them to better reflect the current state of medical practice.</p> <p>(Res. 225, A-13)</p>	Retain – this policy remains relevant.
H-270.955	Allow Physicians to Receive Dual Use Supplies for In-Office Blood Collection	<p>Our AMA supports legislation allowing physicians to receive a limited supply of dual use supplies proportionate with the number of specimens received by a lab each month.</p> <p>(Res. 208, A-13)</p>	Retain – this policy remains relevant.
H-270.974	Acupuncture	<p>It is the policy of the AMA that nonphysician boards should not regulate the clinical practice of medicine.</p> <p>(CME Rep. M, A-93; Modified: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	Retain – this policy remains relevant.
H-270.977	FDA Intrusion into the Practice of Medicine	The AMA strongly opposes the FDA's intrusion into the practice of medicine by making decisions for individual care and mandated informed consent documents	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>written without the input of specialists in the related field of medicine.</p> <p>(Res. 544, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	
H-285.985	Discrimination Against Physicians by Health Care Plans	<p>Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans;</p> <p>(2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans;</p> <p>(3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need;</p> <p>(4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and</p> <p>(5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(BOT Rep. 18, I-93; Appended by BOT Rep. 28, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 110, A-13)	
H-290.988	Monitoring of State Medicaid DUR Programs	<p>The AMA will continue to monitor the progress, quality and problems associated with the Omnibus Budget Reconciliation Act of 1990 mandated state Medicaid Drug Use Review (DUR) programs and assure that DUR programs focus on the quality of patient care and use appropriate scientifically based criteria to evaluate individual patient therapy and the effectiveness of physician and pharmacist activities.</p> <p>(Res. 526, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	<p>Sunset this policy.</p> <p>Our AMA has adopted broader Drug Use Review policy. See: <a href="#">Principles of Drug Utilization Review H-120.978</a> and <a href="#">Drug Utilization Review H-120.981</a>.</p>
H-30.951	Boating Under the Influence	<p>It is the policy of the AMA to support stringent enforcement of regulations regarding boating under the influence of alcohol and other drugs.</p> <p>(Res. 405, I-93; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)</p>	Retain – this policy remains relevant.
H-315.989	Confidentiality of Computerized Patient Records	<p>The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.</p> <p>(BOT Rep. F, A-93; Reaffirmation I-99; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed in lieu of Res. 818, I-07; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 17, A-13)</p>	<p>Sunset this policy.</p> <p>This policy has been superseded by more recent policy. See: <a href="#">Ransomware and Electronic Health Records D-478.960, Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973, Code of Medical Ethics 3.3.2 Confidentiality &amp; Electronic Medical Records</a>.</p>

<b>Policy Number</b>	<b>Title</b>	<b>Text</b>	<b>Recommendation</b>
H-330.887	Submitting Recommendations to Medicare	<p>Our AMA will work with the Centers for Medicare &amp; Medicaid Services and seek federal legislation, if necessary, to provide that the Center for Medicare and Medicaid Innovation Center website accept suggestions from physicians to improve health care and/or reduce costs, acknowledge submission by receipt, and notify the individual of the decision on possible implementation with an explanation of the reasons for the decision and, if the decision is deemed worthy, the submitter should be informed and encouraged to participate in further developing the idea if they wish to remain involved.</p> <p>(Res. 226, A-13)</p>	Retain – this policy remains relevant.
H-330.922	Waiver of Copayments of Certain Medicare Patients	<p>Our AMA seek legislative and/or regulatory action that permits physicians in the exercise of their judgment to provide free medical services and/or waive deductibles and co-payments for patients with Medicare, Medicaid, and other health insurance.</p> <p>(Res. 254, A-98; Reaffirmation I-98; Modified: BOT Rep. 12, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-330.945	Durable Medical Equipment Requirements	<p>Our AMA will: (1) continue to seek legislation to prohibit unsolicited contacts by durable medical equipment suppliers that recommend medically unnecessary durable medical equipment to Medicare beneficiaries; (2) affirm the concept that members of a physician-led interprofessional health care team be enabled to perform delegated medical duties, including ordering durable medical equipment, that they are capable of performing according to their education, training and licensure and at the discretion of the physician team leader; (3) advocate that the initiators of orders for durable medical equipment should be a physician, or a nurse practitioner or physician assistant supervised by a physician within their care team, consistent with state scope of</p>	Retain – this policy remains relevant.

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		<p>practice laws; and (4) reaffirm the concept that physicians are ultimately responsible for the medical needs of their patients.</p> <p>(Sub. Res. 205, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmation A-04; Reaffirmed: BOT Rep. 14, A-13; Modified in lieu of Res. 802, I-13)</p>	
H-330.951	Non-Routine Waiver of Copayments and Deductibles Under Medicare Part B for Indigent Patients	<p>The AMA will seek promulgation of a safe harbor provision by the Office of Inspector General, U.S. Department of Health and Human Services, for the non-routine waiver of Medicare Part B copayments and deductibles for indigent patients.</p> <p>(Res. 210, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-330.960	Cost of Medically Related Services and Supplies	<p>The AMA legislative or other appropriate department will seek a requirement that CMS and/or their contracted home health agencies, durable medical equipment suppliers, and non-emergency transportation services, provide cost estimates to physicians, to be provided along with the physician authorization form.</p> <p>(Res. 812, A-92; Reaffirmed by Rules &amp; Credentials Cmt., A-96; Reaffirmation A-99; Reaffirmation A-04; Reaffirmation A-08; Reaffirmed: BOT Rep. 14, A-13)</p>	Retain – this policy remains relevant.
H-330.992	Medicare Definition of Physician	<p>The AMA supports limiting the application of the definition of the term “physician” under the Medicare program to doctors of medicine or osteopathy.</p> <p>(Sub. Res. 101, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: Res. 821, I-09; Reaffirmation A-13)</p>	Retain – this policy remains relevant.
H-350.976	Improving Health Care of American Indians	<p>Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal</p>	Retain – this policy remains relevant.

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		<p>rights and privileges as other U.S. citizens.</p> <p>(2) The federal government provide sufficient funds to support needed health services for American Indians.</p> <p>(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.</p> <p>(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.</p> <p>(5) Our AMA recognize the “medicine man” as an integral and culturally necessary individual in delivering health care to American Indians.</p> <p>(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.</p> <p>(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.</p> <p>(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.</p> <p>(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.</p> <p>(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.</p> <p>(11) Our AMA strongly supports those</p>	

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		<p>bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.</p> <p>(CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)</p>	
H-350.977	Indian Health Service	<p>The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) <u>Indian Population</u>: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.</p> <p>(2) <u>Federal Facilities</u>: Based on the distribution of the eligible population, transportation facilities and roads, and</p>	Retain – this policy remains relevant.

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		<p>the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.</p> <p>(3) <u>Manpower</u>: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.</p> <p>(4) <u>Medical Societies</u>: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided</p>	



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		<p>under their direction, including professional consultation and involvement in society activities should be pursued.</p> <p>(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.</p> <p>(CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)</p>	
H-355.989	Access to National Practitioner Data Bank “Self-Query” Reports	<p><del>(1) The AMA again requests a written opinion from the Health Resources and Services Administration's Bureau of Health Professions and/or the HHS Office of the Inspector General, as to the confidentiality of National Practitioner Data Bank (NPDB) information that is received directly or indirectly from the NPDB. (21) The AMA recommends that</del></p> <p>physicians who are compelled to release information received from the NPDB to entities not authorized to access the NPDB require that such entity provide them with written documentation that: information disclosed to the entity will be protected from further disclosure under the relevant state peer review immunity statute(s); that the requirements that the physician self-query the NPDB and disclose the information to the entity is in compliance with the intent and protections of the Health Care Quality Improvement Act of 1986; that the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under the relevant state peer review immunity statute(s); and that the entity will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act of 1986. (32) The AMA will provide model language until such legislation is enacted that physicians can use to protect</p>	<p>Retain this policy in part.</p> <p>Delete clause (1). The <a href="#">National Practitioner Data Bank Guidebook</a> specifies that information reported to the NPDB is confidential and cannot be disclosed except as specified in the NPDB statutes and that the Office of the Inspector General can impose civil money penalties on those who violate the confidentiality provisions.</p>

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		<p>confidentiality when they release information received from the NPDB to entities not authorized to access the NPDB. The AMA urges state and county medical societies to develop a mechanism physicians can use to report problems they encounter with these entities.</p> <p>(BOT Rep. L, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	
H-355.990	National Practitioner Data Bank	<p>(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB). (2) The AMA requests that the Health Resources and Services Administration <del>(a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner's self query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than \$30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (eb) and allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB's first year of operation to the AMA by July 1992. (3)</del></p>	<p>Retain this policy in part.</p> <p>Delete clauses (2)(a)(b)(c)(f) and clause (3), which are no longer relevant. Regarding clause (3), Policy H-355.991 was rescinded in 2014.</p>

Policy Number	Title	Text	Recommendation
		<p><del>The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991.</del></p> <p>(BOT Rep. QQ, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	
H-360.983	Registered Nurse Participation in Epidural Analgesia	<p>Our AMA, consistent with the American Society of Anesthesiologists position statement adopts the following statement on the administration of epidural analgesia: In order to provide optimum patient care, it is essential that registered nurses participate in the management of analgesic modalities. A registered nurse--qualified by education, experience and credentials--who follows a patient-specific protocol written by a qualified physician should be allowed to adjust and discontinue catheter infusions.</p> <p>(Res. 530, A-03; Reaffirmed: CME Rep. 2, A-13)</p>	Retain – this policy remains relevant.
H-360.987	Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice	<p>Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.</p> <p>(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.</p> <p>(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.</p> <p>(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.</p> <p>(5) Physicians should encourage state</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.</p> <p>(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.</p> <p>(BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-360.988	Nurse Practitioner Reimbursement Under Medicare	<p>Our AMA supports provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician's supervision and direction regardless of whether such services are performed where the physician is physically present, so long as the ultimate responsibility for these services rests with the physician and so long as the services are provided in conformance with applicable state laws. With regard to physician assistants, such supervision in most settings includes the personal presence or participation of the physician. In certain practice settings where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, appropriate site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times.</p> <p>(BOT Rep. UU, A-90; Reaffirmed: CMS Rep. 1, I-934; Reaffirmed: Res. 240 and Reaffirmation A-00; Reaffirmation A-</p>	Retain – this policy remains relevant.

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		02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed in lieu of Res. 207, A-13)	
H-365.983	Occupational Safety and Health Administration Regulations	<p>The AMA (1) will work to modify the Occupational Safety and Health Administration regulations on Occupational Exposure to Bloodborne Pathogens to address its practicality and to make physician compliance possible; and (2) in conjunction with other national health provider groups, will work with Congress and other government regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact.</p> <p>(Res. 242, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-370.962	Equal Access to Organ Transplantation for Medicaid Beneficiaries	<p>Our AMA supports federal funding of organ transplants for Medicaid patients.</p> <p>(BOT Rep. 15, A-13)</p>	Retain – this policy remains relevant.
H-375.995	Implementation of Voluntary Medical Peer Review	<p>The AMA: (1) reaffirms its policy that “peer review should be assigned the highest priority by state and county medical societies; that where these mechanisms exist, they should be strengthened, and where they do not exist they should be promptly established;” (2) recognizes the propriety of peer review organizations contracting with public as well as private organizations for financing of their review services, so long as professional direction and control are maintained; and (3) supports the development of public information programs to inform consumers about existing and newly developed quality assurance activities.</p> <p>(CMS Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Modified: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-390.885	Advance Payments During Medicare Slow-Downs	The AMA will continue to seek legislation requiring CMS to make interim payments available to physicians	Retain – this policy remains relevant.

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		<p>when disruptions in Medicare claims processing result in undue delays in the normal flow of Medicare payments.</p> <p>(Sub. Res. 242, A-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	
H-400.973	Limited Licensed Practitioners and RBRVS	<p>It is the policy of the AMA to advocate that Medicare expenditure data clearly differentiate between the services of fully licensed physicians and those of limited licensed practitioners and of other Part B services.</p> <p>(Sub. Res. 124, I-91; Reaffirmed: BOT Rep. DD, I-92; Modified: CMS Rep. 10, A-03; Modified: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-405.992	“Doctor” as a Title	<p>The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title “Doctor,” which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.</p> <p>(Res. 138, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: Res. 218, A-12)</p>	Retain – this policy remains relevant.
H-410.950	Pain Management	<p>Our AMA adopts the following guidelines on Invasive Pain Management Procedures for the Treatment of Chronic Pain, Including Procedures Using Fluoroscopy:</p> <p>Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of</p>	Retain – this policy remains relevant.

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		<p>complications, and collaboration with other health care providers.</p> <p>Invasive pain management procedures include interventions throughout the course of diagnosing or treating pain which is chronic, persistent and intractable, or occurs outside of a surgical, obstetrical, or post- operative course of care. Invasive pain management techniques include:</p> <ol style="list-style-type: none"> <li>1. ablation of targeted nerves;</li> <li>2. procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and</li> <li>3. surgical techniques, such as laser or endoscopic disectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators.</li> </ol> <p>At present, invasive pain management procedures do not include major joint injections (except sacroiliac injections), soft tissue injections or epidurals for surgical anesthesia or labor analgesia.</p> <p>When used for interventional pain management purposes such invasive pain management procedures do not consist solely of administration of anesthesia; rather, they are interactive procedures in which the physician is called upon to make continuing adjustments based on medical inference and judgments. In such instances, it is not the procedure itself, but the purpose and manner in which such procedures are utilized, that demand the ongoing application of direct and immediate medical judgment. These procedures are therefore within the practice of medicine, and should be</p>	

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		<p>performed only by physicians with appropriate training and credentialing.</p> <p>Invasive pain management procedures require physician-level training. However, certain technical aspects of invasive pain management procedures may be delegated to appropriately trained, licensed or certified, credentialed non-physicians under direct and/or personal supervision of a physician who possesses appropriate training and privileges in the performance of the procedure being supervised, and in compliance with local, state, and federal regulations. Invasive pain management procedures employing radiologic imaging are within the practice of medicine and should be performed only by physicians with appropriate training and credentialing.</p> <p>(BOT Rep. 16, A-13)</p>	
H-410.951	Physician Practice Drift	<p>Our AMA will: (1) continue to work with interested state and national medical specialty societies to advance truth in advertising legislation, and (2) continue to monitor legislative and regulatory activity related to physician practice drift.</p> <p>(BOT Rep. 5, A-13)</p>	Retain – this policy remains relevant.
H-410.958	Interventional Pain Management: Advancing Advocacy to Protect Patients from Treatment by Unqualified Providers	<p>Our AMA: (1) encourages and supports state medical boards and state medical societies in adopting advisory opinions and advancing legislation, respectively, that interventional pain management of patients suffering from chronic pain constitutes the practice of medicine; and (2) will work to ensure that interventional pain management is the practice of medicine and the treatment rendered to patients by qualified MDs and DOs is directed by best evidence. Further, our AMA will collect, synthesize and disseminate information regarding the educational programs in pain management and palliative care offered by nursing programs and medical</p>	Retain – this policy remains relevant.



<b>Policy Number</b>	<b>Title</b>	<b>Text</b>	<b>Recommendation</b>
		<p>schools in order to demonstrate adherence to current standards in pain management.</p> <p>(Res. 903, I-07; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-425.970	Promoting Health Awareness and Preventive Screenings in Individuals with Disabilities	<p>Our AMA will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities.</p> <p>(Res. 911, I-13)</p>	Retain – this policy remains relevant.
H-435.964	Federal Preemption of State Professional Liability Laws	<p>The AMA supports professional liability reform on the federal level that will preempt state constitutional, statutory, regulatory and common laws that prohibit a cap on liability awards; and such federal legislation shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation.</p> <p>(Res. 237, A-95; Reaffirmed: Sub. Res. 910, I-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-435.965	“Clear and Convincing” Standard of Proof in Medical Liability Cases	<p>1. The AMA continues to support the use of the clear and convincing evidence standard of proof in medical negligence cases in which the plaintiff seeks punitive damages and will continue to advocate civil justice reform designed to prevent non-meritorious claims from being filed or to quickly resolve them before extensive litigation proceeds.</p> <p>2. Our AMA will continue to work with interested state and specialty societies on legislation adopting the clear and convincing evidence standard.</p> <p>(BOT Rep. 51, A-94; Reaffirmed: BOT Rep. 12, A-05; Appended: BOT Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-435.966	Prohibit Third Party Payers from Requiring	The AMA finds unreasonable the demand by any hospital or third party payer that their providers carry	Retain – this policy remains relevant.

<b>Policy Number</b>	<b>Title</b>	<b>Text</b>	<b>Recommendation</b>
	Professional Liability Coverage Beyond Mandated Limits	<p>professional liability coverage in excess of the minimum mandated of physicians by state law; and will design and distribute model legislation that prevents any health care institution or third party payer from requiring their physicians to carry professional liability coverage in excess of the minimum mandated by law.</p> <p>(Res. 203, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	
H-435.998	Equitable Risk Classification in Medical Liability Premiums	<p>Our AMA supports the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles. Further, the policy of the AMA is that physicians who practice part-time should be entitled to reduced professional liability insurance premiums.</p> <p>(Res. 15, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed and Appended: CMS Rep. 12, A-02; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)</p>	Retain – this policy remains relevant.
H-440.926	United States Surgeon General	<p>The AMA, in order to best protect the health care needs of the American people, will seek changes in federal law to require that the Surgeon General of the United States be an MD/DO, whether the Surgeon General is confirmed by the U.S. Senate or appointed to serve on an acting or interim basis.</p> <p>(Sub. Res. 211, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)</p>	Retain – this policy remains relevant.
H-475.986	Surgical Assistants other than Licensed Physicians	<p>Our AMA: (1) affirms that only licensed physicians with appropriate education, training, experience and demonstrated current competence should perform surgical procedures;</p> <p>(2) recognizes that the responsible surgeon may delegate the performance of part of a given operation to surgical</p>	<p>Retain this policy in part.</p> <p>Delete the reference to the American College of Surgeons' (ACS) Statements on Principles. ACS has changed their</p>

Policy Number	Title	Text	Recommendation
		<p>assistants, provided the surgeon is an active participant throughout the essential part of the operation. Given the nature of the surgical assistant's role and the potential of risk to the public, it is appropriate to ensure that qualified personnel accomplish this function;</p> <p>(3) policy related to surgical assistants <del>consistent with the American College of Surgeons' Statements on Principles</del> states: (a) The surgical assistant is limited to performing specific functions as defined in the medical staff bylaws, rules and regulations. These generally include the following tasks: aid in maintaining adequate exposure in the operating field, cutting suture materials, clamping and ligating bleeding vessels, and, in selected instances, actually performing designated parts of a procedure.</p> <p>(b) It is the surgeon's responsibility to designate the individual most appropriate for this purpose within the bylaws of the medical staff. The first assistant to the surgeon during a surgical operation should be a credentialed health care professional, preferably a physician, who is capable of participating in the operation, actively assisting the surgeon.</p> <p>(c) Practice privileges of individuals acting as surgical assistants should be based upon verified credentials and the supervising physician's capability and competence to supervise such an assistant. Such privileges should be reviewed and approved by the institution's medical staff credentialing committee and should be within the defined limits of state law. Specifically, surgical assistants must make formal application to the institution's medical staff to function as a surgical assistant under a surgeon's supervision. During the credentialing and privileging of surgical assistants, the medical staff will review and make decisions on the individual's qualifications, experience, credentials, licensure, liability coverage</p>	policy related to surgical assistants.

Policy Number	Title	Text	Recommendation
		<p>and current competence.</p> <p>(d) If a complex surgical procedure requires that the assistant have the skills of a surgeon, the surgical assistant must be a licensed surgeon fully qualified in the specialty area. If a complication requires the skills of a specialty surgeon, or the surgical first assistant is expected to take over the surgery, the surgical first assistant must be a licensed surgeon fully qualified in the specialty area.</p> <p>(e) Ideally, the first assistant to the surgeon at the operating table should be a qualified surgeon or resident in an education program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) and/or the American Osteopathic Association (AOA). Other appropriately credentialed physicians who are experienced in assisting the responsible surgeon may participate when a trained surgeon or a resident in an accredited program is not available. The AMA recognizes that attainment of this ideal in all surgical care settings may not be practicable. In some circumstances it is necessary to utilize appropriately trained and credentialed unlicensed physicians and non-physicians to serve as first assistants to qualified surgeons.</p> <p>(BOT Rep. 32, A-99; Reaffirmed: Res. 240, 708, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)</p>	
H-475.989	Laser Surgery	<p>Our AMA (1) adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services; and (2) encourages state medical associations to support state legislation and rulemaking in support of this policy.</p> <p>(Sub. Res. 39, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 16, A-13)</p>	Retain – this policy remains relevant.

<b>Policy Number</b>	<b>Title</b>	<b>Text</b>	<b>Recommendation</b>
H-480.947	Medical Patents and Their Infringement on the Art of Medicine	Our AMA supports for the Ganske Compromise and discourages the medical community from soliciting patents on medical methodology.  (BOT Action in response to referred for decision Res. 223, A-03; Modified: CSAPH Rep. 1, A-13)	Sunset this policy.  AMA Code of Medical Ethics <a href="#">7.2.3 Patents &amp; Dissemination of Research Products</a> , modified in 2017, captures the intent of this older policy.
H-520.986	The Future of Genito-Urinary Treatment and Research	1. Our AMA supports legislation and/or regulations to ensure both Active Duty members of the Armed Forces and Veterans suffering from genito-urinary injuries receive the best possible surgical and mental health care. 2. Our AMA, in consultation with relevant medical specialty societies, will promote the study of genito-urinary trauma in members of the Armed Forces and Veterans to improve the diagnosis, prevention and treatment of genito-urinary injuries.  (Res. 227, A-13)	Retain – this policy remains relevant.
H-60.959	Uniformity of State Adoption and Child Custody Laws	The AMA urges: (1) state medical societies to support the adoption of a Uniform Adoption Act that places the best interest of the child as the most important criteria; (2) the National Conference of Commissioners on Uniform State Laws to include mandatory pre-consent counseling for birth parents as part of its proposed Uniform Adoption Act; and (3) state medical societies to support adoption of child custody statutes that place the “best interest of the child” as the most important criterion determining custody, placement, and adoption of children.  (Sub. Res. 219, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13)	Sunset this policy.  The Uniform Adoption Act was retired as an act of the Uniform Law Commission (ULC, previously known as the National Conference of Commissioners on Uniform State Laws) in July 2017. According to ULC meeting minutes, the ULC discontinued the uniform act because it had only been adopted by one state and contained outdated provisions.
H-60.969	Childhood Immunizations	1. Our AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine.</p> <p>2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics.</p> <p>3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards.</p> <p>4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation.</p> <p>5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age.</p> <p>6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare &amp; Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.</p> <p>(Res. 542, A-92; CSA Rep. 4, I-95; Reaffirmed by BOT Rep. 24, A-97; Reaffirmation A-05; Appended: Res. 121, A-13)</p>	
H-70.939	Definition of Consultation: CMS vs. CPT 4 Coding Manual	<p>(1) Our AMA and the Federation make known to CMS that redefining consultation to achieve cost savings is unacceptable to the medical profession.</p> <p>(2) That if necessary the AMA seek regulatory and/or legislative relief to overcome this regulatory decision on the</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>part of CMS. (3) Our AMA urges the CPT Editorial Panel to review the CPT definitions for consultations and make any needed clarifications.</p> <p>(Res. 822, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12)</p>	

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-23

Subject: HPSA and MUA Designation For SNFs  
(Resolution 224-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee B

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At the June 2022 Annual Meeting, the House of Delegates referred Resolution 224-A-22, “HPSA and MUA Designation for SNFs,” sponsored by the Society for Post-Acute and Long-Term Care Medicine (AMDA). Resolution 224-A-22 asked the American Medical Association (AMA) to advocate for legislative action directing the U.S. Department of Health and Human Services (HHS) to “designate all skilled nursing facilities (SNFs), irrespective of their geographic location, as health professional shortage areas (HPSAs) and/or medically underserved areas (MUAs) to facilitate recruitment and retention of health professionals using the usual and customary support made available for such designations.”

Testimony regarding this resolution was generally positive, highlighting the benefits of HPSA and MUA designations to areas in need of additional health care resources. Testimony indicated that, due to a rapidly aging population (along with the lack of commensurate increases in medical school and residency positions, early retirement of health care professionals from burnout and the pandemic, and a lack of direct incentives to practice in senior living communities), there is an acute shortage of health care professionals, including physicians, nurses, and clinical practitioners in nursing facilities. Testimony also indicated that the 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. In addition, testimony stated that AMA policy includes clear instruction for the AMA to support legislation and encourage federal and state governments to provide financial assistance to assist physician practices in shortage areas. Due to the mixed testimony provided, Resolution 224-A-22 was referred. This report focuses on physician shortages in the U.S. and the need to incentivize physicians to practice in nursing facilities and to facilitate recruitment and retention of health professionals in these settings.

### BACKGROUND

Physician shortage is a significant issue in the U.S. To address this issue, the federal government developed HPSA and MUA designations used to identify areas and population groups that experience physician shortages and to improve access to health care for patients in these areas. It is projected that by 2032 there will be a 50 percent growth in the population of those aged 65 and older, compared with only a 3.5 percent growth for those aged 18 or younger.<sup>1</sup> By 2033 it is estimated that there will be a shortage of between 54,100 and 139,000 physicians, which includes a projected primary care physician shortage of between 21,400 and 55,200, as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.<sup>2</sup> Furthermore, the COVID-19 pandemic put an incredible strain on our health care system and drastically exacerbated physician shortages in many rural and underserved areas across the country, which forced states to take



1 extraordinary measures such as recalling retired physicians, expanding scope of practice, and  
2 temporarily amending out of state licensing laws.<sup>3</sup> However, none of these adjustments are  
3 expected to permanently fill the physician shortage gap in the long term.

#### 4 5 HEALTH PROFESSIONAL SHORTAGE AREAS AND MEDICALLY UNDERSERVED 6 AREAS

7  
8 HPSAs are intended to improve access to health care in areas, population groups, or facilities  
9 within the U.S. that experience physician shortages. This designation allows physicians to gain  
10 eligibility for financial incentives, such as loan repayment and scholarships, that can help attract  
11 and retain physicians in rural and underserved areas, which typically experience physician  
12 shortages. However, according to a report by the Government Accountability Office (GAO), only  
13 about one-third of primary care shortage areas were designated as HPSAs as of 2019.<sup>4</sup>

14  
15 MUAs, like HPSAs, allow physicians to be eligible for financial incentives, such as loan repayment  
16 and scholarships, to help attract and retain physicians in shortage areas. In addition, MUAs can  
17 increase the availability of primary care services in areas with high poverty rates. Similar to  
18 HPSAs, MUAs may not cover all shortage areas and the financial incentives may not be enough to  
19 attract and retain physicians.

#### 20 21 ADDITIONAL CONSIDERATIONS

22  
23 To provide financial incentives for physicians who work in shortage areas, several programs have  
24 been implemented to address the financial burden of medical education, which is a major barrier to  
25 physicians choosing to work in shortage areas. In addition, the federal government has  
26 implemented several programs to incentivize physicians and other health care providers to work in  
27 underserved areas and with underserved populations.

#### 28 29 *Incentivizing Physicians and Medical Students*

30  
31 The National Health Service Corps (NHSC) is a federal program that provides scholarships to  
32 medical students starting at the beginning of medical school, and loan repayment post completion  
33 of residency training in a primary care specialty, for a minimum of two years commitment work in  
34 HPSAs throughout the United States and United States territories. The NHSC also has scholarship  
35 and loan repayment programs for dentists, nurse practitioners, nurse midwives, and physician  
36 assistants.<sup>5</sup> In addition to the NHSC, the Indian Health Service (IHS) is a federal program that  
37 provides loan repayment and housing assistance to physicians and other health care providers who  
38 work in Indian Health Service facilities. The IHS is intended to improve the health status of  
39 American Indian and Alaska Native people by increasing access to health care services.<sup>6</sup>

40  
41 To incentivize medical students, some medical schools offer scholarships to students who commit  
42 to working in underserved areas after graduation. For example, the University of Washington  
43 School of Medicine offers the WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho)  
44 program, which provides scholarships to medical students who commit to certain states that  
45 experience physician shortages after graduation.<sup>7</sup> In addition, medical schools may partner with  
46 health care facilities in underserved areas to provide clinical experiences for students, which can  
47 help attract and retain health care professionals.

## J-1 AND H-1B VISAS

As a strategy to help provide additional physicians, international medical graduates (IMGs) often work in rural and underserved areas.<sup>8</sup> In 2017, nearly 30 percent of medical residents were IMGs, with about half working as physicians on non-immigrant visas.<sup>9</sup> The AMA recognizes that it is important to support and create pathways for these physicians to be able to remain in the U.S. and care for their patients.

J-1 visas attract foreign medical graduates with the needed expertise to work in nursing facilities and assisted living facilities where they can help improve the quality of care for patients. By expanding the J-1 visa program to include geriatrics and post-acute and long-term care as designated areas of need, the U.S. can attract more qualified physicians to work in these care settings keeping in mind that J-1 visa programs must have language requirements to ensure that clinicians have a sufficient level of proficiency in English to communicate effectively with patients and other health care workers.

H-1B visas are a type of temporary work visa that allow foreign workers to enter and work in the U.S. in specialty occupations. In health care, this can include physicians who have completed their medical training outside the U.S. and want to practice in the U.S. H-1B visa programs can be effective in addressing the shortage of qualified clinicians in nursing facilities and assisted living, particularly in underserved areas.

## LOAN FORGIVENESS INCENTIVES

Loan forgiveness programs can be an effective way to incentivize clinicians to work in nursing facilities. These programs provide financial assistance to clinicians in exchange for a commitment to work in an underserved area. By providing financial incentives, loan forgiveness programs can help address physician shortages in nursing and assisted living facilities.

## AMA POLICY

AMA policy supports legislation to extend the 10 percent Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' HPSA status (Policy H-465.981, "Enhancing Rural Physician Practices"). The same policy supports legislation that would allow physician practices in shortage areas to qualify as Rural Health Clinics without the need to employ one or more physician extenders and directs the AMA to undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities. This policy recognizes that many rural and low-income areas may have difficulty attracting and retaining physicians with specialized training, including geriatricians, and seeks to address this issue through targeted financial and non-incentives. Additionally, Policy H-200.972, "Primary Care Physicians in Underserved Areas", provides a plan for the AMA to improve the recruitment and retention of physicians in underserved areas with underserved populations and can also help to address the shortage of physicians, including those with geriatrics training, in these areas.

AMA policy also supports efforts to quantify the geographic maldistribution and physician shortage in many specialties and encourages medical schools and residency programs to consider developing admissions policies, practices, and targeted educational efforts aimed at attracting physicians to practice in shortage areas and to provide care to underserved populations; encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other shortage areas as a means to support educational

program objectives and to influence the choice of graduates' practice locations; and encourages medical schools to include criteria and processes in the admission of medical students that are predictive of graduates' eventual practice in shortage areas and with underserved populations (Policy H-200.954, "US Physician Shortage.")

AMA policy also supports full appropriation for the NHSC Scholarship Program, with the provision that medical schools serving states with large rural and underserved populations have a priority and significant voice in the selection of recipients for those scholarships (Policy H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage.")

## DISCUSSION

The shortage of physicians and other qualified clinicians in skilled nursing facilities and assisted living facilities is a growing problem that has a significant impact on patient care. Patients in these settings often have complex medical needs and require specialized care from physicians with expertise in geriatrics and post-acute and long-term care (PALTC). Increasing the supply of qualified physicians (e.g. geriatricians) to SNFs will help to improve the quality of care provided, decrease medical errors, and improve outcomes as the need for physicians with additional training in geriatrics and PALTC continues to grow as the population ages.

Further, improving care in underserved areas and populations is a critical issue in our country. However, designating all SNFs, irrespective of their geographic location, as a HPSA or MUA would be a fundamental shift away from viewing geographic areas and populations as a designation criteria to looking at a specific type of facility, including facilities that may be located outside a HPSA/MUA or facilities that are not financially disadvantaged. Also, the goal of the resolution looks beyond facilitating the recruitment and retention of physicians to potentially extend the HPSA/MUA incentive to non-physicians. AMA policy supports a physician-led team with regard to mid-level trained health care workers such as nurse practitioners, nurse midwives, and physician assistants.

Under the current system, HPSA and MUA designations are a valuable tool for identifying areas with a shortage of physicians and other health care providers, which can help allocate resources to improve access to health care services. Rather than designating a specific type of facility, such as SNFs, they provide a broader framework for addressing health care disparities and physician shortage issues. Regarding scope of practice concerns, SNFs often rely on a team-based approach to care, which includes physicians, nurse practitioners, and other health care professionals. However, without a physician leading the care team, there is a risk that the overall quality of care as well as resident training may suffer. Physicians play a critical role in providing guidance and oversight to the care team, ensuring that residents receive appropriate training and education. In this regard, it is important to note that, to the extent that SNF patients are in a HPSA, MUA, or generally in an underserved area, the AMA already has policy<sup>10</sup> in place to incentivize physicians to practice in those areas.

## CONCLUSION

The Board of Trustees (Board) recognizes that the shortage of physicians in SNFs is a critical issue and shares the goal of ensuring that patients in SNFs receive high-quality care and believes that Resolution 224-A-22 provides another example of how the shortage of physicians is impacting patient access to care, including in SNFs. However, the solution offered in this resolution would fundamentally change how shortage areas and underserved populations are determined and raises scope of practice concerns. As discussed above, the AMA has existing policy that more broadly

addresses the physician shortage issue and can be applied in a way to address the shortage of physicians practicing in SNFs. These policies include efforts to quantify geographic maldistribution, encourage medical schools and residency programs to provide courses and experiences in underserved areas, and support the NHSC Scholarship Program. The Board, therefore, recommends reaffirmation of existing policy in lieu of adopting Resolution 224-A-22.

## RECOMMENDATIONS

The Board of Trustees recommends that the following policies be reaffirmed in lieu of Resolution 224-A-22, and the remainder of the report be filed:

1. That our AMA reaffirm Policy [H-465.981](#), which asks our AMA to:
  - a. support legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status;
  - b. encourage federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements;
  - c. explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result;
  - d. supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders; and
  - e. undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy [H-200.972](#), "Primary Care Physicians in Underserved Areas", which provides a plan for the AMA to improve the recruitment and retention of physicians in underserved areas with underserved populations. (Reaffirm HOD Policy)
3. That our AMA reaffirm Policy [H-280.979](#), which asks our AMA to support the following:
  - a. continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;
  - b. continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;
  - c. efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and
  - d. assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting. (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy [D-200.980](#), which asks our AMA to advocate for the following:
  - a. Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations;
  - b. Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program;

- 1 c. Adequate funding for programs under Title VII of the Health Professions Education  
2 Assistance Act that support educational experiences for medical students and resident  
3 physicians in underserved areas; and  
4 d. Encourages medical schools and their associated teaching hospitals, as well as state medical  
5 societies and other private sector groups, to develop or enhance loan repayment or scholarship  
6 programs for medical students or physicians who agree to practice in underserved areas or  
7 with underserved populations.  
8 (Reaffirm HOD Policy)  
9  
10 5. That our AMA reaffirm Policy [H-200.954](#), which encourages medical schools and residency  
11 programs to consider developing admissions policies and practices and targeted educational  
12 efforts aimed at attracting physicians to practice in underserved areas and to provide care to  
13 underserved populations. (Reaffirm HOD Policy)  
14  
15 6. That our AMA reaffirm Policy [H-465.988](#), which provides educational strategies for meeting  
16 rural health physician shortages. (Reaffirm HOD Policy)

Fiscal Note: Less than \$5000.

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<sup>1</sup> <https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf>.

<sup>2</sup> AAMC (2020, June) The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC: <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projectionsjune-2020.pdf>.

<sup>3</sup> <https://www.nashp.org/states-address-provider-shortages-to-meet-the-health-care-demands-of-the-pandemic>.

<sup>4</sup> U.S. Government Accountability Office. (2020). Health Professional Shortage Areas: Opportunities Remain to Improve Designation Process. GAO-21-47.

<sup>5</sup> <https://nhsc.hrsa.gov/>.

<sup>6</sup> <https://www.ihs.gov/>.

<sup>7</sup> <https://www.uwmedicine.org/school-of-medicine/md-program/wwami>.

<sup>8</sup> <https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained-doctors-are-critical-to-serving-many-us-communities.pdf>.

<sup>9</sup> <https://www.americanprogress.org/article/immigrant-doctors-can-help-lower-physician-shortages-rural-america>.

<sup>10</sup> AMA Policy [D-200.980](#), Effectiveness of Strategies to Promote Physician Practice in Underserved Areas; [H-200.972](#), Primary Care Physicians in Underserved Areas; [H-200.954](#), US Physician Shortage H-200.954; [H-465.988](#), Educational Strategies for Meeting Rural Health Physician Shortage.

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-23

Subject: Promoting Proper Oversight and Reimbursement for Specialty Physician  
Extenders and Non-Physician Practitioners  
(Resolution 248-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee B

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### 1 INTRODUCTION

2  
3 At the 2022 Annual Meeting, the American Medical Association (AMA) House of Delegates  
4 (HOD), referred Resolution 248-A-22 for report at the 2023 Annual Meeting. The resolution was  
5 introduced by the Organized Medical Staff Section and asks:

6  
7 [That] our AMA work with state medical boards to improve oversight and coordination of the  
8 work done with physician extenders and non-physician practitioners (Directive to Take  
9 Action); and be it further

10  
11 That our AMA adopt the position that Boards of Medical Examiners or its equivalent in each  
12 state should have oversight of cases involving specialty care as boards with oversight over  
13 physician extenders and non-physician practitioners do not have the training to oversee  
14 specialty care (New HOD Policy); and be it further

15  
16 That our AMA adopt the position that in each state the Board of Medical Examiners or its  
17 equivalent should have oversight over physician extenders and non-physician practitioners if  
18 billing independently or in independent practice as their respective oversight boards do not  
19 have experience providing accurate oversight for specialty care (New HOD Policy).

20  
21 The Reference Committee heard that our AMA has existing policy and model state legislation that  
22 addresses physician supervision of non-physicians, state medical board oversight of physician-led  
23 teams, and medical board oversight of physician agreements with non-physicians. This policy,  
24 H-35.965, "Regulation of Physician Assistants," H-35.989, "Physician Assistants," and H-360.987,  
25 "Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced  
26 Practice Nurses in Integrated Practice," not only addresses the first Resolve, but also the sentiment  
27 of the entire resolution. Further, there was overall agreement that the intent of the second Resolve  
28 was unclear, yet the Board of Trustees notes that clarification was not provided during testimony.  
29 Finally, the HOD generally supported the concept of the third Resolve but agreed it was too broad  
30 as written. The Reference Committee, as a result, recommended that an alternative resolution be  
31 adopted in lieu of Resolution 248. The alternative resolution, offered by our AMA Council on  
32 Legislation, sought to focus the language, achieve the goal of the third Resolve, and add to existing  
33 AMA policy. Due to the complexity of the issue, the HOD referred Resolution 248 for a report  
34 back at the 2023 Annual Meeting.

1 This report provides background information on the role of health care regulatory boards, including  
2 but not limited to state medical boards and boards of nursing. Moreover, this report discusses  
3 current state laws allowing for joint oversight of certified nurse practitioners and certified nurse  
4 midwives by the state boards of medicine and nursing. This report also includes a summary of  
5 AMA policy and model state legislation that supports joint regulatory board oversight of advanced  
6 practice registered nurses (APRNs). Finally, this report recommends reaffirmation of existing  
7 AMA Policy, H-35.965, "Regulation of Physician Assistants," as well as an amendment to  
8 AMA Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of Medical Care  
9 Delivered by Advanced Practice Nurses in Integrated Practice" by addition and deletion.

## 10 11 BACKGROUND

### 12 13 *The role of occupational boards*

14  
15 The licensing and regulation of health care professionals is within the purview of state occupational  
16 and regulatory boards. Health care professional regulatory boards ensure that only individuals  
17 meeting the minimal qualifications and competencies can obtain a license to practice in the  
18 profession. Typically state legislatures or regulatory boards set forth the standards required to  
19 obtain a license, such as graduation from an accredited educational program and the requisite  
20 degree, certification, passage of a professional examination, and completion of a background  
21 check. These measures are in place to protect the public from unqualified health care professionals  
22 through licensure. Regulatory boards also ensure that the health care professionals whom they  
23 license practice within the applicable standard(s) of care and the scope of practice of their  
24 profession. As such, regulatory boards also have the authority to investigate and discipline their  
25 licensees who fail to meet these standards.

### 26 27 *The role of medical boards*

28  
29 The primary role of a state medical board is to protect the health and safety of the public by  
30 licensing physicians, investigating complaints, and disciplining physicians based on the state  
31 medical practice act. There are currently 71 state and territorial medical boards, including more  
32 than 50 allopathic (MD) and composite (MD and DO) medical boards and 14 osteopathic (DO)  
33 boards. In addition to licensing physicians, state medical boards also license several non-  
34 physicians, such as physician assistants, podiatrists, chiropractors, respiratory therapists,  
35 occupational therapists, genetic counselors, radiologist assistants, certified anesthesiologist  
36 assistants, naturopaths, and acupuncturists. The types of non-physicians licensed and regulated by  
37 state medical boards varies widely by state.

### 38 39 *Regulatory oversight of non-physicians*

40  
41 Non-physicians may be regulated directly by a state medical board, through an advisory committee  
42 to a state medical board, or by an entirely separate licensing board. For example, while physician  
43 assistants are licensed and regulated by the board of medicine in most states, a few states have a  
44 separate physician assistant licensing board, and some states have a physician assistant advisory  
45 committee under the board of medicine. Similarly, naturopaths are typically licensed by a separate  
46 naturopathic board or the board of medicine in states that license naturopaths. Likewise,  
47 acupuncturists may be licensed by the board of medicine or a separate board of acupuncture. In  
48 contrast, in most states, psychologists are licensed and regulated by a separate board of psychology,  
49 and pharmacists are licensed by the board of pharmacy in each state.

1 In most states, certified nurse practitioners, certified nurse midwives, certified registered nurse  
 2 anesthetists, and clinical nurse specialists, often referred to collectively as “Advanced Practice  
 3 Registered Nurses” (APRNs) are licensed and regulated exclusively by the board of nursing. Every  
 4 state has at least one nursing regulatory board and four states (California, Georgia, Louisiana and  
 5 West Virginia) have two nursing boards: one that regulates registered nurses and one that regulates  
 6 licensed practical nurses and vocational nurses. At least one state, Nebraska, has a board for  
 7 registered nurses and a separate board for APRNs. Certified nurse midwives, a type of APRN, are  
 8 regulated by the board of nursing in most states. At least one state, however, has a separate  
 9 midwifery board responsible for regulating certified nurse midwives and certified professional  
 10 midwives. In other states, certified nurse midwives may be regulated by the board of medicine or  
 11 public health, often with a midwifery advisory committee or council.

12  
 13 Similarly, in several states the board of medicine and board of nursing have joint regulation of  
 14 nurse practitioners and other types of APRNs. For example, in Virginia, nurse practitioners are  
 15 jointly licensed by the Virginia Boards of Medicine and Nursing. Other states have created a  
 16 separate joint board for regulatory oversight of nurse practitioners practicing independently. For  
 17 example, in Arkansas, the Full Independent Credentialing Committee (committee) located in the  
 18 Department of Health, reviews and approves all applications for nurse practitioners who have met  
 19 the standards for independent practice and apply for a certificate of full independent practice  
 20 authority. The committee is comprised of four physicians and four nurse practitioners. In addition  
 21 to approving or denying all applications, the committee is also responsible for reviewing  
 22 complaints against nurse practitioners who have a certificate. Finally, in several states, the boards  
 23 of medicine and nursing have joint oversight of some aspect of advanced practice registered  
 24 nursing. For example, the Alabama Board of Medical Examiners and Board of Nursing jointly  
 25 approve collaborative practice agreements between physicians and certified nurse midwives or  
 26 physicians and certified nurse practitioners.

## 27 28 EXISTING AMA MODEL STATE LEGISLATION AND POLICY

### 29 30 *AMA model state legislation*

31  
 32 The AMA’s “Model Act to Support Physician-Led Team Based Health Care” (Model Act) includes  
 33 a provision stating that APRNs shall be jointly licensed and regulated by the state board of  
 34 medicine and board of nursing. The Model Act provides a joint regulatory framework and practice  
 35 parameters including a requirement that the APRN practice as part of a physician-led patient care  
 36 team.

### 37 38 *AMA policy*

39  
 40 The AMA also has existing Policy H-35.965, “Regulation of Physician Assistants,” that supports  
 41 the “authority of medical licensing and regulatory boards to regulate the practice of medicine  
 42 through oversight of physicians, physician assistants and related medical personnel” and “opposes  
 43 legislative efforts to establish autonomous regulatory boards meant to license, regulate and  
 44 discipline physician assistants outside of the existing state medical licensing and regulatory bodies’  
 45 authority and purview.” AMA Policy H-35.989, “Physician Assistants,” indicates that state medical  
 46 boards shall approve physician assistant applications to practice with a licensed physician or group  
 47 of physicians and provides parameters for such applications. AMA Policy H-360.987, “Principles  
 48 Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice  
 49 Nurses in Integrated Practice,” states in part that “[p]hysicians should encourage state medical and  
 50 nursing boards to explore the feasibility of working together to coordinate their regulatory  
 51 initiatives and activities.”



1 DISCUSSION

2  
3 Our AMA has existing policy, H-35.965, "Regulation of Physician Assistants," and H-35.989,  
4 "Physician Assistants," supporting the licensure and regulatory oversight of physician assistants by  
5 state medical boards. These two policies support the current regulatory structure in most states, are  
6 aligned with AMA's scope of practice advocacy, and address the sentiment of Resolution 248. Our  
7 AMA also has policy encouraging state medical and nursing boards to explore working together to  
8 coordinate their regulatory activities, H-360.987, "Principles Guiding AMA Policy Regarding  
9 Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice."  
10 While this language provides the basis for a joint state medical and nursing board regulatory  
11 model, the Board of Trustees believes these policies should be strengthened to affirmatively  
12 support joint state medical and nursing board licensing and regulatory oversight of certified nurse  
13 practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse  
14 specialists, when appropriate. The Board of Trustees believes the proffered amendment provides  
15 clarity as to the appropriate role of state medical boards in regulating the practice of APRNs  
16 seeking scope expansions.

17  
18 As discussed above, there is precedent in state law for joint state medical and nursing board  
19 regulatory oversight of APRNs. Moreover, AMA's Model Act also includes language supporting a  
20 joint medical and nursing board regulatory structure. The AMA will continue to work with state,  
21 specialty and national medical societies interested in pursuing AMA's Model Act.

22  
23 RECOMMENDATIONS

24  
25 The Board of Trustees recommends that the following recommendations be adopted in lieu of  
26 Resolution 248-A-22 and that the remainder of the report be filed.

- 27  
28 1. That our American Medical Association (AMA) reaffirm existing Policy H-35.965,  
29 "Regulation of Physician Assistants," and H-35.989, "Physician Assistants." (Reaffirm  
30 HOD Policy)  
31  
32 2. That Policy H-360.987, "Principles Guiding AMA Policy Regarding Supervision of  
33 Medical Care Delivered by Advanced Practice Nurses in Integrated Practice" be amended  
34 by addition and deletion as follows:  
35  
36 (5) Physicians should encourage Certified nurse practitioners, certified registered nurse  
37 anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and  
38 regulated jointly by the state medical and nursing boards explore the feasibility of working  
39 together to coordinate their regulatory initiatives and activities. (Modify Current HOD  
40 Policy)

Fiscal Note: Less than \$500.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201  
(A-23)

Introduced by: American Association of Clinical Urologists, American Urological Association

Subject: Pharmacists Prescribing for Urinary Tract Infections

Referred to: Reference Committee B

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1 Whereas, American Medical Association Policy D-35.987 Evaluation of the Expanding Scope of  
2 Pharmacist's Practice opposes federal and state legislation allowing pharmacists to  
3 independently prescribe or dispense prescription medication without a valid order by, or under  
4 supervision of a licensed doctor of medicine, osteopathy, dentistry or podiatry; and  
5

6 Whereas, In 2022/2023 several states including Virginia, Oklahoma, Connecticut, Mississippi,  
7 New Mexico and Montana introduced bills to their state legislatures allowing pharmacists to  
8 order, test, screen, and treat many health conditions including urinary tract infections; and  
9

10 Whereas, The diagnosis of urinary tract infections can be extremely nuanced and is one of the  
11 most erroneously diagnosed conditions for which physicians are consulted; and  
12

13 Whereas, Underdiagnosis of the severity of urinary tract infections may miss important  
14 associated clinical situations such as: kidney or ureteral stones, ureteropelvic junction  
15 obstruction, malignant obstruction, etc., which can lead to urinary sepsis and death; and  
16

17 Whereas, Misdiagnosis of genitourinary symptoms such as dysuria, pain, or blood in the urine  
18 as a common urinary tract infection may miss non-infectious conditions such as interstitial  
19 cystitis, overactive bladder, neurogenic bladder, multiple sclerosis, cancer, etc.; and  
20

21 Whereas, Pharmacists may not recognize clinical symptoms indicating the presence of foreign  
22 bodies within the urinary system, infectious stones, urinary fistulae or diverticula, etc.; and  
23

24 Whereas, Urinary tract infections are also one of the most significant sources of antibiotic  
25 resistance due to inappropriately prescribed antibiotics. The inability to follow resistance  
26 patterns and trends in laboratory results impairs the ability of pharmacists to appropriately  
27 prescribe antibiotics; and  
28

29 Whereas, AUA guidelines recommend treating urinary tract infections based on a complete  
30 patient evaluation including history, pertinent physical examination, appropriate laboratory  
31 evaluation and physician follow-up; and  
32

33 Whereas, Physicians possess the knowledge, training, experience, and tools to responsibly  
34 prescribe antibiotics for urinary tract infections without adding to the ongoing issue of bacterial  
35 resistance; therefore be it  
36

37 **RESOLVED**, That our American Medical Association collaborate with relevant stakeholders  
38 including state and specialty societies to oppose legislation or regulation allowing pharmacists  
39 to test, diagnose, and treat urinary tract infections (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA advocate that inappropriate treatment of urinary tract infections with
- 2 antibiotics is a public health concern which can lead to further bacterial antibiotic resistance.
- 3 (Directive to Take Action)

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

Received: 3/14/23

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202  
(A-23)

Introduced by: Medical Student Section

Subject: Support for Mental Health Courts

Referred to: Reference Committee B

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1 Whereas, “Mental health courts” are correctional diversion and rehabilitation programs used by  
2 state and local courts to support individuals with mental illness in the justice system<sup>1-7</sup>; and  
3

4 Whereas, Mental health courts connect individuals with mental illness to mental health  
5 treatment, as an alternative to incarceration or other legal sentences and penalties<sup>1-7</sup>; and  
6

7 Whereas, Two pieces of federal Congressional legislation, the America’s Law Enforcement and  
8 Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act  
9 of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and  
10 resources in the justice system and to establish grants to fund mental health court programs<sup>8-9</sup>;  
11 and  
12

13 Whereas, The continued funding of MIOTCRA programs over the last two decades has been  
14 dependent on Congressional appropriations<sup>10</sup>; and  
15

16 Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in  
17 the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA)  
18 in the Department of Justice administer grants to fund state and local mental health courts<sup>11,12</sup>;  
19 and  
20

21 Whereas, Research demonstrates that mental health courts appear to be associated with  
22 reductions in recidivism, length of incarceration, severity of charges, risk of violence, and  
23 rehospitalization among individuals with mental illness in the justice system<sup>3,13-26</sup>; and  
24

25 Whereas, SAMHSA published a 2015 report noting that because “the vast majority of individuals  
26 who come into contact with the criminal justice system appear” before municipal courts and  
27 “many of these individuals have mental illness and co-occurring substance use disorders,”  
28 municipal courts may be an especially effective “and often overlooked” method of diversion of  
29 individuals with mental illness from the justice system<sup>26</sup>; and  
30

31 Whereas, In addition to SAMHSA and BJA, several nonprofit advocacy organizations, including  
32 Mental Health America, the National Alliance on Mental Illness, the Treatment Advocacy Center,  
33 the National Sheriffs’ Association, the Council on State Governments, and the National Center  
34 for State Courts, support the use of mental health courts<sup>2,27-32</sup>; and  
35

36 Whereas, While several hundred mental health courts exist across all 50 states, mental health  
37 courts do not exist in all counties and localities, indicating that these programs may not be  
38 accessible or available to all individuals who could benefit from them<sup>4</sup>; and

Whereas, Because mental health courts are dependent on participation from national, state, and local governmental agencies, justice systems, and mental health service organizations and on the appropriation of public funds, including federal monies for MIOTCRA programs and grants administered by SAMHSA and BJA<sup>10-12</sup>, the AMA can play a role in advocating for the continued support and funding of mental health courts by policymakers; and

Whereas, Courts that connect individuals with mental illness to treatment as an alternative to incarceration exist under many different names, with each focused on different types of mental illness, including “mental health courts” (for mental illness in general), “drug courts” (for substance use disorders), and “sobriety” or “sober courts” (for alcohol use disorder and sometimes certain other substance use disorders)<sup>32-35</sup>; and AMA policy should be inclusive of all these different types; and

Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts, which are similar in function to mental health courts but narrower in scope, “for individuals with addictive disease who are convicted of nonviolent crimes”; and

Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran courts, which are similar in function to mental health courts but narrower in scope, “for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder”; and

Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with previous Policy H-100.955 on drug courts<sup>36-37</sup>; and

Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was extracted in our HOD to remove the restriction on only using veteran courts for nonviolent offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could potentially be used for criminal offenses in general and not only for nonviolent offenses<sup>36</sup>; and

Whereas, To be consistent with our HOD’s most recent debate on this matter, Policy H-100.955 on drug courts and any future AMA policy on alternatives to incarceration for individuals with mental illness should not be limited to only nonviolent offenses; therefore be it

RESOLVED, That American Medical Association Policy H-100.955, Support for Drug Courts, be amended by addition and deletion as follows:

**Support for Mental Health Drug Courts, H-100.955**

Our AMA: (1) supports the establishment and use of mental health drug courts, including drug courts and sobriety courts, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with mental illness involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health drug courts at the state and local level in the United States; and (3) encourages mental health drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 3/27/23

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## RELEVANT AMA POLICY

### Support for Drug Courts H-100.955

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

Citation: Res. 201, A-12; Appended: BOT Rep. 09, I-19;

### Support for Veterans Courts H-510.979

Our AMA supports the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.

Citation: Res. 202, I-19;

### Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22;

### AMA Support for Justice Reinvestment Initiatives H-95.931

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Citation: Res. 205, A-16;

**Prevention of Impaired Driving H-30.936**

Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21.

Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;" (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals.

Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities.

Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life;

Repeat Offenders: Our AMA: (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses; and (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third.

On-board devices: Our AMA: (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and



safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members.

Citation: (CCB/CLRPD Rep. 3, A-14)

### **E-9.7.2 Court-Initiated Medical Treatment in Criminal Cases**

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments.

Individual physicians who provide care under court order should:

- (a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
- (b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
- (c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
- (d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

Issued: 2016

### **E-2.1.2 Decisions for Adult Patients Who Lack Capacity**

Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

- (a) Identify an appropriate surrogate to make decisions on the patient's behalf:
  - (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
  - (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
- (b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
- (c) Provide advice, guidance, and support to the surrogate.
- (d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
  - (i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
  - (ii) the patient's views about life and how it should be lived;
  - (iii) how the patient constructed his or her life story; and
  - (iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
- (e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
  - (i) the pain and suffering associated with the intervention;

- (ii) the degree of and potential for benefit;
  - (iii) impairments that may result from the intervention;
  - (iv) quality of life as experienced by the patient.
  - (f) Consult an ethics committee or other institutional resource when:
    - (i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
    - (ii) ongoing disagreement about a treatment decision cannot be resolved; or
    - (iii) the physician judges that the surrogate's decision:
      - a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
      - b. could not reasonably be judged to be in the patient's best interest; or
      - c. primarily serves the interests of the surrogate or other third party rather than the patient.
- Issued: 2016

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203  
(A-23)

Introduced by: Medical Student Section

Subject: Drug Policy Reform

Referred to: Reference Committee B

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1 Whereas, In 2019, 197.5 million Americans (71.8%) aged 12 and over used a substance in  
2 the past year, with 179 million using alcohol, 72 million using tobacco, and 57.2 million using  
3 an illicit drug, including 9.7 million using prescription opioids, 6 million using hallucinogens,  
4 5.9 million using prescription tranquilizers or stimulants, 5.5 million using cocaine, 2 million  
5 using methamphetamine, and 745,000 using heroin<sup>1</sup>; and  
6

7 Whereas, In 2019, 20.4 million Americans (9.7% of those who used a substance in the past  
8 year) aged 12 and over met substance use disorder (SUD) criteria, including 14.5 million  
9 Americans with alcohol use disorder and 8.3 million with an SUD involving an illicit drug<sup>1</sup>; and  
10

11 Whereas, The US classifies controlled substances into five schedules, but significant  
12 controversy exists over the schedules of certain drugs deemed to have “no medical use,”  
13 despite research showing that these drugs may have therapeutic potential<sup>2-5</sup>; and  
14

15 Whereas, Sentences and penalties for federal and state drug offenses vary depending on the  
16 drug’s schedule, amount of drug, circumstances of arrest, and previous drug convictions and  
17 criminal record<sup>6-8</sup>; and  
18

19 Whereas, Drug possession is defined as being found with an amount of a drug small enough  
20 for personal use (as determined by the government) without legal justification<sup>6-8</sup>; and  
21

22 Whereas, Under federal statute, drug possession is classified as a criminal misdemeanor and  
23 can be punishable by up to 1 year imprisonment and/or at least \$1,000 in fines for a first-time  
24 offense and up to 3 years imprisonment and/or \$5,000 in fines for repeat offenses, with  
25 greater sentences and penalties depending on amount of drug, previous drug convictions,  
26 and criminal record<sup>7-8</sup>; and  
27

28 Whereas, State statutes are most commonly used to charge people with drug possession  
29 and these statutes vary significantly, with many states (including Indiana, Kentucky, and  
30 Oklahoma) reclassifying possession from felonies to misdemeanors over the last decade,  
31 lowering mandatory minimums, and using savings from reduced incarceration to fund social  
32 services, while many other states (such as Idaho, Missouri, and Nebraska) continue to  
33 charge possession as felonies often punished with multiple years of imprisonment<sup>9-13</sup>; and  
34

35 Whereas, In some states, multiple drug felony convictions can result in being charged with a  
36 “violent offense,” despite no physical violence being committed against any person, which  
37 can further increase sentences and penalties and limit eligibility for parole<sup>14</sup>; and  
38

39 Whereas, Drug possession arrests comprise 10% of all arrests in the US and make up over  
40 80% of all drug offense arrests, and possession arrests drastically increased alongside

1 changing policies of the War on Drugs from 538,100 in 1982 to over 1.4 million in 2018, even  
2 as arrests for drug distribution and manufacture remained relatively stable since 1990<sup>15-16</sup>;  
3 and  
4

5 Whereas, Of the 2.3 million people incarcerated in the US, 450,000 (20%) are incarcerated  
6 for “nonviolent drug offenses,” including 120,000 unconvicted awaiting trial<sup>16</sup>; and  
7

8 Whereas, Defelonization refers to the reclassification of an offense from a felony to a  
9 misdemeanor, reduces the probability and potential length of imprisonment and decreasing  
10 the long-term harms associated with incarceration<sup>17-19</sup>; and  
11

12 Whereas, “Decriminalization” is distinct from legalization and only refers to the removal of  
13 criminal charges associated with drug possession and its reclassification as a civil infraction,  
14 which is a prohibited action that results in civil penalties and sanctions against a person<sup>17-20</sup>;  
15 and  
16

17 Whereas, “Legalization” would move beyond decriminalization by eliminating civil infractions  
18 for drug possession and creating a regulatory system to control legal production and sale of  
19 drugs to adults without a prescription, as with alcohol and tobacco<sup>17-20</sup>; and  
20

21 Whereas, AMA Policy H-95.924, “Cannabis Legalization for Adult Use,” states that our AMA  
22 “supports public health based strategies, rather than incarceration,” and the AMA Council on  
23 Science & Public Health’s Interim 2020 report on cannabis states that “AMA policy supports  
24 decriminalization of cannabis (i.e., reduction in the penalty associated with possession of a  
25 small amount of cannabis from a criminal offense subject to arrest to a civil infraction)”<sup>21</sup>; and  
26

27 Whereas, Various states are considering policies to expunge (destroy) certain offenses (such  
28 as drug offenses, especially those due to cannabis) from a person’s criminal record after  
29 completion of sentences and penalties, but expungement processes can still be costly and  
30 complicated, hindering eligible people from applying (for example, expungement in Missouri  
31 costs \$250)<sup>22-26</sup>; and  
32

33 Whereas, The Marijuana Opportunity Reinvestment & Expungement Act, which was passed  
34 by the US House of Representatives in December 2020 but has not yet been considered in  
35 the Senate, contains language to “create an automatic process, at no cost to the individual,  
36 for the expungement, destruction, or sealing of criminal records for cannabis offenses;  
37 and...eliminate violations or other penalties for persons under parole, probation, pre-trial, or  
38 other State or local criminal supervision for a cannabis offense”<sup>27-28</sup>; and  
39

40 Whereas, The US Department of Health & Human Services’ Healthy People 2020 initiative  
41 considers incarceration a key issue within the broad category of social determinants of  
42 health, due to poor physical and mental health outcomes and cross-generational effects on  
43 the children of those incarcerated, with evidence demonstrating the disproportionate impact  
44 of the “War on Drugs” on minoritized communities<sup>29-31</sup>; and  
45

46 Whereas, While only 5% of people who use drugs are Black, arrests of Black people  
47 comprise nearly 30% of all drug arrests, and Black people are nearly six times more likely to  
48 be arrested for a drug offense than a white person, even when controlling for differences in  
49 drug use, exacerbating racial injustice<sup>32,33</sup>; and

1 Whereas, Research shows that incarceration is ineffective and does not significantly reduce  
2 recidivism, drug use, drug overdose deaths, or drug arrests, with a 2013 Washington state  
3 study finding that overdose was the leading cause of death for people previously  
4 incarcerated<sup>34-36</sup>; and  
5

6 Whereas, Drug criminalization is associated with increased stigma and discrimination against  
7 people who use drugs, impairing their mental and physical health and hindering treatment  
8 efforts; has fueled the growth of illegal markets, organized crime, and violent injuries; and  
9 detrimentally affected public health by increasing overdose deaths due to drug contamination  
10 and spreading HIV and hepatitis C<sup>37-41</sup>; and  
11

12 Whereas, Previous incarceration of people who use drugs is associated with lack of access to  
13 health insurance, even after the implementation of the Affordable Care Act, while possession  
14 arrests, regardless of conviction, can negatively impact employment, housing, and student  
15 loan eligibility, leading to widespread and multifactorial health consequences<sup>42-44</sup>; and  
16

17 Whereas, Drug felony convictions can lead to lifelong bans from receiving government  
18 assistance (such as SNAP and TANF), employment and housing discrimination, and loss of  
19 the right to vote or serve on a jury<sup>7,45-48</sup>; and  
20

21 Whereas, People who are incarcerated are at higher risk of chronic conditions such as  
22 cardiovascular disease, hypertension, and cancer compared to the general population, with  
23 an important 2013 New York state study finding that each year spent in prison corresponded  
24 with a two-year decline in life expectancy<sup>49,50</sup>; and  
25

26 Whereas, Drug criminalization is costly, ineffective, and stigmatizing, exposing people to  
27 incarceration, encouraging more dangerous drug consumption methods, and discouraging  
28 people from receiving health services<sup>51-53</sup>; and  
29

30 Whereas, 83% of Americans believe that the “War on Drugs” has failed, 66% support  
31 “eliminating criminal penalties for drug possession,” and 61% of voters support reducing  
32 sentences of people currently incarcerated for drug offenses, with similar findings replicated  
33 across multiple states<sup>54-58</sup>; and  
34

35 Whereas, California reclassified drug possession from a felony to misdemeanor in 2014 by  
36 passing ballot initiative Proposition 47, “The Safe Neighborhoods and Schools Act,” leading  
37 to the release or resentencing of 3,000 people and saving the state \$156 million, with a later  
38 study finding no associated increase in crime<sup>59-63</sup>; and  
39

40 Whereas, A 2018 study on cannabis decriminalization in five U.S. states did not find an  
41 increase in the prevalence of youth cannabis use as a result of decriminalization<sup>64</sup>; and  
42

43 Whereas, In 2010 the Czech Republic decriminalized personal drug possession after a  
44 comprehensive policy review determined that criminal penalties did not reduce use or harm  
45 and were instead costly and unjustifiable, with later studies demonstrating net societal  
46 benefits without increased rates of drug use<sup>65,66</sup>; and  
47

48 Whereas, Drug decriminalization in Portugal resulted in a decrease in heroin- and cocaine-  
49 related seizures, HIV and drug-related deaths, and decreased societal costs related to drug  
50 use<sup>67,68</sup>; and

Whereas, In 2019 the United Nations Chief Executives Board for Coordination issued a statement calling for the “promot[ion of] alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use”<sup>18,69</sup>; and

Whereas, Decriminalization of personal use and possession of drugs is supported by the World Health Organization, American Public Health Association, Human Rights Watch, Global Commission on Drug Policy, International Federation of Red Cross and Red Crescent Societies, NAACP, and National Latino Congress<sup>70-76</sup>; therefore be it

RESOLVED, That our American Medical Association advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug-related felonies (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individual (New HOD Policy); and be it further

RESOLVED, That our AMA support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession. (New HOD Policy)

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

Received: 3/27/23

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## RELEVANT AMA POLICY

### Federal Drug Policy in the United States H-95.981

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

Citation: BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13; Reaffirmed: BOT Rep. 14, I-20;

### Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement

policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids. Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20;

#### **Support for Drug Courts H-100.955**

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

Citation: Res. 201, A-12; Appended: BOT Rep. 09, I-19;

#### **Youth Incarceration in Adult Facilities H-60.916**

1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records.

2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities.

Citation: Alt. Res. 917, I-16;

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

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.

Citation: Res. 408, A-18; Reaffirmed: Res. 234, A-22;

#### **The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954**

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.

Citation: (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)

#### **Syringe and Needle Exchange Programs H-95.958**

Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and

possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

**Pilot Implementation of Supervised Injection Facilities H-95.925**

Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.

Citation: Res. 513, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204  
(A-23)

Introduced by: Medical Student Section

Subject: Supporting Harm Reduction

Referred to: Reference Committee B

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1 Whereas, In 2016 it was estimated that 26.8 million people were living with opioid use disorder  
2 (OUD) worldwide, almost 10% of whom (2.1 million) were living in the USA<sup>1,2</sup>; and  
3

4 Whereas, Those with OUD are at increased risk of long term negative outcomes including  
5 overdose; fatal overdoses involving opioids in the USA have almost quadrupled in the past  
6 decade with 80,411 deaths in 2021 alone<sup>1,3</sup>; and  
7

8 Whereas, Medications for OUD (MOUD), which include the opioid agonist treatments (OAT)  
9 buprenorphine and methadone in addition to the opioid antagonist naltrexone, are the gold-  
10 standard for treating OUD and are associated with decreased risk of negative outcomes  
11 including overdose<sup>4,5</sup>; and  
12

13 Whereas, In the US, over 70% of those who need treatment for OUD do not receive it and this is  
14 often a result of a lack of access to adequate (or any) treatment services; only 36% of  
15 substance use disorder (SUD) treatment facilities offer at least one MOUD, and just 6.1% offer  
16 access to all three<sup>6,7</sup>; and  
17

18 Whereas, Even if patients gain access to MOUD, not all of them will keep that access long  
19 enough for therapeutic efficacy; prior to implementing a low-barrier MOUD chronic treatment  
20 philosophy of “MedFirst” in Missouri, only 17% of uninsured patients receiving treatment for  
21 OUD were prescribed buprenorphine and of these patients, 78% received the medication for  
22 fewer than 5 months<sup>8</sup>; and  
23

24 Whereas, The COVID-19 pandemic has exacerbated and amplified pre-existing barriers to  
25 MOUD access by prompting closures of OUD treatment services, transitions to telehealth visits,  
26 fears of COVID-19 exposure during methadone treatments, and changes in MOUD regulations<sup>9</sup>;  
27 and  
28

29 Whereas, Deaths from opioid overdose increased dramatically during the COVID-19 pandemic;  
30 for example, the state of Kentucky saw a 50% increase in emergency medical service runs for  
31 deaths from suspected overdoses<sup>10,11</sup>; and  
32

33 Whereas, In one study, only 76% of subjects were able to remain adherent to their  
34 buprenorphine regimen during the COVID-19 pandemic with inadequate access to treatment  
35 serving as a key obstacle<sup>12</sup>; and  
36

37 Whereas, One consequence of inadequate treatment access is that people with OUD may  
38 attempt to self-medicate with street-purchased MOUD such as buprenorphine for the purposes  
39 for treatment; studies have repeatedly demonstrated that the majority of people who use non-

1 prescribed buprenorphine do so in a manner consistent with therapeutic treatment for  
2 withdrawal sickness or attempts to reduce opioid use<sup>13–15</sup>; and  
3

4 Whereas, Studies show that illicit buprenorphine is rarely used recreationally due to its partial  
5 agonist effects and extremely low potential for overdose; US surveys have indicated that of  
6 those with OUD who reported using illicit buprenorphine, 97% used it to prevent cravings and  
7 90% used it to prevent withdrawal symptoms<sup>15–23</sup>; and  
8

9 Whereas, Motivators for use of unprescribed buprenorphine include: to prevent withdrawal, to  
10 maintain abstinence or weaning off drugs, to avoid the overly stringent demands of formal  
11 treatment, to prepare for formal treatment, to gain a sense of self-determination and agency in  
12 recovery, and to use while geographically relocating; the majority of respondents to a global  
13 survey indicated they would prefer using prescribed buprenorphine if they could<sup>13,21</sup>; and  
14

15 Whereas, Some physicians are hesitant to prescribe buprenorphine due to concerns over its  
16 potential diversion and potential for subsequent prosecution of those involved, which may hold  
17 the prescribing physician accountable<sup>24</sup>; and  
18

19 Whereas, Current legislation indicates that a person in possession of buprenorphine not  
20 prescribed to them is guilty of the misdemeanor crime of possession of a narcotic, which can  
21 result in arrest and jail time<sup>25</sup>; and  
22

23 Whereas, Criminal justice solutions to OUD are not effective and at present only 4.6% of those  
24 with OUD referred to treatment by the criminal justice system are given the gold-standard opioid  
25 agonist therapies, versus 40.9% of those referred to treatment from elsewhere<sup>26</sup>; and  
26

27 Whereas, Although people with OUD are overrepresented in the criminal justice system, few  
28 criminal justice systems use validated tools to screen those entering for OUD or provide full  
29 access to MOUD to those who are incarcerated thereby impairing individuals access to  
30 treatment<sup>27–31</sup>; and  
31

32 Whereas, In 2018, Chittenden County in Vermont implemented several evidence-based  
33 interventions including: access to buprenorphine at its syringe exchange and emergency  
34 departments, elimination of the waitlist for MOUD, and decriminalization and a non-arrest policy  
35 for the possession of non-prescribed buprenorphine; these resulted in a 50% decline in opioid  
36 overdose deaths despite overdose deaths increasing by 20% in the remainder of the state<sup>24,25</sup>;  
37 and  
38

39 Whereas, In 2020, following the success of the Chittenden County intervention, the Philadelphia  
40 District Attorney's Office announced that people will no longer be arrested or prosecuted for the  
41 possession of non-prescribed buprenorphine-based medications<sup>32,33</sup>; and  
42

43 Whereas, Removal of buprenorphine from the misdemeanor list, as opposed to full  
44 decriminalization, would eliminate consequences such as jail time and probation but may still  
45 result in an infraction, which burdens the person accused with fines, an appearance in court,  
46 and possible remediation requirements<sup>34–36</sup>; and  
47

48 Whereas, As opposed to misdemeanors and felonies, when charged as a civil infraction,  
49 possession of substances are generally not visible under background checks but may still be  
50 listed as public records<sup>37</sup>; and

1 Whereas, Our existing AMA policy (D-95.987) does not address the legal designation of  
2 unprescribed buprenorphine possession thus the policy will not allow our AMA to advocate for  
3 the decriminalization of buprenorphine nor for its removal from the misdemeanor list; and  
4

5 Whereas, It is important to update our AMA policy to allow for the most up to date advocacy  
6 (such as supporting State bill H.225 introduced in February 2021 from Vermont to decriminalize  
7 therapeutic dosage of buprenorphine), especially in the midst of rising number of overdoses  
8 during the COVID-19 pandemic<sup>38</sup>; and  
9

10 Whereas, Another method for harm reduction is safer smoking, wherein tools to more safely  
11 consume drugs via smoking, including glass stems and pipes, plastic mouthpieces for burn  
12 prevention, screens, wooden push sticks, and alcohol wipes, are provided to patients<sup>39,40</sup>; and  
13

14 Whereas, Providing safer smoking supplies at syringe service programs provides individuals  
15 with a safer alternative to injection drug use, thus reducing risk of overdose, soft tissue  
16 infections and endocarditis, and risk of infectious disease transmission (including Hepatitis C  
17 and HIV) from injection drug use<sup>39-44</sup>; and  
18

19 Whereas, Providing safer smoking supplies has been shown to reduce risky smoking  
20 behaviors<sup>45,46</sup>; and  
21

22 Whereas, Lack of access to new pipes is a reported reason why people who use drugs use  
23 damaged pipes, report sharing pipes, or use self-made pipes<sup>47,48</sup>; and  
24

25 Whereas, Self-made pipes increase risk for injury and chemical burns inside the mouth and  
26 near the lips since materials such as plastic bottles or tin cans can give off toxic vapors and  
27 cause respiratory damage<sup>49,50</sup>; and  
28

29 Whereas, A 2017 study by Prangnell et al in the *BMC Public Health* journal evaluated rates of  
30 health problems associated with crack smoking during the expansion of safer smoking kit  
31 distribution in Vancouver, Canada, and found that study participants who obtained safer  
32 smoking kits were significantly less likely to report health problems from smoking crack than  
33 participants who made their own pipes or acquired them elsewhere<sup>51</sup>; and  
34

35 Whereas, International studies elsewhere in North America and abroad demonstrate the harm  
36 reduction efficacy of safer smoking kits<sup>50-54</sup>; and  
37

38 Whereas, The sale, import, and export of safer smoking supplies is illegal under Title 21 U.S.  
39 Code 863 – Drug paraphernalia, which prevents syringe service programs and other harm  
40 reduction programs from distributing them, and prevents the allocation of public funds for their  
41 distribution<sup>39,46,55</sup>; and  
42

43 Whereas, AMA policy D-95.987 supports the “continued study and implementation of  
44 appropriate treatments and risk mitigation methods for patients at risk for opioid overdose”;  
45 therefore be it  
46

47 RESOLVED, That our American Medical Association advocate for the removal of buprenorphine  
48 from the misdemeanor crime of possession of a narcotic (Directive to Take Action); and be it  
49 further  
50

51 RESOLVED, That our AMA support any efforts to decriminalize the possession of non-  
52 prescribed buprenorphine (New HOD Policy); and be it further

1 RESOLVED, That our AMA amend Policy D-95.987 by addition and deletion to read as  
2 follows:  
3

4 **Prevention of Drug-Related Overdose, D-95.987**

5 1. Our AMA: (a) recognizes the great burden that substance  
6 use disorders (SUDs) and drug-related overdoses and death  
7 places on patients and society alike and reaffirms its support  
8 for the compassionate treatment of patients with a SUD and  
9 people who use drugs; (b) urges that community-based  
10 programs offering naloxone and other opioid overdose and  
11 drug safety and prevention services continue to be  
12 implemented in order to further develop best practices in this  
13 area; (c) encourages the education of health care workers and  
14 people who use drugs about the use of naloxone and other  
15 harm reduction measures in preventing opioid and other drug-  
16 related overdose fatalities; and (d) will continue to monitor the  
17 progress of such initiatives and respond as appropriate.

18 2. Our AMA will: (a) advocate for the appropriate education of  
19 at-risk patients and their caregivers in the signs and symptoms  
20 of a drug-related overdose; and (b) encourage the continued  
21 study and implementation of appropriate treatments and risk  
22 mitigation methods for patients at risk for a drug-related  
23 overdose.

24 3. Our AMA will support the development and implementation  
25 of appropriate education programs for persons receiving  
26 treatment for a SUD or in recovery from a SUD and their  
27 friends/families that address harm reduction measures.

28 4. Our AMA will advocate for and encourage state and county  
29 medical societies to advocate for harm reduction policies that  
30 provide civil and criminal immunity for the possession,  
31 distribution, and use of "drug paraphernalia" designed for harm  
32 reduction from drug use, including but not limited to drug  
33 contamination testing, safer smoking, and injection drug  
34 preparation, use, and disposal supplies.

35 5. Our AMA will implement an education program for patients  
36 with substance use disorder and their family/caregivers to  
37 increase understanding of the increased risk of adverse  
38 outcomes associated with having a substance use disorder and  
39 a serious respiratory illness such as COVID-19.

40 6. Our AMA will advocate for supports efforts to increased  
41 access to and decriminalization of fentanyl test strips, and other  
42 drug checking supplies, and safer smoking kits for purposes of  
43 harm reduction. (Modify Current HOD Policy)

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

Received: 3/27/23

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## RELEVANT AMA POLICY

### Prevention of Drug-Related Overdose D-95.987

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

2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.

6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

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

#### **Treating Opioid Use Disorder in Hospitals D-95.967**

1. Our AMAs Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease.

2. Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder.

3. Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations.

Citation: Res. 223, A-18;

#### **Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972**

1. Our AMAs Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.

2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

Citation: Res. 506, A-17; Appended: BOT Action in response to referred for decision: Res. 506, A-17;

#### **Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944**

Our AMA opposes federal, state, third-party and other laws, policies, rules and procedures, including those imposed by Pharmacy Benefit Managers working for Medicaid, Medicare, TriCare, and commercial health plans, that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care.

Citation: Res. 710, A-13; Reaffirmed in lieu of: Res. 228, I-18;

**Opioid Treatment and Prescription Drug Monitoring Programs D-95.980**

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

Citation: BOT Rep. 11, A-10; Reaffirmed: CSAPH Rep. 01, A-20;

**Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999**

Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.

Citation: CSA Rep. 12, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19;

**Opioid Mitigation H-95.914**

Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws.

Citation: BOT Rep. 09, I-19;

**Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968**

1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.

2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.

3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.

Citation: Res. 222, A-18; Appended: BOT Rep. 02, I-19;

**Syringe and Needle Exchange Programs H-95.958**

Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

Citation: Res. 231, I-94; Reaffirmed Ref. Cmt. D, I-96; Modified by CSA Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: Res. 203, A-13; Modified: Res. 914, I-16;

**The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954**

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use; (2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society; (3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction; (4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is

urgent, considering the contribution of injection drug use to the epidemic of HIV infection; (5) encourages a comprehensive review of the risks and benefits of U.S. state-based drug legalization initiatives, and that until the findings of such reviews can be adequately assessed, the AMA reaffirm its opposition to drug legalization; (6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and (7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients.

Citation: (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205  
(A-23)

Introduced by: Medical Student Section

Subject: Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness

Referred to: Reference Committee B

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1 Whereas, The rates of chronically homeless sheltered individuals have increased by 20%  
2 between 2020 and 2021, particularly in high cost cities and suburbs, driven by factors including,  
3 but not limited to, the implications of the COVID-19 pandemic, a tightening housing market, and  
4 reductions in social services<sup>1-3</sup>; and

5  
6 Whereas, Housing market demand has exceeded pre-pandemic levels of supply, and new  
7 construction cannot fill the large gap in the short term due to increases in second-home buying<sup>2</sup>;  
8 and

9  
10 Whereas, Despite unprecedented levels of federal, state, and local support during the COVID-  
11 19 pandemic, the number of individuals experiencing chronic homelessness increased by 15%  
12 between 2020 and 2022<sup>4</sup>; and

13  
14 Whereas, In major metropolitan areas, rents have increased by more than 30% between  
15 January 2021 to January 2022, placing lower income families, individuals, and veterans at an  
16 increased risk for eviction and homelessness<sup>5-7</sup>; and

17  
18 Whereas, The Department of Housing and Urban Development found median rent increases of  
19 \$100 per month were associated with a 9% increase in homelessness in the metropolitan areas  
20 they examined<sup>8</sup>; and

21  
22 Whereas, At-risk populations, including low-income households, minorities, veterans, and adults  
23 over the age of 65 are especially vulnerable to the impacts of uncontrolled rent increases, job  
24 insecurity in sectors most affected by the pandemic (i.e., leisure and hospitality; food, clothing,  
25 and other goods), and medical debt<sup>3,5,9</sup>; and

26  
27 Whereas, A report by the National Coalition of Asian Pacific American Community Development  
28 in March 2021 revealed eviction moratoriums would affect 26% of Asian and 27% of Native  
29 Hawaiians or Other Pacific Islander (NHOPI) renters and 16% of Asian and 12% of NHOPI  
30 homeowners who are severely cost-burdened (i.e., greater than 50% of their income is spent on  
31 housing)<sup>10</sup>; and

32  
33 Whereas, Severely cost-burdened Asian Pacific Islander American communities are especially  
34 at risk for eviction and subsequent homelessness as more than half (54%) of Asian households  
35 have limited English proficiency compared to white households (9%)<sup>10</sup>; and

36  
37 Whereas, Between 2020 and 2021, unaccompanied transgender, gender non-conforming, and  
38 Native American youths (under the age of 25) experienced dramatic increases in the rates of  
39 homelessness of 29%, 26%, and 21%, respectively<sup>1</sup>; and

1 Whereas, Youths (under the age of 25) experiencing homelessness who identify as a minority,  
2 LGBTQ+, refugee, and/or immigrant are more likely to suffer from an increased number of  
3 health disparities, including malnutrition, asthma, obesity, mood disorders, anxiety, physical and  
4 emotional abuse, post-traumatic stress, developmental delays, high-risk sexual behaviors, drug  
5 use, and rape, compared to their stably housed peers<sup>11,12</sup>; and  
6

7 Whereas, Maternal and child health is significantly impacted by homelessness with increases in  
8 adverse childhood experiences, depressive symptoms, and negative effects on both mental and  
9 physical well-being<sup>13</sup>; and  
10

11 Whereas, The costs of healthcare for individuals suffering from homelessness tend to be  
12 disproportionately high when compared to others receiving healthcare with increases in  
13 Veterans Affairs and Medicare utilization and cost<sup>14,15</sup>; and  
14

15 Whereas, One study conducted over six years in California found that connecting frequent users  
16 of the emergency department to housing reduced their healthcare costs overall by 59%,  
17 decreased their emergency department costs by 61%, and reduced the number of inpatient  
18 hospitalizations by 77%<sup>16,17</sup>; and  
19

20 Whereas, Homelessness is a public health problem associated with increased mortality (where  
21 one in three homeless deaths are due to preventable causes), increased prevalence of acute  
22 and chronic health conditions, and increased behavioral and mental health conditions with  
23 nearly 23% of homeless persons reporting having mental health conditions compared to 3% of  
24 never homeless persons<sup>18,19</sup>; and  
25

26 Whereas, Feasible solutions to the homelessness crisis include rent-control laws that protect  
27 tenants that are unable to afford their rental payments and just cause eviction statutes that  
28 protect residents from being arbitrarily evicted<sup>20,21</sup>; and  
29

30 Whereas, Cities that have implemented just cause eviction statutes have lower rates of eviction  
31 and filings (-0.808% points and -0.780% points respectively)<sup>21</sup>; and  
32

33 Whereas, Right to counsel policies would ensure legal counsel representation for tenants in  
34 eviction proceedings, and the creation of local, state, and/or national rental registries to monitor  
35 tenant and landlord contracts and prevent unlawful evictions<sup>20</sup>; and  
36

37 Whereas, There are several existing AMA policies (H-160.903, H-160.978, H-160.894, H-  
38 20.903, H-345.975, H-440.938) that advocate for and support measures that improve access to  
39 adequate health care for people experiencing homelessness through methods such as waiving  
40 co-pays, or providing care through free clinics; and  
41

42 Whereas, H-160.903 specifically asks that the AMA “recognizes adaptive strategies based on  
43 regional variations, community characteristics and state and local resources are necessary to  
44 address [homelessness] on a long-term basis”, and as such has set precedence for feasibly  
45 supporting such measures; therefore be it  
46

47 RESOLVED, That our American Medical Association recognize and support the use of Street  
48 Medicine programs by amending policy H-160.903 Eradicating Homelessness by addition and  
49 deletion to read as follows:

**Eradicating Homelessness, H-160.903**

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
- (5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
- (8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
- (11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;

(12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals; (13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement; and (14) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 3/27/23

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## RELEVANT AMA POLICY

### Housing Insecure Individuals with Mental Illness H-160.978

(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: BOT Rep. 16, A-19; Reaffirmed: Res. 414, A-22;

### Maintaining Mental Health Services by States H-345.975

Our AMA:

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

### E-11.1.4 Financial Barriers to Health Care Access

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.

In view of this obligation,

(a) Individual physicians should:

- (i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.

(ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.

(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.

(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.

(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

Issued: 2016

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206  
(A-23)

Introduced by: Medical Student Section

Subject: Tribal Public Health Authority

Referred to: Reference Committee B

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Whereas, American Indian and Alaska Native Tribes and Villages (“Tribal Nations”) and Tribal Epidemiology Centers (TECs) are “public health authorities” under federal law at 25 U.S.C. §1621m and federal regulation at 45 C.F.R. § 164.501<sup>1</sup>; and

Whereas, Tribal Nations and TECs have the legal authority to collect, receive, and disseminate public health data as necessary to respond to public health threats<sup>1</sup>; and

Whereas, As such, Tribal Nations and TECs have the same public health authority designation as, for example, the United States (US) Centers for Disease Control and Prevention (CDC), and state and local health departments<sup>1</sup>; and

Whereas, Despite their recognition as public health authorities, Tribal Nations and TECs have varying access to data from the CDC and the Indian Health Service (IHS)<sup>2</sup>; and

Whereas, The U.S. Government Accountability Office, in a 2022 report, found a lack of policies affirming Tribal Nations and TECs' authority to access CDC and IHS data, guidance for TECs on how to request data, and agency procedures on how to respond to such requests<sup>2</sup>; and

Whereas, During the COVID-19 pandemic, reports emerged that county and state public health agencies refused to share case and mortality data with Tribal Nations and TECs in California and the Great Plains Area, citing a lack of authority to access such data and restrictions outlined by the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA)<sup>3-4</sup>; and

Whereas, As public health authorities, Tribal Nations and TECs are authorized to access and manage HIPAA-inclusive data, given that they are Covered Entities<sup>5-6</sup>; and

Whereas, By preventing Tribal Nations and TECs from accessing their public health data, local and state governments and federal agencies like the IHS, infringe upon Tribal sovereignty and do not give special attention to the health and health-related needs of American Indians and Alaska Natives, potentially harming their quality of life and healthcare outcomes (AMA Policy H-350.976); therefore be it

RESOLVED, That our American Medical Association advocate to achieve enactment of reforms to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers' status as public health authorities (Directive to Take Action); and be it further

RESOLVED, That our AMA make a suggestion to the Department of Health and Human Services to develop sub-agency (e.g, CDC, IHS) guidance on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA encourage the use of data-sharing agreements between local and
- 2 state public health departments and American Indian and Alaska Native Tribes and Villages and
- 3 Tribal Epidemiology Centers. (New HOD Policy)

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

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#### RELEVANT AMA POLICY

##### **Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922**

Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; (2) develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress; (3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; and (4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs.

Citation: Res. 407, I-20; Modified: CSAPH Rep. 2, I-21; Reaffirmed: CMS Rep. 5, A-22;

##### **Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data H-406.998**

Our AMA: (1) believes that physicians, as patient advocates and possessing unique qualifications in the review and analysis of health care data, must take the initiative in developing data collection systems at the local level which maintain high standards of confidentiality, accuracy and fairness; (2) urges state medical societies, national medical specialty societies, hospital medical staffs and individual physicians to: (a) participate in health care data collection programs designed to improve the quality of care; (b) be aware of the limitations of health care data; (c) encourage active involvement of physician organizations and practicing physicians in all aspects of health care data collection and interpretation; and (d) develop strategies to assist state agencies and others in improving the collection and interpretation of health data; (3) urges health data commissions and other entities that collect, evaluate, and disseminate health care data to: (a) facilitate active involvement of physician organizations and practicing physicians in all aspects of the efforts to collect health care data; (b) provide adequate opportunity for physician organizations and

practicing physicians to review and respond to proposed data interpretations and disclosures; (c) ensure accuracy of information in the data base; and (d) assure valid interpretation and use of health care data; (4) encourages relevant physician organizations to develop effective mechanisms to assist physicians in evaluating, using, and responding to physician-specific health care data; (5) encourages medical societies to use this information for educational purposes and for addressing such areas as utilization variation, quality assessment and appropriate cost containment activities; (6) encourages medical societies to play an active role in appropriate data collection and dissemination activities at the local level; and (7) urges state medical societies, hospital medical staffs and physicians to propose, monitor, and seek to influence quality of care and cost containment legislation to comply with AMA principles.  
 Citation: (BOT Rep. Y, I-85; Reaffirmed: CLRPD Rep. 2, I-95; BOT Rep. P, A-91; BOT Rep. Q, I-92; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-05; Reaffirmed: CMS Rep. 1, A-15)

### **Indian Health Service H-350.977**

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

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

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

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

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

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

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

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

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

- (3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
  - (4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
  - (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
  - (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
  - (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
  - (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
  - (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
  - (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
  - (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.
- Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

#### **Plan for Continued Progress Toward Health Equity H-180.944**

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

Citation: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21;

#### **Universal Access for Essential Public Health Services D-440.924**

Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities; (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB); (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions.

Citation: Res. 419, A-19; Modified: CSAPH Rep. 2, A-22;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207  
(A-23)

Introduced by: Medical Student Section

Subject: Ground Ambulance Services and Surprise Billing

Referred to: Reference Committee B

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1 Whereas, Emergency Medical Services (EMS) and ground ambulance services play a critical  
2 role in the network of healthcare in each community<sup>1</sup>; and  
3

4 Whereas, People insured under Medicare or Medicaid are not at risk for surprise billing<sup>2</sup>; and  
5

6 Whereas, Ten percent of emergency room visits for privately insured individuals require an  
7 ambulance ride to the hospital<sup>3</sup>; and  
8

9 Whereas, Anywhere from 71-86% of ground ambulance rides involve potential surprise bills with  
10 patients being charged an aggregate of \$129 million per year due to out-of-network charges<sup>1,4</sup>;  
11 and  
12

13 Whereas, 39% of Americans would struggle to cover an unexpected expense of just \$400<sup>5</sup>; and  
14

15 Whereas, Eight percent of all medical debt stems from ambulance charges<sup>6</sup>; and  
16

17 Whereas, Medical debt disproportionately impacts poor and minority communities, with 80% of  
18 medical debt being held by households with zero or negative net worth, and 27% of Black  
19 households holding medical debt compared to only 17% of non-black households<sup>7</sup>; and  
20

21 Whereas, EMS and ambulance service reimbursement from governmental sources is inadequate  
22 and subject to significant year-to-year fluctuations<sup>4</sup>; and  
23

24 Whereas, Patients bear a disproportionate and unintentional financial burden due to out-of-  
25 network ambulance service charges<sup>8</sup>; and  
26

27 Whereas, Financial concerns have been linked to reduced utilization of ground ambulance  
28 services, increasing risk of morbidity and mortality<sup>9</sup>; and  
29

30 Whereas, Low-income patients are 160% more likely to utilize emergency medical services when  
31 cost concerns are eliminated<sup>10</sup>; and  
32

33 Whereas, Only Colorado, Delaware, Florida, Illinois, Maine, Maryland, New York, Ohio, Vermont,  
34 West Virginia have protections against ground ambulance surprise billing<sup>11</sup>; and  
35

36 Whereas, The No Surprises Act supplements existing state surprise billing laws to protect patients  
37 from receiving surprise medical bills by requiring private health plans to cover eligible out-of-  
38 network costs, and by prohibiting covered healthcare providers from billing more than the in-  
39 network cost-sharing amount<sup>12-14</sup>; and

Whereas, The No Surprises Act called for the creation of a “Ground Ambulance and Patient Billing” advisory committee in January 2022 to develop recommendations on how to address surprise billing in the context of ground ambulance services, but has neither chosen representing members nor published a meeting date<sup>11,15</sup>; and

Whereas, The No Surprises Act addresses air ambulance services by including “medical transport by helicopter” and “medical transport by airplane”, but does not include ground ambulance services<sup>16-17</sup>; therefore be it

RESOLVED, That our American Medical Association oppose surprise billing practices for ground ambulance services. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 3/27/23

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## RELEVANT AMA POLICY

### Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Citation: Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22;

### Billing Procedures for Emergency Care H-130.978

(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.

Citation: (CMS Rep. J, I-86; Reaffirmed by Res. 118, I-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 808, I-15

**Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975**

Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status.

Citation: BOT Rep. 2, I-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17;

**Balance Billing for All Physicians D-380.996**

1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.

2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.

3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.

4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.

Citation: Res. 925, I-07; Reaffirmed: BOT Rep. 22, A-17;

**Medicare Balance Billing D-390.986**

Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.

Citation: Res. 713, I-02; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: BOT Rep. 9, A-22;

**Balance Billing H-385.991**

Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.

Citation: Sub. Res. 128, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704, A-01;

Reaffirmation A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 01, A-16;

**Freedom of Choice H-390.854**

(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.

Citation: Res. 117, I-92; Reaffirmed: CMS Rep. 10, A-03; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16;

**Medicare's Ambulance Service Regulations H-240.978**

1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patients needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.

2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

Citation: Res. 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Modified: Res. 124, A-17;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208  
(A-23)

Introduced by: Medical Student Section

Subject: Medicaid Managed Care for Indian Health Care Providers

Referred to: Reference Committee B

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1 Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health and  
2 Human Services, is responsible for providing health services to American Indians and Alaska  
3 Natives (AI/AN)<sup>1</sup>; and  
4

5 Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita  
6 health care expenditures are \$4,078, while figures for Veterans Healthcare Administration is  
7 \$10,692 and Medicaid and Medicare are \$8,109 and \$13,185, respectively<sup>2</sup>; and  
8

9 Whereas, The IHS is considered the payor of last resort, ensuring that no payments shall be  
10 made from the Indian Health Service to any provider of treatment at an IHS, Tribal, and Urban  
11 Indian Health Program to the extent that such provider is eligible to receive payment for the  
12 treatment from any other federal, state, local, or private source of reimbursement for which the  
13 patient is eligible<sup>3</sup>; and  
14

15 Whereas, IHS' sources of reimbursement include, but are not limited to, Medicare Part A and B,  
16 State Medicaid, State or other federal health programs (e.g., Veterans Health Administration),  
17 private insurance, and funds from Tribal health programs<sup>3</sup>; and  
18

19 Whereas, Payments for IHS patients' medical care received from public programs such as  
20 Medicaid and Medicare or from private insurers—increased from about \$943 million in fiscal  
21 year 2015 to about \$1.15 billion in fiscal year 2019 at its federal facilities<sup>4</sup>; and  
22

23 Whereas, IHS third-party collections are increasingly important, as they represent a significant  
24 portion of IHS, Tribal, and Urban Indian Health Programs' health care delivery budget and are  
25 also used to procure services, supplies, and pharmaceuticals<sup>4-5</sup>; and  
26

27 Whereas, An estimated 725,000 AI/AN patients served by the IHS (28.3% of population served)  
28 have Medicaid coverage<sup>5</sup>; and  
29

30 Whereas, As of July 2021, 41 states, including the District of Columbia, contract with Managed  
31 Care Organizations (MCO) to provide for the delivery of Medicaid health benefits and additional  
32 services<sup>6-7</sup>; and  
33

34 Whereas, Managed Care Organizations (MCO) play a significant role in the delivery of  
35 healthcare to Medicaid enrollees because states choose which populations and services to  
36 include in managed care contracts (e.g. persons with disabilities, dual-eligible Medicaid and  
37 Medicare beneficiaries)<sup>7</sup>; and

1 Whereas, There are Indian Health Care Medicaid Managed Care Provisions (42 C.F.R. §  
2 438.14) protecting the rights of Indian Health Care Providers (IHCP) that must be followed by  
3 state Medicaid programs or their contracted MCO<sup>8</sup>; and  
4

5 Whereas, An IHCP is a health care program operated by the IHS or by an Indian Tribe, Tribal  
6 Organization, or Urban Indian Organization, as those terms are defined in section 4 of the  
7 Indian Health Care Improvement Act (25 U.S.C. 1603)<sup>9</sup>; and  
8

9 Whereas, These provisions include: (1) allowing AI/AN Medicaid enrollees to obtain MCO-  
10 covered services from out-of-network IHCPs; (2) requiring MCOs to pay out-of-network IHCPs  
11 that are federally qualified health centers (FQHC) at the same rate that they would pay an in-  
12 network FQHC; and (3) requiring MCOs to pay out-of-network IHCPs that are not an FQHC at  
13 the IHS rate<sup>8</sup>; and  
14

15 Whereas, In 2019, the Center for Medicare and Medicaid Services (CMS) Tribal Technical  
16 Advisory Group (TTAG) formed a Managed Care Subcommittee to address Medicaid managed  
17 care issues identified by IHCPs, AI/AN Medicaid enrollees, and Tribal leaders<sup>8</sup>; and  
18

19 Whereas, Key issues identified by the CMS TTAG Subcommittee included denying AI/AN  
20 enrollees the right to receive services from an IHCP of their choice, denial of claims made by  
21 IHCPs to MCOs, inadequate State oversight of MCOs, and incorrect reimbursement from MCOs  
22 to IHCPs for their services<sup>8</sup>; and  
23

24 Whereas, Greater compliance with Indian Health Care Medicaid Managed Care Provisions (42  
25 C.F.R. § 438.14) will improve the availability of health care services offered by IHCPs<sup>9</sup>; therefore  
26 be it  
27

28 RESOLVED, That our American Medical Association urge stronger federal enforcement of  
29 Indian Health Care Medicaid Managed Care Provisions and other relevant laws to ensure state  
30 Medicaid agencies and their Medicaid managed care organizations (MCO) are complying with  
31 their legal obligations to Indian health care providers (New HOD Policy); and be it further  
32

33 RESOLVED, That our AMA collaborate with other stakeholders to encourage state Medicaid  
34 agencies to follow the Center for Medicare and Medicaid Services Tribal Technical Advisory  
35 Group's recommendations to improve care coordination and payment agreements between  
36 Medicaid managed care organizations and Indian health care providers by, including, but not  
37 limited to:

- 38 1. Convening Tribal Advisory Committees or hiring Tribal liaisons within state Medicaid  
39 agencies.
- 40 2. Increasing the utilization of the Center for Medicare and Medicaid Services Indian  
41 Managed Care Addendum.
- 42 3. Offering employee onboarding and annual refresher training regarding Indian Health  
43 Care Medicaid Managed Care Provisions. (Directive to Take Action)  
44

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

Received: 3/27/23

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**RELEVANT AMA POLICY****Indian Health Service H-350.977**

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

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

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

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

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

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

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

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

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

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

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

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

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

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

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

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

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

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

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

**Racial and Ethnic Disparities in Health Care H-350.974**

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations. Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21;

#### **Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982**

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

- (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
- (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
- (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
- (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
- (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
- (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
- (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
- (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22;

### **Monitoring Medicaid Managed Care H-290.985**

As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

- (1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.
- (2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.
- (3) Geographic dispersion and accessibility of participating physicians and other providers.
- (4) Education of beneficiaries regarding appropriate use of services, including the emergency department.
- (5) Availability of off-hours, walk-in primary care.
- (6) Coverage for clinically effective preventive services.
- (7) Responsiveness to cultural, language and transportation barriers to access.
- (8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
- (9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
- (10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
- (11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.



- (12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
  - (13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
  - (14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
  - (15) Preservation of private right of action for physicians and other providers and beneficiaries.
  - (16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
  - (17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
  - (18) Absence of gag rules.
  - (19) Fairness in procedures for selection and deselection.
  - (20) Realistic payment levels based on costs of care and predicted utilization levels.
  - (21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
  - (22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis.
- Citation: CMS Rep. 5 A-96; Reaffirmed and Appended: Sub. Res. 704, I-97; Reaffirmation A-00; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 1, I-22;

**Medicaid Waivers for Managed Care Demonstration Projects H-290.987**

- (1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education. (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that children have access to medically necessary services not specified in the plan's benefit package.
- Citation: (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209  
(A-23)

Introduced by: Medical Student Section

Subject: Purchased and Referred Care Expansion

Referred to: Reference Committee B

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1 Whereas, The Indian Health Service (IHS), an agency within the United States (U.S.)  
2 Department of Health and Human Services, is responsible for providing health services to  
3 American Indians and Alaska Natives (AI/AN)<sup>1</sup>; and  
4

5 Whereas, The IHS is funded each year through appropriations by the U.S. Congress<sup>1</sup>; and  
6

7 Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita  
8 health care expenditures are \$4,078, while the Veterans Healthcare Administration is \$10,692  
9 and Medicaid and Medicare are \$8,109 and \$13,185, respectively<sup>2</sup>; and  
10

11 Whereas, The IHS is considered the payor of last resort, ensuring that no payments shall be  
12 made from the Indian Health Service to any provider of treatment at an IHS, Tribal, and Urban  
13 Indian Health Program to the extent that such provider is eligible to receive payment for the  
14 treatment from any other federal, state, local, or private source of reimbursement for which the  
15 patient is eligible<sup>3</sup>; and  
16

17 Whereas, These sources of reimbursement include, but are not limited to, Medicare Part A and  
18 B, State Medicaid, State or other federal health programs (e.g., Veterans Health Administration),  
19 private insurance, and funds from Tribal health programs<sup>3</sup>; and  
20

21 Whereas, AI/AN individuals have the highest rates of uninsurance compared to other racial and  
22 ethnic groups, even after passage of the Affordable Care Act, with 48.7% of people served by  
23 the Indian Health Service having no insurance coverage<sup>4</sup>; and  
24

25 Whereas, IHS, Tribal, and Urban Indian Health Programs are often limited to primary care  
26 services due to funding limitations and facility constraints, among other factors<sup>5</sup>; and  
27

28 Whereas, The IHS operates the Purchased/Referred Care Program (PRCP), a non-entitlement  
29 referral program that may cover medical and dental care provided away from an IHS or Tribal  
30 Health Program<sup>5,7</sup>; and  
31

32 Whereas, If the IHS is requested to pay through PRCP, then an AI/AN patient must meet the  
33 PRCP residency requirements, notification requirements, medical priority, and use of alternate  
34 resources such as private insurance, Medicaid, other sources of health funding<sup>5</sup>; and  
35

36 Whereas, PRCP funding is limited, restricting access to non-emergent medical specialty care  
37 part-way through the fiscal year unless an AI/AN patient is facing a "life-or-limb" situation<sup>6-8</sup>; and  
38

39 Whereas, Reporting of PRCP claims is limited, but in a recent 2018 report on federal funding  
shortfalls, the U.S. Commission on Civil Rights reported that in Fiscal Year 2013, the IHS PRCP

denied an estimated 147,000 medical claims as needed by AI/AN patients—amounting to \$761 million in unmet need<sup>9</sup>; and

Whereas, Tribal Health Programs often augment PRCP funding with their own funds to increase access to medical specialty care<sup>10</sup>; and

Whereas, More than 70 percent of the AI/AN population lives in Urban Areas, yet Urban Indian Health Programs are not eligible to participate in PRCP, limiting access to care<sup>5,11</sup>; and

Whereas, Community benefit is a legal term for expenditures made by non-profit hospitals to fulfill their charitable obligations as tax-exempt health care institutions<sup>12</sup>; and

Whereas, In 2019, 180 California nonprofit hospitals reported a total of over \$6 billion in community benefit expenditures, \$2.9 billion of which were attributed to coverage of Medicaid shortfalls, and another \$861 million attributed to financial assistance for uninsured patients (63% of all expenditures)<sup>12</sup>; and

Whereas, Community benefit dollars have the potential to increase access to comprehensive, high-quality specialty care for AI/AN patients in states with large AI/AN populations, like California<sup>12</sup>; and

Whereas, Our American Medical Association supports special allocations of community benefit dollars to meet unmet health needs (H-215.961); therefore be it

RESOLVED, That our American Medical Association advocate to Congress to 1) increase funding to the Indian Health Service Purchased/Referred Care Program to enable the program to fully meet the healthcare needs of AI/AN patients and 2) expand eligibility to patients served by Urban Indian Health Programs (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage nonprofit hospitals to allocate community benefit dollars to increase access to specialty care for patients referred from Indian Health Service, Tribal, and Urban Indian Health Programs. (New HOD Policy)

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

Received: 3/24/23

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## RELEVANT AMA POLICY

### Community Benefit Dollars for Diabetes Prevention H-215.961

1. Our AMA supports allocating community benefit dollars to cover the cost of enrolling patients in an in-person or virtual diabetes prevention program that is part of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program.
2. Our AMA will work with the American Hospital Association and other stakeholders to develop and disseminate a position paper with guidance for covering the costs of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program with community benefit dollars.
3. Our AMA encourages each state medical society to work with their respective hospitals and local Diabetes Prevention Program providers to offer the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients.
4. Our AMA encourages that private and public payors offer the Centers for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients as part of their suite of benefits.

Citation: Res. 427, A-16;

### Access to Specialty Care H-160.952

The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct patient self-referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines.

Citation: (CMS Rep. 1, A-94; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmation A-09; Reaffirmed in lieu of Res. 815, I-13)

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

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

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

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

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

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

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

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

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

(9) State and county medical associations establish liaisons with intertribal health councils in those states

where American Indians reside.

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

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

Citation: (CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210  
(A-23)

Introduced by: Medical Student Section

Subject: The Health Care Related Effects of Recent Changes to the US Mexico Border

Referred to: Reference Committee B

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1 Whereas, The U.S Mexico border extends 1980 miles from San Diego, California to  
2 Brownsville, Texas with hundreds of thousands of undocumented immigrants entering the  
3 U.S illegally every year<sup>1</sup>; and  
4

5 Whereas, On January 24th, 2017, President Trump signed the “Border Security and  
6 Immigration Enforcement Improvements” Executive Order that resulted in an increase in the  
7 height of the border wall from 17 to 30 feet and initiated the addition of 49 miles of new wall<sup>2</sup>;  
8 and  
9

10 Whereas, The Biden administration halted all border wall construction initiated by the Trump  
11 administration upon taking office but has recently been approving projects along the border to  
12 continue construction <sup>3-5</sup>; and  
13

14 Whereas, On March 20th, 2020, the Center for Disease Control under the Trump  
15 administration issued a public health order, Title 42, a law that allows removals by the U.S.  
16 government of persons who have recently been in a country where a communicable disease  
17 was present, which effectively shut the border to asylum seekers<sup>6</sup>; and  
18

19 Whereas, The US has to date expelled over 1.8 million individuals under Title 42, and the  
20 border has experienced a significant increase in repeat and overall crossings at the border<sup>7</sup>;  
21 and  
22

23 Whereas, Crossing the border for many results in injuries requiring medical assistance such  
24 as physical trauma, rhabdomyolysis, dehydration, and death<sup>8,9</sup>; and  
25

26 Whereas, Study comparing cases of fatal injuries from falls sustained when climbing the US  
27 Mexico border wall determined that the implication of both lateral and vertical expansion of  
28 the wall is increased severity and cost of the trauma <sup>10,11</sup>; and  
29

30 Whereas, A study found that 55% of migrants crossing the border experienced moderate to  
31 grave psychological suffering when screened by Doctors Without Borders<sup>12</sup>; and  
32

33 Whereas, A study from Arizona described damage to the cranium and spine as a clinically  
34 prevalent and costly result of border wall crossing that needs to be addressed to decrease  
35 the detrimental impacts felt both by immigrants and surrounding health care systems <sup>9</sup>; and  
36

37 Whereas, One study of the San Diegan US - Mexico Border compared medical outcomes pre  
38 and post changes to the border by the Trump administration and saw a greater than fivefold

1 increase in admissions, significantly increased hospital and scene mortality, as well as  
 2 admissions costs in 2021 which exceeded 13 million USD<sup>11</sup>; and

3  
 4 Whereas, A study on the Rio Grande Valley of 121 undocumented immigrants who were  
 5 injured in their travels incurred a cost of 1.1 million USD to the healthcare system that  
 6 provided care for this patient population<sup>13</sup>; and

7  
 8 Whereas, One study found the majority of deaths at the US-Mexico border were highly  
 9 preventable<sup>14</sup>; therefore be it

10  
 11 RESOLVED, That our American Medical Association recognize the health-related effects and  
 12 humanitarian consequences of increasing the U.S. Mexico border barrier height on immigrant  
 13 populations and the resulting effects on the U.S. healthcare system (New HOD Policy); and  
 14 be it further

15  
 16 RESOLVED, That our AMA oppose efforts to increase the height or length of border walls  
 17 and fences at the US-Mexico border, and other policies that deter people from crossing the  
 18 border by increasing or creating risks to their health and safety. (New HOD Policy)

19  
 Fiscal Note: Minimal - less than \$1,000

Received: 3/31/23

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## **RELEVANT AMA POLICY**

### **Financial Impact of Immigration on American Health System D-160.988**

Our AMA will: (1) ask that when the US Department of Homeland Security officials have physical custody of undocumented foreign nationals, and they deliver those individuals to US hospitals and physicians for medical care, that the US Office of Customs and Border Protection, or other appropriate agency, be required to assume responsibility for the health care expenses incurred by those detainees, including detainees placed on "humanitarian parole" or otherwise released by Border Patrol or immigration officials and their agents; and (2) encourage that public policy solutions on illegal immigration to the United States take into consideration the financial impact of such solutions on hospitals, physicians serving on organized medical staffs, and on Medicare, and Medicaid.

Citation: Res. 235, A-06; Reaffirmation I-10; Reaffirmed: BOT Rep. 04, A-20;

### **Improving Healthcare of Hispanic Populations in the United States H-350.975**

It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community.

(2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community.

(3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies.

(4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization.

(5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics.

(6) Promote research into effectiveness of Hispanic health education methods.

(7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border.

Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20;

### **Patient and Physician Rights Regarding Immigration Status H-315.966**

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Citation: Res. 018, A-17;

### **Separation of Children From Their Caregivers at Border H-440.818**

Our AMA will: (1) oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and (2) urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families.

Citation: Res. 253, A-18;

### **Addressing and Banning Nonconsensual Medical Procedures Among Migrant Women at the Border D-350.978**

Our AMA: (1) condemns the performance of nonconsensual, invasive medical procedures; (2) will advocate against forced sterilizations of any kind, including against migrant women in detention facilities, and advocate for appropriate associated disciplinary action (including license revocation); and (3) will advocate for safer medical practices and protections for migrant women.

Citation: Res. 016, A-22;



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211  
(A-23)

Introduced by: Medical Student Section

Subject: Amending Policy H-80.999, "Sexual Assault Survivors", to Improve Knowledge and Access to No-cost Rape Test Kits

Referred to: Reference Committee B

---

1 Whereas, Rape/sexual assault affected 319,950 individuals in the United States in the year  
2 2020, which is a rate of 1.2 individuals per 1,000<sup>1</sup>; and  
3

4 Whereas, The estimated lifetime cost of rape is \$122,461 per victim including but not limited  
5 to medical forensic examination, hospitalization/emergency department bills, sexually  
6 transmitted infection testing/treatment, criminal justice costs, mental health costs such as  
7 depression and/or PTSD treatment, abortion costs, and emergency contraceptive costs<sup>2</sup>; and  
8

9 Whereas, With more restricted access to abortion, the financial burden to rape/sexual assault  
10 victims is likely to increase as patients may now need to cross state lines, obtain a hotel/find  
11 temporary housing, take days off work, or incur additional costs to receive appropriate  
12 medical care<sup>3-5</sup>; and  
13

14 Whereas, The mental effect of rape/sexual assault may impact how victims present to the  
15 hospital, as victims may be in a vulnerable state with impaired rational thought, memory  
16 consolidation, and reduced energy and/or tonic immobility due to trauma<sup>6</sup>; and  
17

18 Whereas, Medical forensic exams, also known as rape test kits, involve a partnership  
19 between the healthcare provider and the crime lab to collect any DNA evidence on the body  
20 of the victim or at the scene of the crime, physical examination to look for signs of abuse, and  
21 medical history taking to aid in criminal case investigation<sup>7,8</sup>; and  
22

23 Whereas, Rape test kits, are not financially covered by all states if the provider administering  
24 the examination is not a registered Sexual Assault Nurse Examiner (SANE) or Sexual  
25 Assault Forensic Examiner (SAFE)<sup>9</sup>; and  
26

27 Whereas, Receiving care by SANE/SAFEs is associated with better psychological well-being  
28 of survivors, increased use of STI prophylaxis and emergency contraception, and higher  
29 quality evidence collection resulting in better legal outcomes<sup>10</sup>; and  
30

31 Whereas, Healthcare staff not trained as SANE/SAFEs have reported discomfort providing  
32 sexual assault services due to lack of knowledge about evidence collection and support  
33 needs, leading to increased isolation and stigmatization of victims<sup>11</sup>; and  
34

35 Whereas, The speed at which medical forensic examinations must be done is between 72  
36 and 96 hours after the assault has taken place, making this a time-sensitive examination<sup>12</sup>;  
37 and

1 Whereas, While there are more than 6,000 hospitals nationally; only 800-900 SANE  
2 programs have been identified in the United States<sup>9</sup>; and  
3

4 Whereas, The Department of Justice explains that states are required to work with local  
5 medical providers to inform victims of the availability of no-cost forensic exams such that a  
6 victim can call their local police department or hotline/crisis center to obtain information about  
7 local SANEs/SAFEs<sup>9</sup>; and  
8

9 Whereas, Victims who do not interact with law enforcement may not know how to access no-  
10 cost medical forensic examinations; and  
11

12 Whereas, Groups of individuals that have historically under-reported rape and sexual assault,  
13 such as African-American and Hispanic women and the LGBTQ+ community, are less likely  
14 to interact with law enforcement and therefore less likely to be informed about no-cost rape  
15 test kits<sup>13-15</sup>; and  
16

17 Whereas, Information about the availability of SANE/SAFEs is currently limited, and existing  
18 databases are only available in certain areas, are outdated, and are often missing information<sup>16</sup>;  
19 and  
20

21 Whereas, Creating and ensuring accessibility to a national database of Sexual Assault Nurse  
22 Examiner and Sexual Assault Forensic Examiner providers would allow all victims to quickly  
23 access information on where and how to receive a time-sensitive, no-cost medical forensic  
24 examination; and  
25

26 Whereas, Increasing accessibility to information on SANE/SAFE locations and providers  
27 would allow minority and other vulnerable populations to have more equal opportunities to  
28 receive no-cost medical forensic examination; therefore be it  
29

30 RESOLVED, That our American Medical Association amend Policy H-80.999, "Sexual  
31 Assault Survivors," by addition to read as follows:  
32

33 **Sexual Assault Survivors, H-80.999**

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

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

- 1        3. Our AMA will collaborate with relevant stakeholders to develop  
2        recommendations for implementing best practices in the treatment of  
3        sexual assault survivors, including through engagement with the joint  
4        working group established for this purpose under the Survivor's Bill of  
5        Rights Act of 2016.
- 6        4. Our AMA will (a) advocate for increased post-pubertal patient access to  
7        Sexual Assault Nurse Examiners, and other trained and qualified  
8        clinicians, in the emergency department for medical forensic  
9        examinations; (b) support and advocate that appropriate stakeholders,  
10       such as the Health Resources and Services Administration, the United  
11       States Government Accountability Office, and the Office on Violence  
12       Against Women, create and implement a national database of Sexual  
13       Assault Nurse Examiner and Sexual Assault Forensic Examiner  
14       providers.
- 15       5. Our AMA will advocate at the state and federal level for (a) the timely  
16       processing of all sexual examination kits upon patient consent; (b) timely  
17       processing of "backlogged" sexual assault examination kits with patient  
18       consent; and (c) additional funding to facilitate the timely testing of sexual  
19       assault evidence kits. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 4/3/23

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## RELEVANT AMA POLICY

### Sexual Assault Survivors H-80.999

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 limitation; (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 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.

Citation: Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18; Appended: Res. 210, A-22;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212  
(A-23)

Introduced by: Oklahoma

Subject: Marijuana Product Safety

Referred to: Reference Committee B

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1 Whereas, Physicians prioritize patient safety, and the American Medical Association Code of  
2 Medical Ethics underscores its commitment "to promote the art of medicine and the betterment  
3 of public health"; and  
4

5 Whereas, There are many legal implications due to the passage of state marijuana laws and the  
6 associated regulations passed by State Departments of Health; and  
7

8 Whereas, Current American Medical Association policy H-95.952, "Cannabis and Cannabinoid  
9 Research" calls for adequate and well-controlled studies of marijuana and urges that  
10 marijuana's status as a federal schedule I controlled substance be reviewed with the goal of  
11 facilitating the conduct of clinical research; and  
12

13 Whereas, Current AMA policy D-95.969, "Cannabis Legalization for Medicinal Use" states: Our  
14 AMA (3) will develop model legislation requiring the following warning on all cannabis products  
15 not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for  
16 abuse. This product has not been approved by the Food and Drug Administration for preventing  
17 or treating any disease process."; and  
18

19 Whereas, To date, the FDA has not approved a marketing application for cannabis for the  
20 treatment of any disease or condition<sup>1</sup>; and  
21

22 Whereas, The FDA has, approved one cannabis-derived drug product: Epidiolex  
23 (cannabidiol)(oral solution for the treatment of seizures associated with two rare and severe  
24 forms of epilepsy, Lennox-Gastaut syndrome and Dravet syndrome), and three synthetic  
25 cannabis-related drug products: Marinol (dronabinol), Syndros (dronabinol), and Cesamet  
26 (nabilone)<sup>1,2</sup>; and  
27

28 Whereas, The FDA is aware that some companies are marketing products containing cannabis  
29 and cannabis-derived compounds in ways that violate the Federal Food, Drug and Cosmetic Act  
30 (FD&C Act) and that may put the health and safety of consumers at risk<sup>3</sup>; and  
31

32 Whereas, The FDA is committed to protecting the public health while also taking steps to  
33 improve the efficiency of regulatory pathways for the lawful marketing of appropriate cannabis  
34 and cannabis-derived products<sup>3</sup>; and  
35

36 Whereas, Under the drug application process, a sponsor of a nonprescription drug submits a  
37 New Drug Application (NDA) or an Abbreviated New Drug Application (ANDA) to FDA for  
38 approval with the sponsor not able to market the nonprescription drug until FDA approves the  
39 NDA or ANDA<sup>4</sup>; therefore be it

1 RESOLVED, That our American Medical Association support the policy against marijuana use,  
 2 either medical or recreational, until such time scientifically valid and well-controlled clinical trials  
 3 are done to assess the safety and effectiveness as any new drug for medical use, prescription  
 4 or nonprescription (New HOD Policy); and be it further

5  
 6 RESOLVED, That our AMA Council on Legislation draft state model legislation for states that  
 7 have legalized “medical” or “recreational” marijuana that (1) prohibit dispensaries from selling  
 8 marijuana products if they make any misleading health information and/or therapeutic claims,  
 9 (2) to require dispensaries to include a hazardous warning on all marijuana product labels  
 10 similar to tobacco and alcohol warnings and (3) ban the advertising of marijuana dispensaries  
 11 and marijuana products in places that children frequent. (Directive to Take Action)

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

Received: 4/20/23

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3. <https://www.fda.gov/news-events/public-health-focus/fda-regulation-cannabis-and-cannabis-derived-products-including-cannabidiol-cbd>
4. <https://www.fda.gov/drugs/special-features/how-fda-strives-ensure-safety-otc-products>

#### RELEVANT AMA POLICY

##### **Cannabis and Cannabinoid Research H-95.952**

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana’s status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

Citation: CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of: Res. 434, A-19; Appended: Res. 913, I-19; Reaffirmation: A-22;

**CBD Oil Use and the Marketing of CBD Oil H-95.911**

Our AMA supports: (1) banning the advertising of cannabidiol (CBD) as a component of marijuana in places that children frequent; and (2) legislation and regulatory actions at the federal and state level to prohibit companies from selling CBD products if they make any unproven health and therapeutic claims. Citation: Res. 505, A-22;

**Cannabis Legalization for Medicinal Use D-95.969**

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

Citation: CSAPH Rep. 05, I-17; Appended: Res. 211, A-18; Appended: CSAPH Rep. 3, I-19;

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213  
(A-23)

Introduced by: Senior Physicians Section

Subject: Telemedicine Services and Health Equity

Referred to: Reference Committee B

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1 Whereas, Seniors with complex health conditions increasingly rely on telemedicine to receive  
2 specialized care from out-of-state expert physicians; and  
3

4 Whereas, Telemedicine reciprocity is limited to only 36 states, and some state boards prohibit  
5 telemedicine across state lines except in emergencies; and  
6

7 Whereas, The AMA Principles of Medical Ethics addresses provision of appropriate patient care  
8 as well as activities contributing to the betterment of public health for all people<sup>1</sup>; and  
9

10 Whereas, Telemedicine evaluation and management has been approved at parity with in-  
11 person professional visits and accepted positively by the majority of patients and doctors<sup>2</sup>; and  
12

13 Whereas, Access to virtual care positively affects underserved populations, rural seniors,  
14 patients who suffer from chronic conditions, and patients with mobility or transportation issues;  
15 and  
16

17 Whereas, Nationwide telemedicine is increasingly accepted as optimal care under many  
18 circumstances, and revised state licensure could improve access to care; and  
19

20 Whereas, Extension of telehealth coverage and payment parity may expire or be threatened as  
21 exemplified by national and some state insurance/support programs; and  
22

23 Whereas, Some government and other payers require once-a-year in-person physician  
24 encounters besides usual telemedicine visits; therefore be it  
25

26 RESOLVED, That our American Medical Association advocate for preservation of the physician  
27 telemedicine waiver and reimbursement at parity with in-person visits beyond December 31,  
28 2024 (Directive to Take Action); and be it further  
29

30 RESOLVED, That our AMA encourage research to determine the scope and circumstances of  
31 telehealth improved health outcomes, especially for underserved populations and seniors with  
32 complex health conditions that includes how best to ensure patients have the training in the use  
33 of technology needed to maximize its benefits. (New HOD Policy)  
34

Fiscal Note:

First Resolved: Modest - between \$1,000 - \$5,000

Second Resolved: Minimal - less than \$1,000

Received: 4/26/23



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2. Henry, T.A. "Patients, Doctors Like Telehealth. Here's What Should Come Next." AMA Website, 2021. Retrieved 03/13/23 from <https://www.ama-assn.org/practice-management/digital/patients-doctors-telehealth-here-s-what-should-come-next>

**RELEVANT AMA POLICY****Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980**

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Citation: Res. 208, I-18; Reaffirmed: CMS Rep. 7, A-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 2, A-22; Reaffirmed: CSAPH Rep. 2, A-22;

**Addressing Equity in Telehealth H-480.937**

Our AMA:

- (1) recognizes access to broadband internet as a social determinant of health;
- (2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
- (3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
- (4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
- (5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
- (6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
- (7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
- (8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians; and
- (9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

Citation: CMS Rep. 7, A-21; Reaffirmation: A-22;

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

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

Citation: Alt. Res. 203, I-20; Reaffirmed: CMS Rep. 7, A-21; Reaffirmed: Res. 239, A-22; Reaffirmation: A-22;

### **The Promotion of Quality Telemedicine H-480.969**

(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).

Citation: CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19; Modified: CMS Rep. 8, A-21; Reaffirmed: Res. 239, A-22;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214  
(A-23)

Introduced by: Senior Physicians Section

Subject: Advocacy and Action for a Sustainable Medical Care System

Referred to: Reference Committee B

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1 Whereas, Medicare has given financial raises to hospitals, ambulatory care facilities and  
2 pharmaceutical companies while physicians and their practices have also experienced rising  
3 costs for personnel, supplies, rent and other expenses without similar raises; and  
4

5 Whereas, Many senior physicians in private practice are financially vulnerable and are  
6 contemplating retiring earlier than expected due to inadequate revenue and refusal of Congress  
7 to adjust Medicare rates consistent with rising costs and inflation; and  
8

9 Whereas, Our American Medical Association via the AMA Recovery Plan for America's  
10 Physicians, and 120 state medical and national specialty societies, have endorsed ten principles  
11 to guide Congress in an overhaul to remedy the financial instabilities affecting physician  
12 practices in an unsustainable six-year payment freeze<sup>1</sup>; and  
13

14 Whereas, Payments to physicians are the only economic segment of the US health care system  
15 without inflation-based updates, a 22% lag when adjusted for inflation over the past 20 years;  
16 and  
17

18 Whereas, Small independent practices are more cost-efficient care centers than larger or  
19 institutional practices, so loss of independent practices will ultimately cost more,<sup>2,3</sup> reduce  
20 competition, and diminish access to care<sup>4,5</sup>; therefore be it  
21

22 RESOLVED, That our American Medical Association continue to strongly advocate for fair  
23 reimbursement of all segments of health care, particularly physicians, to undo inadequate  
24 payment relative to inflation (Directive to Take Action); and be it further  
25

26 RESOLVED, That our AMA seek ongoing reimbursement adjustments for fair physician  
27 payment at least on an annual basis in order to match that given to hospitals, extended and  
28 ambulatory care facilities, medical device and pharmaceutical companies for rising practice  
29 costs and inflation. (Directive to Take Action)  
30

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

Received: 4/26/23

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**RELEVANT AMA POLICY****Sequestration D-390.946**

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

Citation: Res. 212, I-21; Reaffirmed: Res. 240, A-22;

**The Site-of-Service Differential D-330.902**

1. Our AMA supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments.
2. Our AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings (eg, physician offices, HOPDs, and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.
3. Our AMA will urge CMS to update the data used to calculate the practice expense component of the Medicare physician fee schedule by administering a physician practice survey (similar to the Physician Practice Information Survey administered in 2007-2008) every five years, and that this survey collect data to ensure that all physician practice costs are captured.
4. Our AMA encourages CMS to both: a) base disproportionate share hospital payments and uncompensated care payments to hospitals on actual uncompensated care data; and b) study the costs to independent physician practices of providing uncompensated care.
5. Our AMA will collect data and conduct research both: a) to document the role that physicians have played in reducing Medicare spending; and b) to facilitate adjustments to the portion of the Medicare budget allocated to physician services that more accurately reflects practice costs and changes in health care delivery.
6. Our AMA will produce a graphic report illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.
7. Our AMA will consider disseminating the resulting educational materials and graphics.

Citation: CMS Rep. 04, I-18; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Appended: Res. 826, I-22;

**Federal EMR and Electronic Prescribing Incentive Program H-478.991**

Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize

or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required.

Citation: (Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13; Reaffirmed in lieu of Res. 214, I-13; Reaffirmed in lieu of Res. 221, I-13; Reaffirmed in lieu of Res. 222, I-13; Reaffirmed in lieu of Res. 223, I-14)

#### **Accurate Reporting of Physician Charges H-380.991**

The AMA believes that, since actual payment from Medicare and private insurers is substantially lower than submitted charges, it is misleading and inappropriate to draw inferences about physician fee inflation from submitted charge data.

Citation: BOT Rep. I, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215  
(A-23)

Introduced by: Medical Student Section

Subject: Supporting Legislative and Regulatory Efforts Against Fertility Fraud

Referred to: Reference Committee B

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1 Whereas, Illicit insemination, or fertility fraud, is defined as the failure on the part of a fertility  
2 doctor to obtain consent from a patient before inseminating her with his own sperm normally  
3 in the context of patients using assisted reproductive technology<sup>1</sup>; and  
4

5 Whereas, The results of a 1987 survey conducted showed that as many of 2% of fertility  
6 doctors polled had used their own sperm to inseminate their patients<sup>2</sup>; and  
7

8 Whereas, Over the past several years, more than 50 fertility doctors in the United States  
9 have been accused of fertility fraud and nearly all of the physicians who have been accused  
10 were discovered as a result of DNA tests taken by their offspring<sup>3</sup>; and  
11

12 Whereas, Physicians' inseminations of nonconsenting and unaware patients represent a  
13 gross trespass against all standards of modern practice<sup>4</sup>; and  
14

15 Whereas, Engaging in illicit insemination exploits patients' ignorance of circumstance, trust,  
16 intense desire to conceive, and vulnerability and breaches other ethical obligations, including  
17 the duty to disclose all relevant medical information to patients and to deal honestly with  
18 them, robbing them of their decision-making autonomy<sup>4</sup>; and  
19

20 Whereas, Former patients of these physicians speak of feeling violated and assaulted, their  
21 personal dignity and bodily integrity trampled, their family plans routed, and their trust  
22 broken<sup>5</sup>; and  
23

24 Whereas, Illicit insemination is a violation of the ethical principle of respecting individual  
25 autonomy to make an informed decision regarding the nature of one's health<sup>5</sup>; and  
26

27 Whereas, Illicit insemination is a violation of the ethical principle and physicians' responsibility  
28 to truth-telling<sup>5,6</sup>; and  
29

30 Whereas, These ethical, medical, and psychological issues patients and their children face  
31 as a result of physician actions directly contradicts the medical ethics principle of  
32 nonmaleficence<sup>7</sup>; and  
33

34 Whereas, Only four states specifically penalize physicians for inseminating their own sperm  
35 into patients without express consent and there are no federal penalties<sup>2,8</sup>; and  
36

37 Whereas, In Texas, Senate Bill 1259 classified illicit insemination as a form of sexual  
38 assault<sup>9</sup>; and

1 Whereas, Indiana lawmakers introduced Senate Bill 174, making it legal for victims of fertility  
2 fraud to pursue legal action against physicians who commit acts of fertility fraud<sup>10</sup>; and

3  
4 Whereas, Arizona lawmakers approved Senate Bill 1237 in 2021, giving victims and children  
5 conceived from illicit insemination the opportunity to pursue civil damages against the  
6 physician committing fertility fraud<sup>11</sup>; and

7  
8 Whereas, Utah House Bill 192 states that healthcare providers may not knowingly use their  
9 own gametes during assisted reproductive treatment without the patient's written consent,  
10 otherwise punishable as a third degree felony<sup>12</sup>; and

11  
12 Whereas, A lack of laws regarding illicit insemination in the majority of states requires people  
13 and families affected to seek legal action through application of existing criminal laws, such  
14 as those written for criminal deception, sexual battery, or rape, which do not fully apply to or  
15 encompass the actions conducted<sup>5,13</sup>; and

16  
17 Whereas, The use of applicable criminal laws that were written without consideration for illicit  
18 insemination may result in relevant cases being a poor fit for existing law, expiring past the  
19 statutes of limitation, or lacking evidence due to temporal constraints<sup>5,13</sup>; and

20  
21 Whereas, The rise of consumer genetic testing is growing in popularity with estimates of 26  
22 million testing kits bought in 2019 and an annual growth rate of 12.25%<sup>14,15</sup>; and

23  
24 Whereas, Hundreds of people who have been fathered by non-consensual insemination have  
25 discovered this information through consumer genetic testing<sup>16,17</sup>; and

26  
27 Whereas, A number of countries already have legislation that restrict the number of  
28 conceptions by an individual sperm donor in order to prevent unintentional consanguinity<sup>7</sup>;  
29 and

30  
31 Whereas, The American Society of Reproductive Medicine recommends restricting  
32 conceptions by individual donors to 25 births per population of 800,000 to avoid unintentional  
33 consanguinity<sup>7</sup>; and

34  
35 Whereas, Without measures to prevent illicit insemination by physicians, increased risk of  
36 consanguinity in communities can pose a significant threat to public health and lead to  
37 medical, psychological and ethical issues patients and their children must face<sup>18</sup>; therefore be  
38 it

39  
40 RESOLVED, That our American Medical Association oppose physicians using their own  
41 sperm to artificially inseminate patients without proper explicit and informed patient consent,  
42 otherwise known as illicit insemination or fertility fraud (New HOD Policy); and be it further

43  
44 RESOLVED, That our AMA support legislative and regulatory efforts to protect patients  
45 from physicians and healthcare practitioners who inseminate their own sperm into patients  
46 without their consent. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 4/3/23

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## RELEVANT AMA POLICY

## E-4.2.1 Assisted Reproductive Technology

Assisted reproduction offers hope to patients who want children but are unable to have a child without medical assistance. In many cases, patients who seek assistance have been repeatedly frustrated in their attempts to have a child and are psychologically very vulnerable. Patients whose health insurance does not cover assisted reproductive services may also be financially vulnerable. Candor and respect are thus essential for ethical practice.

"Assisted reproductive technology" is understood as all treatments or procedures that include the handling of human oocytes or embryos. It encompasses an increasingly complex range of interventions—such as therapeutic donor insemination, ovarian stimulation, ova and sperm retrieval, in vitro fertilization, gamete intrafallopian transfer—and may involve multiple participants.

Physicians should increase their awareness of infertility treatments and options for their patients.

Physicians who offer assisted reproductive services should:

- (a) Value the well-being of the patient and potential offspring as paramount.
- (b) Ensure that all advertising for services and promotional materials are accurate and not misleading.
- (c) Provide patients with all of the information they need to make an informed decision, including investigational techniques to be used (if any); risks, benefits, and limitations of treatment options and alternatives, for the patient and potential offspring; accurate, clinic-specific success rates; and costs.



- (d) Provide patients with psychological assessment, support and counseling or a referral to such services.
- (e) Base fees on the value of the service provided. Physicians may enter into agreements with patients to refund all or a portion of fees if the patient does not conceive where such agreements are legally permitted.
- (f) Not discriminate against patients who have difficult-to-treat conditions, whose infertility has multiple causes, or on the basis of race, socioeconomic status, or sexual orientation or gender identity.
- (g) Participate in the development of peer-established guidelines and self-regulation.

Issued: 2016

#### **E-4.2.3 Therapeutic Donor Insemination**

Therapeutic donor insemination using sperm from a woman's partner or a third-party donor can enable a woman or couple who might not otherwise be able to do so to fulfill the important life choice of becoming a parent (or parents).

However, the procedure also raises ethical considerations about safety for the woman and potential offspring, donor privacy, and the disposition of frozen semen, as well as the use of screening to select the sex of a resulting embryo.

Physicians who choose to provide artificial insemination should:

- (a) Provide therapeutic donor insemination in a nondiscriminatory manner. Physicians should not withhold or refuse services on the basis of nonclinical considerations, such as a patient's marital status.
- (b) Obtain informed consent for therapeutic donor insemination, after informing the patient (and partner, if appropriate):
  - (i) about the risks, benefits, likelihood of success, and costs of the intervention;
  - (ii) about the need to screen donated semen for infectious disease agents and genetic disorders when an individual proposes to donate sperm specifically for the patient's use in therapeutic donor insemination;
  - (iii) about the need to address in advance what will be done with frozen sperm (if any) from a known donor in the event the donor dies;
  - (iv) that state law will govern the status, obligations, and rights of the sperm donor, known or anonymous, in relation to a resulting child.
- (c) When sperm is collected specifically for use by an identified patient, obtain informed consent from the prospective donor, after informing the individual:
  - (i) about the need to test donated semen for infectious disease agents and genetic disorders;
  - (ii) whether and how the donor will be informed in the event the semen tests positive for infectious disease or genetic disorder;
  - (iii) that state law will govern the status, obligations, and rights of the donor in relation to a resulting child.
- (d) Counsel patients who choose to be inseminated with sperm from an anonymous donor to involve their partner (if any) in the decision.
- (e) Provide sex selection of sperm only for purposes of avoiding a sex-linked inheritable disorder.

Physicians should not participate in sex selection of sperm for reasons of gender preference.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216  
(A-23)

Introduced by: American Academy of Pediatrics

Subject: Improved Foster Care Services for Children

Referred to: Reference Committee B

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1 Whereas, The Family First Prevention Services Act (FFPSA) was signed into law in February  
2 2018 with a goal within the child welfare system on keeping children safely with their families to  
3 avoid the trauma that results when children are placed in out-of-home care; and  
4

5 Whereas, The FFPSA provides at risk families with access to mental health services, substance  
6 use treatment, and/or parenting skills courses; and  
7

8 Whereas, The FFPSA created the Title IV-E Prevention Services Clearinghouse which  
9 maintains a continuously updated and comprehensive list of evaluated and tested prevention  
10 services and programs for families at risk for entry into the child welfare system; and  
11

12 Whereas, States are allowed under FFPSA to use Title IV-E funds toward services which can  
13 help prevent family progression into the child welfare system and/or removal of a child from the  
14 family unit and must submit a 5-year Title IV-E prevention plan for approval prior to drawing  
15 down this funding; and  
16

17 Whereas, State, territory, and tribe implementation of this Act has been varied and additional  
18 state funding is required for administration of the Act in addition to adoption of improved foster  
19 care placement avoiding residential placement where possible; therefore be it  
20

21 RESOLVED, That our American Medical Association encourage and support state, territory, and  
22 tribe activities to implement changes to the child welfare system directed toward safely keeping  
23 children with their families when appropriate (New HOD Policy); and be it further  
24

25 RESOLVED, That our AMA support federal and state efforts to expand access to evidence -  
26 based services which can prevent foster care and keep families safely together, including  
27 mental health, substance use disorder treatment, and in-home parent skills-based services  
28 (Directive to Take Action); and be it further  
29

30 RESOLVED, That our AMA encourage and support state efforts expanding use of kinship and  
31 family foster care placement and state efforts to eliminate the use of non-therapeutic congregate  
32 foster care placement (New HOD Policy); and be it further  
33

34 RESOLVED, That our AMA support both federal and state funding for improvements to the child  
35 welfare system which minimize harm to the child and help provide additional services to families  
36 that will safely prevent child separation from the family (New HOD Policy); and be it further  
37

38 RESOLVED, That our AMA urge the development and promotion of a continuously updated and  
39 comprehensive list of evaluated and tested prevention services and programs for families at risk  
40 for entry into the child welfare system. (New HOD Policy)

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

Received: 5/2/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217  
(A-23)

Introduced by: American Academy of Child and Adolescent Psychiatry, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry, American Psychiatric Association, American Society of Addiction Medicine

Subject: Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools

Referred to: Reference Committee B

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1 Whereas, Our American Medical Association with other interested organizations declare the  
2 opioid epidemic as one of the many factors within the National Child Mental Health Crisis; and  
3

4 Whereas, Drug overdose deaths in youths from ages 10 to 19 years of age increased 109%  
5 from 2019-2021; and  
6

7 Whereas, There is increased access of illicit manufactured fentanyl (IMF) pills associated with  
8 higher risk of adolescent overdose, with IMF deaths increasing 182% from 2019-2021; and  
9

10 Whereas, The increased morbidity and mortality of adolescent substance use is a national  
11 crisis; and  
12

13 Whereas, Naloxone is a life-saving medication that can reverse an overdose from opioids; and  
14

15 Whereas, Opioid overdose reversal must be immediate as opioid overdose can quickly result in  
16 death; and  
17

18 Whereas, Naloxone is a safe medicine and only reverses overdoses in people with opioids in  
19 their systems; and  
20

21 Whereas, Our AMA supports legislative, regulatory, and national advocacy efforts to increase  
22 access to affordable naloxone, including but not limited to collaborative practice agreements  
23 with pharmacists and standing orders for pharmacies and, where permitted by law, community-  
24 based organizations, law enforcement agencies, correctional settings, schools, and other  
25 locations that do not restrict the route of administration for naloxone delivery; and  
26

27 Whereas, Our AMA supports the widespread implementation of easily accessible Naloxone  
28 rescue stations (public availability of Naloxone through wall-mounted display/storage units that  
29 also include instructions) throughout the country following distribution and legislative edicts  
30 similar to those for Automated External Defibrillators; and  
31

32 Whereas, All 50 states and the District of Columbia have enacted laws permitting pharmacy-  
33 based naloxone dispensing; and  
34

35 Whereas, Most states have enacted laws that provide laypersons with civil and criminal  
36 immunity for good faith administration of naloxone; and

1 Whereas, Roughly half of US states have statutory language regarding access to naloxone in  
2 schools; therefore be it  
3

4 RESOLVED, That our American Medical Association encourage states, including communities  
5 and school districts therein, to adopt legislative and regulatory policies that allow schools to  
6 make naloxone readily accessible to school staff, teachers, and students to prevent opioid  
7 overdose deaths on school campuses (New HOD Policy); and be it further  
8

9 RESOLVED, That our AMA encourage states, including communities and school districts  
10 therein, to eliminate barriers that preclude students from carrying naloxone in school. (New  
11 HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 5/2/23

#### REFERENCES

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#### RELEVANT AMA POLICY

##### Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
  2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
  3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
  4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
  5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
  6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
  7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
  8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
  9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.
- Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21;

**Prevention of Drug-Related Overdose D-95.987**

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

2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.

6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218  
(A-23)

Introduced by: Mississippi

Subject: Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners

Referred to: Reference Committee B

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1 Whereas, "Direct supervision of emergency services" refers to an individual actively practicing  
2 clinical medicine in the emergency department and overseeing all medical decisions in the  
3 emergency department at the point of care<sup>1</sup>; and  
4

5 Whereas, Direct supervision of emergency care is distinct from medical direction; and  
6

7 Whereas, Only 10% of nurse practitioners nationwide are trained in emergency care<sup>2</sup>; and  
8

9 Whereas, Nursing and medical leaders strongly recommend that, because of variations in  
10 training, licensure, and certification, nurse practitioners should not work alone in emergency  
11 departments<sup>2-4</sup>; and  
12

13 Whereas, Centers for Medicare & Medicaid Services (CMS) provides clear regulations on the  
14 direct supervision of emergency care in hospitals<sup>1</sup>, and  
15

16 Whereas, In the conditions of participation, CMS requires that for a hospital to provide  
17 emergency care, all emergency departments must have direct supervision by a qualified  
18 member of medical staff present in the hospital at all hours emergency services are provided<sup>1</sup>;  
19 and  
20

21 Whereas, "Direct supervision for emergency services" is defined as being physically in the  
22 hospital and not telemedicine<sup>1</sup>; and  
23

24 Whereas, The word "must" indicates without exception; and  
25

26 Whereas, The words "qualified member" are clearly proscribed by the American College of  
27 Emergency Physicians (ACEP) and American Association of Emergency Medicine (AAEM)<sup>2,3</sup>;  
28 and  
29

30 Whereas, While the words "medical staff," according to CMS, may include physicians, nurse  
31 practitioners, and physicians assistants<sup>1</sup>, there is a clear requirement for additional specialized  
32 training; and  
33

34 Whereas, it is the responsibility of the national organizations of emergency medicine physicians  
35 ACEP and AAEM to set standards for the practice of emergency medicine<sup>3,4</sup>; and

1 Whereas, ACEP and AAEM determine standards for the practice of emergency medicine and  
2 explicitly set the standard that nurse practitioners are unqualified to directly supervise medical  
3 care (i.e. work alone) in emergency departments<sup>2,3</sup>; and  
4

5 Whereas, When a nurse practitioner directly supervises the emergency department (i.e. works  
6 alone), they are in violation of CMS regulations, and  
7

8 Whereas, The risk of nurse practitioners directly supervising emergency care in emergency  
9 departments puts patients at risk of misdiagnosis, incorrect treatment, delay in care, or  
10 inadequate care when time-sensitive diseases present<sup>2-4</sup>; and  
11

12 Whereas, A waiver for telemedicine can mitigate staffing shortages, but it remains a temporary  
13 solution and does not change the CMS regulation or standards defined by AAEM or ACEP<sup>5</sup>; and  
14

15 Whereas, The American Medical Association acknowledges that it cannot directly hold  
16 regulatory bodies accountable, but will advocate for the enforcement of CMS regulations and  
17 the adoption of standards set by national organizations of emergency medicine physicians;  
18 therefore be it  
19

20 RESOLVED, That our American Medical Association, in accordance with Centers for Medicare  
21 & Medicaid Services (CMS) Regulations and standards of practice for emergency medicine as  
22 defined by American College of Emergency Physicians and American Association of  
23 Emergency Medicine, advocate for the enforcement of CMS regulations and the adoption of  
24 standards set by national organizations of emergency medicine physicians, and hold  
25 accountable hospital systems, staffing organizations, medical staff groups, and individual  
26 physicians supporting systems of care that promote direct supervision of emergency  
27 departments by nurse practitioners. (Directive to Take Action)

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

Received: 5/2/23

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## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219  
(A-23)

Introduced by: Mississippi

Subject: Repealing the Ban on Physician-Owned Hospitals

Referred to: Reference Committee B

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1 Whereas, The COVID-19 pandemic has highlighted the importance of physician leadership in  
2 healthcare and the critical need for innovation and flexibility during times of crisis; and  
3

4 Whereas, Physician-owned hospitals (POHs) often specialize in specific areas of medicine,  
5 leading to better outcomes for patients and promoting innovation in healthcare delivery; and  
6

7 Whereas, Physician ownership of hospitals can foster innovation and improve competition in the  
8 healthcare market, which could help to reduce healthcare costs and improve access to care,  
9 particularly in underserved areas; and  
10

11 Whereas, There are concerns that physician-owned hospitals may be more likely to engage in  
12 self-referral or overutilization of services, which could lead to higher costs and lower quality of  
13 care; and  
14

15 Whereas, Safeguards and regulations can be put in place to ensure that physician-owned  
16 hospitals are operating in the best interests of patients; and  
17

18 Whereas, Physician leadership is critical in healthcare, particularly during times of crisis, such  
19 as the COVID-19 pandemic; and  
20

21 Whereas, Restrictions on physician ownership of hospitals may limit access to quality care for  
22 patients in underserved areas; and  
23

24 Whereas, The American Medical Association has a longstanding policy of supporting the role of  
25 physicians in healthcare leadership and advocating for policies that promote physician  
26 ownership of healthcare facilities; and  
27

28 Whereas, It is critical to ensure that physicians are able to provide the highest quality care and  
29 make decisions based solely on the best interests of their patients; and  
30

31 Whereas, Allowing physicians to have ownership in hospitals can provide incentives for quality  
32 improvement, cost control, and greater coordination of care, leading to better patient outcomes  
33 and satisfaction; and  
34

35 Whereas, The Affordable Care Act and other healthcare policy reforms have emphasized the  
36 importance of value-based care and alternative payment models, which align with the goals of  
37 POHs and their emphasis on quality, efficiency, and cost-effectiveness; and

1 Whereas, Physician ownership of hospitals is common in many other countries, including  
2 Canada, Germany, and the United Kingdom, and has not been associated with negative  
3 consequences for patient care or healthcare costs; and  
4

5 Whereas, POHs have played a critical role in providing essential services during natural  
6 disasters and pandemics, as demonstrated by their response to Hurricanes Katrina and Rita in  
7 2005 and the COVID-19 pandemic in 2020; and  
8

9 Whereas, POHs provide valuable opportunities for physician training and education, research,  
10 and innovation; and  
11

12 Whereas, Physicians have a unique perspective and expertise that can be valuable in hospital  
13 governance and decision-making, and can help to ensure that the patient's best interests are  
14 always at the forefront of hospital operations; therefore be it  
15

16 RESOLVED, That our American Medical Association advocate for policies that alleviate any  
17 restriction upon physicians from owning, constructing, and/or expanding any hospital facility  
18 type - in the name of patient safety, fiscal responsibility, transparency, and in acknowledgment  
19 of physicians dedication to patient care (Directive to Take Action); and be it further  
20

21 RESOLVED, That our AMA advocate for the implementation of safeguards and regulations to  
22 ensure that physician-owned hospitals are operating in the best interests of patients (Directive  
23 to Take Action); and be it further  
24

25 RESOLVED, That our AMA encourage further study and research into the benefits and  
26 drawbacks of physician-owned hospitals and their impact on patient care, as well as the  
27 potential impact of regulatory safeguards to ensure transparency and accountability in  
28 physician-owned hospitals (New HOD Policy); and be it further  
29

30 RESOLVED, That our AMA work with policymakers to develop regulations that promote  
31 transparency and accountability in physician-owned hospitals, and protect against any potential  
32 conflicts of interest, while also fostering competition and innovation in the healthcare market  
33 (Directive to Take Action); and be it further  
34

35 RESOLVED, That our AMA continue to support physician leadership in healthcare and  
36 advocate for policies that enable physicians to provide the highest quality care to their patients,  
37 including policies that remove unnecessary barriers to physician ownership of hospitals  
38 (Directive to Take Action); and be it further  
39

40 RESOLVED, That our AMA work to educate its members and the public on the potential  
41 benefits of physician ownership of hospitals and the need for policies that support such  
42 ownership (Directive to Take Action); and be it further  
43

44 RESOLVED, That our AMA collaborate with other stakeholders, including hospital associations,  
45 patient advocacy groups, and government agencies, to develop and promote policies that  
46 support physician ownership of hospitals (Directive to Take Action); and be it further  
47

48 RESOLVED, That our AMA direct the appropriate stakeholders to report back to the AMA on the  
49 progress made in implementing these resolutions, with recommendations for future action as  
50 appropriate. (Directive to Take Action)

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

Received: 5/2/23

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#### RELEVANT AMA POLICY

##### **Hospital Consolidation H-215.960**

Our AMA: (1) affirms that: (a) health care entity mergers should be examined individually, taking into account case-specific variables of market power and patient needs; (b) the AMA strongly supports and encourages competition in all health care markets; (c) the AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on patients and providers; and (d) antitrust relief for physicians remains a top AMA priority; (2) will continue to support actions that promote competition and choice, including: (a) eliminating state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing administrative burdens that make it difficult for physician practices to compete; and (d) achieving meaningful price transparency; and (3) will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.

Citation: CMS Rep. 07, A-19; Reaffirmation I-22;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220  
(A-23)

Introduced by: Connecticut; Maine; Massachusetts; New Hampshire;  
Rhode Island; Vermont; Maryland; American College of Radiation Oncology;  
American Society for Radiation Oncology; American Society of Clinical  
Oncology; Association of University Radiologists

Subject: Coverage of Routine Costs in Clinical Trials by Medicare Advantage  
Organizations

Referred to: Reference Committee B

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1 Whereas, Our American Medical Association is a powerful advocate for clinical research; and

2  
3 Whereas, Our AMA believes it is an inherent obligation of managed care organizations to invest  
4 in broad-based clinical research (AMA policy H-460.930, "Importance of Clinical Research");  
5 and

6  
7 Whereas, Our AMA advocates that the Centers for Medicare and Medicaid Services (CMS)  
8 regulate Medicare Advantage Plans to assure the same treatment and authorization guidelines  
9 are followed for both fee-for-service Medicare and Medicare Advantage patients (AMA policy D-  
10 285.959, "Prevent Medicare Advantage Plans from Limiting Care"); and

11  
12 Whereas, Our AMA supports that Medicare Advantage plans, at a minimum, must provide  
13 enrollees with coverage for all Part A and Part B original Medicare services, if the enrollee is  
14 entitled to benefits under both parts (AMA policy H-330.878, "Medicare Advantage Policies");  
15 and

16  
17 Whereas, In contrast, current Medicare policy states, "For clinical trials covered under the  
18 Clinical Trials National Coverage Determination 310.1, original Medicare covers the routine  
19 costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in MA  
20 [Medicare Advantage] plans... [Emphasis added.]" (Medicare Managed Care Manual, Chapter  
21 4, Section 10.7.1); and

22  
23 Whereas, Current Medicare policy only holds that the Medicare Advantage Organization (MAO)  
24 is responsible for paying the enrollee the cost-sharing portion that was incurred with the original  
25 Medicare coverage for qualified clinical trial items (paragraph 3 of Section 10.7.1); and

26  
27 Whereas, For the enrollee to receive reimbursement from the MAO for this cost-sharing portion,  
28 current Medicare policy states, "To be eligible for reimbursement, an enrollee must notify their  
29 plan that the enrollee received a qualified clinical trial service and provide documentation of the  
30 cost-sharing incurred, as a provider bill" (paragraph 4 of section 10.7.1); and

31  
32 Whereas, This means that a Medicare Advantage enrollee who enters a qualified clinical trial is  
33 obligated to pay the cost-sharing portion of their standard-of-care services, and then to seek  
34 reimbursement from the MAO, even though the enrollee would otherwise never have been billed  
35 by the MAO for such standard services, including the cost-sharing portion; and  
36

1 Whereas, The cost-sharing portion of standard services for patients enrolling on clinical trials  
2 (trials that address critical questions in oncology, heart disease, and a host of other serious  
3 conditions) can amount to tens of thousands of dollars across months of treatment for a single  
4 patient; and

5  
6 Whereas, These policies annually affect many thousands of patients enrolling on large-scale  
7 clinical trials (including many funded by NIH and its individual Institutes); and

8  
9 Whereas, These policies punish public-spirited patients who enter clinical trials that will provide  
10 future generations with better medical treatments and improved health outcomes, even though  
11 that individual has no rational expectation of benefit, given the clinical equipoise inherent in a  
12 clinical trial; and

13  
14 Whereas, These policies create a profound financial disincentive for patients to enter clinical  
15 trials, who thereby incur many thousands of dollars in liabilities in exchange only for the promise  
16 of potential future reimbursement, making trial enrollment very unattractive; and

17  
18 Whereas, Most Medicare Advantage patients will not enroll in clinical trials if they are informed  
19 of these financial liabilities; and

20  
21 Whereas, Such policies effectively provide the MAO these sums free-of-charge for many  
22 months, even though the MAO ultimately will be liable to pay these sums – in short, a “loan”  
23 from the enrollee to the MAO; and

24  
25 Whereas, A recent inquiry across member organizations of the Association of American Cancer  
26 Institutes (AACI) identified numerous institutions across the country that reported increasing  
27 difficulties with billing and reimbursement for their MAO patients; and

28  
29 Whereas, At least one of these institutions (namely, Dartmouth Cancer Center) has incurred  
30 significant costs to employ additional financial services staff to advise and support patients who  
31 are wrestling with these payment difficulties, a fact that vividly demonstrates the needs of these  
32 vulnerable, public-spirited patients and the demands on institutions attempting to support them;  
33 and

34  
35 Whereas, Such individual institutional interventions can only serve as temporary stopgaps and  
36 cannot serve as long-term solutions to this issue, inasmuch as they create unsustainable costs  
37 at the single institutional level and would engender massive expenditures if implemented across  
38 larger systems and disease types; therefore be it

39  
40 RESOLVED, That our American Medical Association advocate that the Centers for Medicare  
41 and Medicaid Services require that Medicare Advantage Organizations (MAOs) pay for routine  
42 costs for services that are provided as part of clinical trials covered under the Clinical Trials  
43 National Coverage Determination 310.1, just as the MAO would have been required to do so  
44 had the patient not enrolled in the qualified clinical trial. (Directive to Take Action)

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

Received: 5/2/23

## **RELEVANT AMA POLICY**

### **Importance of Clinical Research H-460.930**

(1) Given the profound importance of clinical research as the transition between basic science discoveries and standard medical practice of the future, the AMA will a) be an advocate for clinical research; and b) promote the importance of this science and of well-trained researchers to conduct it.

(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense.

(3) The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research.

(4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research.

(5) Our AMA encourages and supports development of community and practice-based clinical research networks.

Citation: CSA Rep. 2, I-96; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CME Rep. 4, I-08; Modified: CSAPH Rep. 01, A-18;

### **Prevent Medicare Advantage Plans from Limiting Care D-285.959**

Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.

Citation: Res. 706, A-21;

### **Medicare Advantage Policies H-330.878**

1. Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.

2. Our AMA will advocate: (a) for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients; (b) that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided; and (c) that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Citation: Res. 116, A-17; Reaffirmation: I-18; Appended: Res. 809, I-22;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221  
(A-23)

Introduced by: Pennsylvania

Subject: In Support for Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool

Referred to: Reference Committee B

---

1 Whereas, The Center for Disease Control and Prevention (CDC) reports that over the past 12  
2 months alone, 100,000 Americans have died from opioid-related overdoses<sup>1</sup>; and  
3

4 Whereas, The medical community recognizes Opioid Use Disorder (OUD) as a condition  
5 necessitating treatment and comprehensive preventative measures to curtail the harms  
6 associated with it<sup>3</sup>; and  
7

8 Whereas, The presence of highly potent synthetic opioid adulterants, namely fentanyl and its  
9 analogues<sup>4</sup>, in the illicit drug market has fueled a national public health crisis and increase in  
10 opioid overdoses<sup>5</sup>; and  
11

12 Whereas, The US Drug Enforcement Administration's 2020 National Drug Threat Assessment  
13 reports an increasing number of deaths attributable to fentanyl contamination of the illicit drug  
14 supply ("lacing") in 38 states<sup>6</sup>; and  
15

16 Whereas, In 2021, the United Nations Global Commission on Drug Policy called for the  
17 inclusion of drug checking services, such as Fentanyl Test Strips (FTS), as an additional harm-  
18 reduction tool in combating overdoses<sup>8</sup>; and  
19

20 Whereas, A study of self-reported drug-using adults in Rhode Island demonstrated that  
21 approximately 50% of individuals who used FTS and whose drug tested positive for fentanyl  
22 took steps to reduce their risk of overdose, including decreasing their dose, not using alone,  
23 having Naloxone nearby, or discarding the supply<sup>10</sup>; and  
24

25 Whereas, A multi-site analysis concluded that FTS, compared to other portable drug checking  
26 technologies, have the lowest detection threshold and highest specificity for fentanyl, detecting  
27 over 10-fentanyl analogs<sup>11,12</sup>; and  
28

29 Whereas, The CDC and the Substance Abuse and Mental Health Services Administration  
30 approved the use of federal funding for the purchase and distribution of FTS<sup>13</sup>; and  
31

32 Whereas, FTS remain classified as drug paraphernalia in a majority of states under the  
33 Controlled Substance, Drug, Device and Cosmetic Act<sup>14</sup>—which is a hindrance to their  
34 widespread adoption, distribution, and acceptance; and  
35

36 Whereas, A 2021 correspondence<sup>15</sup> between the American Medical Association and the White  
37 House's Acting Director of the Office of National Drug Control Policy, as well as a 2021 JAMA  
38 Network report, shared this concern regarding the impact of FTS's legality on their  
39 accessibility<sup>16</sup>; therefore be it

1 RESOLVED, That our American Medical Association amend AMA Policy D-95.987, "Prevention  
2 of Drug-Related Overdose," by addition to read as follows:

- 3
- 4 1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and  
5 drug-related overdoses and death places on patients and society alike and reaffirms its  
6 support for the compassionate treatment of patients with a SUD and people who use  
7 drugs; (b) urges that community-based programs offering naloxone and other opioid  
8 overdose and drug safety and prevention services continue to be implemented in order  
9 to further develop best practices in this area; (c) encourages the education of health care  
10 workers and people who use drugs about the use of naloxone and other harm reduction  
11 measures in preventing opioid and other drug-related overdose fatalities; and (d) will  
12 continue to monitor the progress of such initiatives and respond as appropriate.
- 13 2. Our AMA will: advocate for the removal of FTS from the legal definition of drug  
14 paraphernalia.
- 15 3. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their  
16 caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the  
17 continued study and implementation of appropriate treatments and risk mitigation  
18 methods for patients at risk for a drug-related overdose.
- 19 4. Our AMA will support the development and implementation of appropriate education  
20 programs for persons receiving treatment for a SUD or in recovery from a SUD and their  
21 friends/families that address harm reduction measures.
- 22 5. Our AMA will advocate for and encourage state and county medical societies to  
23 advocate for harm reduction policies that provide civil and criminal immunity for the  
24 possession, distribution, and use of "drug paraphernalia" designed for harm reduction  
25 from drug use, including but not limited to drug contamination testing and injection drug  
26 preparation, use, and disposal supplies.
- 27 6. Our AMA will implement an education program for patients with substance use disorder  
28 and their family/caregivers to increase understanding of the increased risk of adverse  
29 outcomes associated with having a substance use disorder and a serious respiratory  
30 illness such as COVID-19.
- 31 7. Our AMA supports efforts to increase access to fentanyl test strips and other drug  
32 checking supplies for purposes of harm reduction by supporting both legalization of FTS  
33 use by patients, as well as training in FTS use, by pertinent professionals. (Modify  
34 Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 5/2/23

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## RELEVANT AMA POLICY

### Prevention of Drug-Related Overdose D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222  
(A-23)

Introduced by: Pennsylvania

Subject: Physician Ownership of Hospital Blocked by the ACA

Referred to: Reference Committee B

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1 Whereas, The Affordable Care Act (ACA) has prohibited physician ownership of new hospitals  
2 as well as placing onerous restrictions on previously existing physician-owned facilities; and  
3

4 Whereas, Consolidation in the healthcare space has lowered the number of hospitals available  
5 to treat patients; and  
6

7 Whereas, Lack of competition results in higher prices, fewer choices, and potentially longer wait  
8 times for Americans seeking inpatient care; and  
9

10 Whereas, Data shows that physician-owned specialty hospitals and surgical centers have  
11 superior safety and quality metrics as well as overall outcomes compared to similar non-  
12 physician owned entities; and  
13

14 Whereas, The ban on physician ownership of new hospitals both harms patient access to care  
15 and unfairly restricts physician participation in potential solutions to the multiple healthcare  
16 crises facing our population; therefore be it  
17

18 RESOLVED, That our American Medical Association explore and report back to the House of  
19 Delegates at the 2024 Annual Meeting, the feasibility of filing judicial or legislative challenges to  
20 the ban on physician ownership of new hospitals under the relevant provisions of the Affordable  
21 Care Act. (Directive to Take Action)

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

Received: 5/2/23

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223  
(A-23)

Introduced by: The Endocrine Society, American Association of Clinical Endocrinology,  
American Society for Reproductive Medicine

Subject: Protecting Access to Gender Affirming Care

Referred to: Reference Committee B

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1 Whereas, Gender-affirming care is defined by the United States Department of Health and  
2 Human Services as a “supportive form of healthcare” consisting of “an array of services that  
3 may include medical, surgical, mental health, and non-medical services for transgender and  
4 nonbinary people”<sup>1</sup>; and  
5

6 Whereas, Gender incongruence refers to when the gender identity of a person does not align  
7 with the gender assigned at birth, and gender dysphoria is a condition in which a person with  
8 gender incongruence experiences significant burden associated with DSM classification; people  
9 experiencing gender incongruence and/or gender dysphoria may or may not identify as  
10 transgender or non-binary<sup>2</sup>; and  
11

12 Whereas, World Professional Association for Transgender Health (WPATH) establishes  
13 standards of care for children and adolescents that allow for puberty suppressing hormones (a  
14 fully reversible intervention) at onset of puberty, hormone replacement therapy for adolescents  
15 who have begun the physical changes of puberty, and limited gender-affirming surgical  
16 treatments in some cases<sup>3</sup>; and  
17

18 Whereas, The Endocrine Society recommends that gender-affirming hormone therapy, which is  
19 partially reversible, be offered to adolescents who continue to demonstrate gender  
20 incongruence with pubertal hormone suppression, and who demonstrate the ability to provide  
21 informed consent, usually beginning at 16 years old<sup>4</sup>; and  
22

23 Whereas, The American Academy of Pediatrics (AAP) states that gender-affirming medical care  
24 for gender-diverse and transgender adolescents may include puberty blockers during puberty  
25 and/or cross-sex hormone therapy from early adolescence onward<sup>5</sup>; and  
26

27 Whereas, Data from the AAP showed that 50% of transgender male teens, 30% of transgender  
28 female teens, and 42% of nonbinary youth reported attempting suicide in their lifetime<sup>6</sup>; and  
29

30 Whereas, Studies of transgender and non-binary youth and adults show that those receiving  
31 gender-affirming hormone therapy or puberty blockers have decreased anxiety and depression  
32 symptoms, reduced suicidality, and increased appearance congruence, positive affect, and life  
33 satisfaction<sup>7-10</sup>; and  
34

35 Whereas, The ACLU is currently tracking several hundred anti-LGBTQ bills in the United States,  
36 many of which are targeted towards transgender youth and directly outline, ban, and/or  
37 criminalize gender-affirming medical and surgical procedures, name them as child abuse,  
38 prohibit physicians from providing said procedures by subjecting them to felony charges and/or

1 other legal repercussions, and/or deny public funding or insurance coverage for their  
2 provision<sup>11,12</sup>; and  
3

4 Whereas, As of April 2023, laws that prohibit or restrict access to gender-affirming care for  
5 transgender youth have already passed at the state-level in twelve states, and Florida has  
6 banned gender-affirming care for minors via votes of the Florida Board of Medicine and Florida  
7 Board of Osteopathic Medicine<sup>12-14</sup>; and  
8

9 Whereas, Some proposed bills extend restrictions on gender-affirming care to include  
10 transgender young adults up to 21-26 years old in addition to transgender minors and/or  
11 effectively ban gender affirming care for all adults by restricting reimbursement for providers or  
12 prohibiting coverage with public funds<sup>15-17</sup>; and  
13

14 Whereas, The Human Rights Campaign reports that over half of transgender youth, ages 13 to  
15 17, have lost or are at risk of losing access to medically necessary gender-affirming care in their  
16 state<sup>18</sup>; and  
17

18 Whereas, Surveys of transgender and gender-diverse youth and parents of these youth show  
19 that debates about the rights of transgender people and proposed legislation restricting access  
20 to gender-affirming care have negatively impacted mental health and led to increased  
21 discrimination for youth<sup>19,20</sup>; and  
22

23 Whereas, Several states, including Minnesota, Illinois, New Mexico, Vermont, and New Jersey,  
24 have enacted bills or policies that protect physicians and patients providing and receiving  
25 gender-affirming care and/or declared themselves as “safe haven” states, and several other  
26 states have similar bills being introduced<sup>21,22</sup>; and  
27

28 Whereas, In 2022, Boston Children’s Hospital and Akron Children’s Hospital received threats of  
29 violence due to the fact that these hospitals provide gender-affirming care for youth, and the  
30 AMA and AAP spoke out against these instances<sup>23-25</sup>; and  
31

32 Whereas, Several other medical organizations, including the American Academy of Child and  
33 Adolescent Psychiatry, American College of Physicians, American Psychiatric Association,  
34 American Psychological Association, Endocrine Society, and Pediatric Endocrine Society, have  
35 spoken against these bills restricting gender-affirming care for transgender youth<sup>26-31</sup>; and  
36

37 Whereas, Over the last few years, the AMA has written several correspondences to state  
38 governments and the National Governors Association to oppose legislative efforts to restrict and  
39 criminalize gender-affirming care for minors<sup>32-38</sup>; and  
40

41 Whereas, The American Medical Association supports “treatment models for gender diverse  
42 people that promotes informed consent, personal autonomy, increased access for gender  
43 affirming treatments and eliminates unnecessary third party involvement outside of the  
44 physician-patient relationship in the decision making process” (AMA Policy H-140.824);  
45 therefore be it  
46

47 RESOLVED, That our American Medical Association work with state and specialty societies and  
48 other interested organizations to oppose any and all criminal and other legal penalties against  
49 patients seeking gender-affirming care and against parents and guardians who support minors  
50 seeking and receiving gender-affirming care; including the penalties of loss of custody and the  
51 inappropriate characterization of gender-affirming care as child abuse (Directive to Take Action);  
52 and be it further

1 RESOLVED, That our AMA advocate for protections from violence, criminal or other legal  
2 penalties, adverse medical licensing actions, and liability, including responsibility for future  
3 medical costs, for (a) healthcare facilities that provide gender-affirming care; (b) physicians and  
4 other healthcare providers who provide gender-affirming care; and (c) patients seeking and  
5 receiving gender-affirming care (Directive to Take Action); and be it further

6  
7 RESOLVED, That our AMA work with state and specialty societies and other interested  
8 organizations to advocate against state and federal legislation that would prohibit or limit  
9 gender-affirming care (Directive to Take Action); and be it further

10  
11 RESOLVED, That our AMA work with other interested organizations to communicate with the  
12 Federation of State Medical Boards about the importance of preserving gender-affirming care  
13 despite government intrusions (Directive to Take Action); and be it further

14  
15 RESOLVED, That our AMA amend policy H-185.927, "Clarification of Medical Necessity for  
16 Treatment of Gender Dysphoria," by insertion and deletion as follows:

17  
18 **Clarification of Medical Necessity for Treatment of Gender Dysphoria, H-185.927**

19 Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria and  
20 gender incongruence, as determined by shared decision making between the patient  
21 and physician, are medically necessary as outlined by generally-accepted standards of  
22 medical and surgical practice; (2) will advocate for federal, state, and local policies to  
23 provide medically necessary care for gender dysphoria and gender incongruence; and  
24 ~~(3) opposes the criminalization and otherwise undue restriction of evidence-~~  
25 ~~based gender-affirming care will support legislation, ballot initiatives and state and~~  
26 federal policies to protect access to gender affirming care. (Modify Current HOD Policy)

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

Received: 5/2/23

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## **RELEVANT AMA POLICY**

### **Removing Financial Barriers to Care for Transgender Patients H-185.950**

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Citation: Res. 122; A-08; Modified: Res. 05, A-16; Reaffirmed: Res. 012, A-22;

### **Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927**

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes the criminalization and otherwise undue restriction of evidence-based gender-affirming care.

Citation: Res. 05, A-16; Modified: Res. 015, A-21;

### **Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824**

Our AMA supports: (1) shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers; and (2) treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third party involvement outside of the physician-patient relationship in the decision making process.

Citation: Res. 014, A-22;

### **Affirming the Medical Spectrum of Gender H-65.962**

Our AMA opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity.

Citation: Res. 005, I-18;

### **Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991**

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18;

#### **Access to Basic Human Services for Transgender Individuals H-65.964**

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.

Citation: Res. 010, A-17;

#### **Preventing Anti-Transgender Violence H-65.957**

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths; (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

Citation: Res. 008, A-19;

#### **Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927**

Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.

Citation: Res. 402, A-12; Reaffirmed: CSAPH Rep. 1, A-22;

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

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.

2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:

a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;

b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;

c. Training, including collaborating with interested medical schools, residency and fellowship programs,



academic centers, and clinicians to mitigate radically diminished training opportunities;

d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and

g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Citation: Res. 621, A-22;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224  
(A-23)

Introduced by: American Society for Metabolic and Bariatric Surgery  
Society of American Gastrointestinal and Endoscopic Surgeons

Subject: Advocacy Against Obesity-Related Bias by Insurance Providers

Referred to: Reference Committee B

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1 Whereas, Our American Medical Association has recognized obesity as a disease; and

2  
3 Whereas, Obesity is the most common chronic disease in adulthood; and

4  
5 Whereas, Untreated obesity leads to significant morbidity, premature mortality, and an enormous  
6 financial burden to society from health care costs and lost productivity; and

7  
8 Whereas, Our AMA is committed to promoting the highest standards of medical care and  
9 improving public health; and

10  
11 Whereas, Effective treatment of the disease obesity requires a comprehensive multi-disciplinary  
12 approach delivered lifelong, including lifestyle therapy, anti-obesity medications, and metabolic  
13 and bariatric surgery, either sequentially or in an adjuvant fashion; and

14  
15 Whereas, Our AMA recognizes the importance of bariatric surgery as an effective treatment for  
16 obesity and related comorbidities; and

17  
18 Whereas, Metabolic Bariatric Surgery in the United States is associated with consistently low  
19 mortality and morbidity rates, and

20  
21 Whereas, The practice of Metabolic Bariatric Surgery in the United States is overwhelmingly  
22 subjected to accreditation and oversight by the American College of Surgeons and the Society  
23 for Metabolic and Bariatric Surgeons; and

24  
25 Whereas, Studies have shown that access to bariatric surgery reduces healthcare costs and  
26 improves patient outcomes; and

27  
28 Whereas, Studies have shown that Metabolic Bariatric Surgery results in a reduction on the  
29 incidence of several cancers and improves survivorship in patients with cancer; and

30  
31 Whereas, In 2022, the American Society for Metabolic and Bariatric Surgery established  
32 baseline criteria for the indications for the practice of metabolic surgery based on the available  
33 scientific evidence; and

34  
35 Whereas, Despite ample evidence to the contrary, many public and private insurance providers  
36 currently impose arbitrary restrictions and discriminatory practices that limit or deny coverage for  
37 metabolic surgery, such as mandatory preoperative weight management programs and time-  
38 based delays. Such tactics discourage patients from completing preoperative programs and  
39 lead to continued comorbidity related to the disease of obesity; and

Whereas, Recent AMA policy D-440.954, "*Addressing Adult and Pediatric Obesity*," establishes the AMA as working to improve national understanding of the obesity epidemic and address gaps in medical obesity education and health disparities, and the lack of insurance coverage for obesity treatment; therefore be it

RESOLVED, That our American Medical Association urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to

1. Revise their policies to ensure that bariatric surgery is covered for patients who meet the appropriate medical criteria.
2. Eliminate criteria that place unnecessary time-based mandates that are not clinically supported nor directed by the patient's medical provider
3. Ensure that insurance policies in their states do not discriminate against potential metabolic surgery patients based on age, gender, race, ethnicity, socioeconomic status.
4. Advocate for the cost-effectiveness of all obesity treatment modalities in reducing healthcare costs and improving patient outcomes (Directive to Take Action); and be it further

RESOLVED, That the AMA support and provide resources to state delegations in their efforts to advocate for the reduction of bias against patients that suffer from obesity for the actions listed. (Directive to Take Action)

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

Received: 5/2/23

## RELEVANT AMA POLICY

### Addressing Adult and Pediatric Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.
2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).
3. Our AMA will work with interested national medical specialty societies and state medical associations to increase public insurance coverage of and payment for the full spectrum of evidence-based adult and pediatric obesity treatment.
4. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.
5. Our AMA will leverage existing channels within AMA that could advance the following priorities:
  - Promotion of awareness amongst practicing physicians and trainees that obesity is a treatable chronic disease along with evidence-based treatment options.

- Advocacy efforts at the state and federal level to impact the disease obesity.
- Health disparities, stigma and bias affecting people with obesity.
- Lack of insurance coverage for evidence-based treatments including intensive lifestyle intervention, anti-obesity pharmacotherapy and bariatric and metabolic surgery.
- Increasing obesity rates in children, adolescents and adults.
- Drivers of obesity including lack of healthful food choices, over-exposure to obesogenic foods and food marketing practices.

6. Our AMA will conduct a landscape assessment that includes national level obesity prevention and treatment initiatives, and medical education at all levels of training to identify gaps and opportunities where AMA could demonstrate increased impact.

7. Our AMA will convene an expert advisory panel once, and again if needed, to counsel AMA on how best to leverage its voice, influence and current resources to address the priorities listed in item 5. above.

Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18; BOT Action in response to referred for decision: Res. 415, A-22; Modified: Res. 818, I-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225  
(A-23)

Introduced by: American Thoracic Society

Subject: Regulation of “Cool/Non-Menthol” Tobacco Products

Referred to: Reference Committee B

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1 Whereas, Smoking leads to disease and disability and harms nearly every organ of the body;  
2 and  
3

4 Whereas, Cigarette smoking remains the leading cause of preventable disease, disability, and  
5 death in the United States; and  
6

7 Whereas, The tobacco industry spends billions of dollars each year on marketing cigarettes;  
8 and  
9

10 Whereas, In 2020, 12.5% of U.S. adults (an estimated 30.8 million people) currently smoked  
11 cigarettes: 14.1% of men, 11% of women; and  
12

13 Whereas, Each day, about 1,600 youth try their first cigarette; and  
14

15 Whereas, The Food and Drug Administration has proposed rules to ban menthol flavored  
16 cigarettes and flavored cigars; and  
17

18 Whereas, The state of California has enacted legislation banning menthol cigarettes; and  
19

20 Whereas, Several tobacco companies have introduced new tobacco products that produce the  
21 same “cooling” sensation of a menthol product, but does not include a menthol taste; and  
22

23 Whereas, The flavoring additives used to achieve the cooling sensation work on the same  
24 receptors as does the menthol flavors; and  
25

26 Whereas, The tobacco industry has marketed these new “cooling/non-menthol” products using  
27 terms like “cool” and “fresh” – the same terms used to describe menthol tobacco products; and  
28

29 Whereas, Documents released as a result of the tobacco action master settlement showed the  
30 tobacco industry knowingly and intentionally used flavored tobacco products to lure children and  
31 marginalized communities into tobacco addiction; and  
32

33 Whereas, The tobacco industry appears to be designing new products to intentionally evade  
34 menthol bans and to continue marketing flavored tobacco products to youth and marginalized  
35 populations; therefore be it  
36

37 RESOLVED, That our American Medical Association advocate that tobacco products that use  
38 additives that create a “cooling effect” should be treated as a tobacco product with a  
39 characterizing flavor for legal and regulatory purposes. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 5/8/23

**RELEVANT AMA POLICY**

**Opposition to Exempting the Addition of Menthol to Cigarettes H-495.976**

Our AMA: (1) will continue to support a ban on the use and marketing of menthol in cigarettes as a harmful additive; and (2) encourages and will assist its members to seek state bans on the sale of menthol cigarettes.

Citation: BOT Action in response to referred for decision Res. 436, A-08; Modified: CSAPH Rep. 01, A-18;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226  
(A-23)

Introduced by: Michigan

Subject: Vision Qualifications for Driver's License

Referred to: Reference Committee B

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1 Whereas, Current vision qualifications for operating motor vehicles were derived by various  
2 states in the 1920s and 1930s; and  
3

4 Whereas, The American Medical Association (2003) in its Physician's Guide to Assessing and  
5 Counseling Older Drivers stated, "Although many states currently require far visual acuity of  
6 20/40 for an unrestricted license, current research indicates that there is no scientific basis for  
7 this cut-off. In fact, studies undertaken in some states have demonstrated that there is no  
8 increased crash risk between 20/40 and 20/70 resulting in several new state requirements;" and  
9

10 Whereas, Good data exists to recommend reconsideration of visual acuity standards in many  
11 states; and  
12

13 Whereas, It has been well known that some persons with reduced acuity continue to drive  
14 safely; and  
15

16 Whereas, Persons with significant visual field defects that violate state licensure requirements  
17 can be taught to drive safely; and  
18

19 Whereas, Tests for cognitive well-being are generally not used in motor vehicle licensure testing  
20 protocols in most states; and  
21

22 Whereas, Denying drivers licensure without evidence to support that denial frequently causes  
23 isolation, depression, and increased expenses for ill-advised and unnecessary medical visits;  
24 and  
25

26 Whereas, Crash avoidance systems, unimagined one century ago, are routinely incorporated in  
27 automotive and roadway systems; and  
28

29 Whereas, Autonomous vehicle technology is in advanced stages of development and has been  
30 supported by the Michigan State Medical Society (MSMS), the AMA, and the National Highway  
31 Traffic and Safety Administration (NHTSA); and  
32

33 Whereas, It is well known that a large proportion of mortality involved auto crashes are  
34 accompanied by "driver error;" and  
35

36 Whereas, Studies have been performed that show that drivers with the visual acuity less than  
37 20/50 can be safe and competent drivers; and  
38

39 Whereas, The Michigan Society of Eye Physicians and Surgeons (MiSEPS) has submitted a  
40 Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology

(AAO) urging state ophthalmologic societies to approach their legislators to consider reviewing, perhaps relaxing, the visual acuity / visual field requirements for licensure while simultaneously advocating for simple appropriate tests where cognitive decline is suspected; therefore be it

RESOLVED, That our American Medical Association engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on standardized vision requirements for unrestricted and restricted driver's licensing privileges. (Directive to Take Action)

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

Received: 5/3/23

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## **RELEVANT AMA POLICY**

### **E8.2 Impaired Drivers & Their Physicians**

A variety of medical conditions can impair an individual's ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique opportunities to assess the impact of physical and mental conditions on patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.

Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patient's ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.

To serve the interests of their patients and the public, within their areas of expertise physicians should: (a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene. (b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patient's ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments. (c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses. (d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely. (e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver: (i) when the physician identifies a medical condition clearly related to the ability to drive; (ii) when continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving; or (iii) when required by law. (f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician. (g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227  
(A-23)

Introduced by: Michigan

Subject: Reimbursement for Postpartum Depression Prevention

Referred to: Reference Committee B

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1 Whereas, The Centers for Disease Control and Prevention (CDC) reports that more than one in  
2 eight women with a recent live birth experience postpartum depression; and  
3

4 Whereas, Untreated mood and anxiety disorders amongst pregnant women and new mothers  
5 cost approximately \$14.2 billion over five years, with more than half the costs occurring within  
6 the first year due to pregnancy and birth complications; and  
7

8 Whereas, The United States Preventive Services Task Force (USPSTF) recommends  
9 prevention of depression in pregnant and postpartum women by a wide range of providers in  
10 standard prenatal care settings and provides a grade of B; and  
11

12 Whereas, Section 2713 of the Affordable Care Act requires private insurers to cover preventive  
13 services recommended by the USPSTF with a grade of A or B, along with those recommended  
14 by the Advisory Committee on Immunization Practices (ACIP), Bright Futures, and the Health  
15 Resources and Services Administration's (HRSA's) guidelines for women's health; and  
16

17 Whereas, The Affordable Care Act requires insurers to cover these services with no cost-  
18 sharing (i.e., no deductible and no co-pay); and  
19

20 Whereas, Given this USPSTF recommendation to provide postpartum depression prevention,  
21 these services should be reimbursable under the Affordable Care Act; and  
22

23 Whereas, The USPSTF recommends two postpartum depression prevention programs,  
24 including the Reach Out, Stay Strong, Essentials for Mothers of Newborns (ROSE) Program  
25 and the Mothers & Babies (MB) Program; and  
26

27 Whereas, Research has shown that receiving either the MB or ROSE intervention during  
28 pregnancy reduces the odds of developing postpartum depression by 53 percent and 50  
29 percent respectively; and  
30

31 Whereas, Prenatal health care providers currently must provide a mental health diagnosis code  
32 to bill for postpartum depression prevention, and thus primary prevention does not qualify; and  
33

34 Whereas, Useful Current Procedural Terminology Codes (CPT) for postpartum depression  
35 prevention include but are not limited to 98960-98962 regarding a "non-physician health care  
36 professional uses a standard curriculum to educate a patient about his or her disease or  
37 disorder to enable the patients and caregivers to effectively manage disease;" and  
38

39 Whereas, California reimburses for these services, but is currently the only state that has done  
40 so; and

Whereas, Administration of postpartum prevention interventions by nurses, health educators, community health workers, and other paraprofessionals has been shown to be non-inferior to licensed mental health providers in reducing rates of postpartum depression; therefore be it

RESOLVED, That our American Medical Association amend Policy H-420.95, "*Improving Mental Health Services for Pregnant and Postpartum Mothers*," by addition and deletion to read as follows:

**Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953**

Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; ~~and~~ (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs; and (5) will advocate for evidence-based postpartum depression prevention services to be recognized as the standard of care for all federally-funded health care programs for pregnant women. (Modify Current HOD Policy)

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

Received: 5/3/23

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## **RELEVANT AMA POLICY**

### **Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953**

Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.

Citation: Res. 102, A-12; Modified: Res. 503, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228  
(A-23)

Introduced by: Michigan

Subject: Reducing Stigma for Treatment of Substance Use Disorder

Referred to: Reference Committee B

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1 Whereas, Treatment and services for substance use disorders are health care and should not  
2 be considered a “carve out” or an exception to health care; and  
3

4 Whereas, Medicaid benefits may provide coverage for transportation costs for patients traveling  
5 to/from an office visit for general health care or mental health care visits; and  
6

7 Whereas, Treatment of substance use disorder (SUD) may also require transportation to office  
8 visits for treatment with medication for opioid use disorder (MOUD) and/or for counseling; and  
9

10 Whereas, The cost of transportation may be a barrier to ongoing participation in the treatment  
11 and recovery process for patients with SUD; and  
12

13 Whereas, The cost of transportation (and lack of access) may be an added barrier to accessing  
14 MOUD for the uninsured, underinsured, or patients insured through Medicaid; and  
15

16 Whereas, This lack of coverage for transportation costs for patients seeking treatment for SUD  
17 potentially adds to the stigma for SUD and may discourage people from accessing treatment;  
18 therefore be it  
19

20 RESOLVED, That our American Medical Association support and advocate for coverage for  
21 transportation costs for all Medicaid or Medicare health care services without a “carve out” for  
22 patients diagnosed with a substance use disorder who are being treated with medication for  
23 opioid use disorder. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 5/3/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229  
(A-23)

Introduced by: Michigan

Subject: Firearm Regulation for Persons Charged with or Convicted of a Violent Offense

Referred to: Reference Committee B

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1 Whereas, Title 18 U.S. Code Section 3553 “Imposition of a Sentence” defines “violent offense”  
2 as “a crime of violence, as defined in [Title 18, Part I, Chapter 1,] Section 16 [Crime of Violence  
3 Defined], that is punishable by imprisonment;” and  
4

5 Whereas, A “crime of violence” under the U.S. Code of Public Law of the 98th Congress under  
6 Title 18, Part I, Chapter 1, Section 16, Subsection (a) is defined as “an offense that has as an  
7 element the use, attempted use, or threatened use of physical force against the person or  
8 property of another;” and  
9

10 Whereas, The Gun Control Act of 1988 only prohibits the sale to, and possession of firearms by,  
11 a person indicted or convicted of misdemeanors punishable by more than two years of  
12 imprisonment; and  
13

14 Whereas, “Handgun possession is prohibited for people who have committed a violent  
15 misdemeanor punishable by less than 1 year of imprisonment” in five states including California,  
16 Hawaii, New York, Connecticut, and Maryland since 2016; and  
17

18 Whereas, Aggravated assaults accounted for 68.2 percent of violent crimes reported to law  
19 enforcement in 2019; and  
20

21 Whereas, California saw a “37% lower gun death rate than the national average” as of June  
22 2022 since enacting firearm safety laws; and  
23

24 Whereas, Hawaii had the lowest gun death rate at 2.5 deaths per capita in 2019 following its  
25 history of strict firearm legislation; and  
26

27 Whereas, 15 states have adopted a similar policy which bans the purchase of firearms for those  
28 that have been convicted of a violent misdemeanor; and  
29

30 Whereas, States like California and Hawaii have subsequently rescinded firearm possession for  
31 periods of 10 years up to indefinite suspension of possession, respectively; and  
32

33 Whereas, Adoption of this and similar policies by other states have correlated in an 18 percent  
34 reduction in total homicide rates; and  
35

36 Whereas, The American Medical Association has set precedent for supporting firearm  
37 restrictions in purchasing and possession in the cases of domestic violence; therefore be it

- 1 RESOLVED, That our American Medical Association study the effect of including a rescindment  
 2 period of 10 years for the possession of a firearm by persons convicted of a violent offense in  
 3 accordance with other established rescindment periods adopted by other states. (Directive to  
 4 Take Action)

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

Received: 5/3/23

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#### RELEVANT AMA POLICY

##### **Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975**

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
4. Our AMA and other organizations will develop and disseminate a formal educational program to enable clinicians to effectively and efficiently address suicides with an emphasis on seniors and other high-risk populations.
5. Our AMA will develop with other interested organizations a toolkit for clinicians to use addressing

Extreme Risk Protection Orders in their individual states.

6. Our AMA will partner with other groups interested in firearm safety to raise public awareness of the magnitude of suicide in seniors and other high-risk populations, and interventions available for suicide prevention.

7. Our AMA and all interested medical societies will: (a) educate physicians about firearm epidemiology, anticipatory guidance, and lethal means screening for and exploring potential restrictions to access to high-lethality means of suicide such as firearms. Health care clinicians, including trainees, should be provided training on the importance of anticipatory guidance and lethal means counseling to decrease firearm injuries and deaths and be provided training introducing evidence-based techniques, skills and strategies for having these discussions with patients and families; (b) educate physicians about lethal means counseling in health care settings and intervention options to remove lethal means, either permanently or temporarily from the home.

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21; Reaffirmed: Res. 907, I-22; Appended: Res. 909, I-22;



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230  
(A-23)

Introduced by: Michigan

Subject: Address Disproportionate Sentencing for Drug Offenses

Referred to: Reference Committee B

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1 Whereas, Crack cocaine is no more dangerous than powdered cocaine, it presents different  
2 dangers because it is smoked or injected while powder cocaine is snorted; and  
3

4 Whereas, Current sentencing disparities would land a powder-cocaine offender in prison for one  
5 day and put a crack-cocaine offender behind bars for 18 days (1:18) for possession of the same  
6 amount; and  
7

8 Whereas, Five grams of crack cocaine is punished like 90 grams of powder cocaine; and  
9

10 Whereas, The crack and powder cocaine sentencing disparity has disproportionately impacted  
11 people of color for the past three decades, a vestige of the War on Drugs; and  
12

13 Whereas, 85 percent of offenders convicted under the crack cocaine sentencing law (Anti-Drug  
14 Abuse Act of 1986) are Black Americans; and  
15

16 Whereas, The War on Drugs continues to disproportionately consume human potential and  
17 inflict trauma and suffering on communities of color despite wide-ranging evidence of its  
18 misguided origins and devastating impacts; and  
19

20 Whereas, Incarceration is linked to adverse health effects extending far beyond prison walls;  
21 and  
22

23 Whereas, People who have been incarcerated face higher rates of mental illness, substance  
24 use disorder, communicable diseases, and chronic diseases; and  
25

26 Whereas, Individuals incarcerated have lower life expectancies, with each year in prison taking  
27 two years of life; and  
28

29 Whereas, The majority of an estimated five hundred thousand people incarcerated for drug  
30 offenses are arrested for simple possession, a nonviolent crime; and  
31

32 Whereas, 74 percent of the public (majorities across the political spectrum) support ending the  
33 sentencing disparity between crack and powder cocaine offenses; therefore be it  
34

35 RESOLVED, That our American Medical Association actively lobby for federal and state  
36 legislation aimed at eliminating the national crack and powder cocaine sentencing disparity  
37 (from 18:1 to 1:1) and apply it retroactively to those already convicted or sentenced (Directive to  
38 Take Action); and be it further

- 1 RESOLVED, That our AMA collaborate with appropriate stakeholders, including, but not limited
- 2 to, courts, government agencies, professional organizations, and criminal/social justice
- 3 organizations to advocate for addressing excessive legal punishments for low-level, nonviolent
- 4 drug crimes at state and federal levels. (Directive to Take Action)

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

Received: 5/3/23

#### REFERENCES

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2. Prison Policy Initiative <https://www.prisonpolicy.org/reports.html>
3. Booker and Durbin Announce Legislation to Eliminate Federal Crack and Powder Cocaine Sentencing Disparity <https://www.booker.senate.gov/news/press/booker-and-durbin-announce-legislation-to-eliminate-federal-crack-and-powder-cocaine-sentencing-disparity>
4. A bill that would have impacted racial disparity in cocaine crimes died in the Senate <https://www.michiganradio.org/2023-01-09/a-bill-that-would-have-impacted-racial-disparity-in-cocaine-crimes-died-in-the-senate>
5. The Racist Roots of the War on Drugs and the Myth of Equal Protection for People of Color <https://lawrepository.ualr.edu/cgi/viewcontent.cgi?article=2106&context=lawreview>

#### RELEVANT AMA POLICY

##### **Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession H-95.910**

1. Our AMA supports 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 decriminalized under subsequent state legalization or decriminalization of adult use or medicinal cannabis.
2. Our AMA supports 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.
3. Our AMA will 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.
4. Our AMA supports 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.

Citation: BOT Rep. 17, A-22;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231  
(A-23)

Introduced by: Michigan

Subject: Equitable Interpreter Services and Fair Reimbursement

Referred to: Reference Committee B

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1 Whereas, All patients deserve equitable, fair, and high-level care in a language in which they  
2 can comprehend; and  
3

4 Whereas, More than 25 million Americans speak English “less than very well,” according to the  
5 U.S. Census Bureau, and the National Center for Health Statistics reports about 37.6 million  
6 adults have difficulty with their hearing; and  
7

8 Whereas, This population is less able to access health care and is at higher risk of adverse  
9 outcomes such as medication complications, noncompliance, and decreased patient  
10 satisfaction; and  
11

12 Whereas, Title VI of the Civil Rights Act and Executive Order 13166 mandate that interpreter  
13 services be provided for patients with limited English proficiency (LEP) who need this service,  
14 and Section 1557 of the Affordable Care Act has also created protections for medical interpreter  
15 services as part of its protections from discrimination on the basis of race, color, or country of  
16 origin; and  
17

18 Whereas, Unfortunately, there are currently only 14 states and 1 district that offer  
19 reimbursements for this service, including Connecticut, District of Columbia, Iowa, Idaho,  
20 Kansas, Maine, Minnesota, Montana, New Hampshire, New York, Texas (only sign language  
21 interpreters), Utah, Vermont, Washington, and Wyoming; and  
22

23 Whereas, In the aforementioned states, providers can claim an administrative match for 50-75  
24 percent of translation and interpretation claimed as an administrative expense if they are not  
25 already reimbursed as part of the direct service rates; and  
26

27 Whereas, As of 2009, oral interpreter services can be claimed using billing code T-1013 along  
28 with the Current Procedural Terminology (CPT) Code appropriate for the clinical encounter; and  
29

30 Whereas, In the 36 other states in which reimbursement for interpreter services is not codified,  
31 physicians sometimes have to bear the burden of the cost, which can cost up to \$150.00/hour;  
32 and  
33

34 Whereas, Studies have shown enforcement of hospital regulations to provide interpreters is  
35 inconsistent, and lack of reimbursement decreases hospital incentive to comply and many  
36 hospitals are not providing language services in a manner consistent with related CLAS  
37 standards; and  
38

39 Whereas, Although coding methods are available, their use is limited because payers expect  
40 physicians to absorb the cost of interpretation services as part of their business expenses; and

1 Whereas, In 2000, the CPT Editorial Panel responded to a request of the House of Delegates to  
2 review the development of a CPT Code for use of medical interpreters by using the modifier  
3 “32,” and  
4

5 Whereas, In addition to accrued cost, physicians often spend more time per visit with patients  
6 requiring medical interpreters due to initial set-up, dialogue in multiple languages, as well as  
7 additional clarifications; therefore be it  
8

9 RESOLVED, That our American Medical Association support the standardization of physician  
10 reimbursement in regard to interpreter services, whether it be through the usage of a Current  
11 Procedural Terminology (CPT) code or direct reimbursement by payers including Medicaid  
12 programs and Medicaid managed care plans (New HOD Policy); and be it further  
13

14 RESOLVED, That our AMA reaffirm Policy D-385.957, “*Certified Translation and Interpreter*  
15 *Services*,” which advocates for legislative and/or regulatory changes to require that payers  
16 including Medicaid programs and Medicaid managed care plans cover interpreter services and  
17 directly pay interpreters for such services and relieve the burden of the costs associated with  
18 translation services. (Reaffirm HOD Policy)

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

Received: 5/5/23

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1. Juckett G, Unger K. Appropriate use of medical interpreters. *American family physician*. 2014 Oct 1;90(7):476-80
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6. Diamond LC, Wilson-Stronks A, Jacobs EA. Do hospitals measure up to the national culturally and linguistically appropriate services standards?. *Medical care*. 2010 Dec 1:1080-7

#### RELEVANT AMA POLICY

##### **Certified Translation and Interpreter Services D-385.957**

Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

Citation: Res. 703, A-17; Reaffirmed: CMS Rep. 7, A-21;

##### **Interpreter Services and Payment Responsibilities H-385.917**

Our AMA supports efforts that encourage hospitals to provide and pay for interpreter services for the follow-up care of patients that physicians are required to accept as a result of that patient's emergency room visit and Emergency Medical Treatment and Active Labor Act (EMTALA)-related services.

Citation: CMS Rep. 5, A-11; Reaffirmed: CMS Rep. 1, A-21;

**Language Interpreters D-385.978**

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.

Citation: Res. 907, I-03; Reaffirmed in lieu of Res. 722, A-07; Reaffirmation A-09; Reaffirmation A-10;

Reaffirmed: CMS Rep. 5, A-11; Reaffirmed in lieu of Res. 110, A-13; Reaffirmation: A-17;

**Appropriate Reimbursement for Language Interpretive Services D-160.992**

1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.

2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

Citation: Res. 209, A-03; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 114, A-12; Reaffirmed: Res. 702, A-12; Reaffirmation A-14; Reaffirmation: A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:232  
(A-23)

Introduced by: Minnesota

Subject: Supervised Injection Facilities (SIFs) Allowed by Federal Law

Referred to: Reference Committee B

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1 Whereas, Drug overdose deaths have risen fivefold in the past 20 years in the United States<sup>1</sup>;  
2 and

3  
4 Whereas, Between 2020 and 2021, in the wake of the COVID-19 pandemic, the age-adjusted  
5 rate of drug overdose deaths rose more than 14% in the United States, with 106,699 drug  
6 overdose deaths occurring in 2021<sup>2</sup>; and,

7  
8 Whereas, A rigid, treatment-only approach to substance use disorder (SUD) is not sufficient to  
9 reduce drug overdoses among people with SUD who (a) are not accepting of treatment, or (b)  
10 have accepted treatment but have since relapsed on a difficult road to recovery; and

11  
12 Whereas, People with SUD who die from drug overdose will never have the opportunity to  
13 successfully enter or complete treatment; and

14  
15 Whereas, In other countries, the introduction of supervised injection facilities (SIFs), or facilities  
16 that allow people who use drugs to use previously obtained substances under the supervision of  
17 healthcare professionals, has been associated with lower rates of overdose-induced mortality  
18 and morbidity, safer injection behavior, greater take-up of addiction treatment programs, and  
19 constant, or lower, rates of crime and drug-related public nuisance<sup>3,4</sup>; and

20  
21 Whereas, While the evidence supporting SIFs in other countries may not be generalizable to the  
22 United States, it supports the reasonableness of conducting American-based SIF pilot programs  
23 and evaluations; and

24  
25 Whereas, Any operation of an SIF, including SIF pilot programs and evaluations, are prohibited  
26 under federal law<sup>5</sup>; and

27  
28 Whereas, In 2021, a federal appellate court ruled in favor of a lawsuit originally filed by the  
29 Trump Administration against a Philadelphia-based SIF in 2019<sup>6</sup>; and

30  
31 Whereas, The Biden Administration has not actively filed suit against, or actively permitted, the  
32 operation of two SIFs in New York City that have been operating since November 2021<sup>7</sup>; and

33  
34 Whereas, Between November 2021 and December 2022, the two operating SIFs in New York  
35 City served more than 2,300 people with substance use disorder and reversed more than 700  
36 overdoses<sup>8</sup>; and

37  
38 Whereas, The uncertainty about Executive Branch enforcement of the federal law prohibiting  
39 SIFs deters the potential operators of American-based SIF pilot programs and evaluations; and

Whereas, While the current policy of this American Medical Association supports American-based SIF pilot programs and evaluations, it does not sufficiently address the need for this American Medical Association to pursue the amendments to federal law, and/or commitments from the Executive Branch, necessary to address the legal concerns of potential operators of American-based SIF pilot programs and evaluations<sup>9</sup>; therefore be it

RESOLVED, That our American Medical Association amend policy H-95.925, "*Pilot Implementation of Supervised Injection Facilities*," by addition to read as follows:

**Pilot Implementation of Supervised Injection Facilities H-95.925**

"Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use, including supporting changes to federal law to permit the operation of pilot SIFs in the United States. Until federal law permits the operation of pilot SIFs in the United States, our AMA will regularly pursue explicit commitments from each active presidential administration that federal lawsuits will not be filed against operators of pilot SIFs. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 5/3/23

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3. AMA wants new approaches to combat synthetic and injectable drugs. American Medical Association. <https://www.ama-assn.org/press-center/press-releases/ama-wants-new-approaches-combat-synthetic-and-injectable-drugs>. Published June 12, 2017. Accessed February 21, 2023.
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**RELEVANT AMA POLICY**

**Pilot Implementation of Supervised Injection Facilities H-95.925**

Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.

Citation: Res. 513, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233  
(A-23)

Introduced by: Missouri

Subject: Dobbs – EMTALA Medical Emergency

Referred to: Reference Committee B

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1 Whereas, The U.S. Supreme Court's decision in *Dobbs v Jackson Women's Health*  
2 *Organization* found that no constitutional right to abortion of a pregnancy was found to exist  
3 under Constitution of the United States; and  
4

5 Whereas, The matter of what types of abortions of pregnancies would be considered legal  
6 versus what types of abortions of pregnancies would be considered illegal was therefore left to  
7 the states, each of which could define these matters independently; and  
8

9 Whereas, The diagnosis of the existence of certain abnormal conditions of pregnancy  
10 represents *upon their recognition* a threat to the life and/or reproductive potential of a woman,  
11 because delays in remediating these conditions increases the risks to the mother of morbidity  
12 and mortality; and  
13

14 Whereas, The federal law that provides the greatest clarity on this matter, and which governs  
15 the obligations of physicians and medical teams as well as those who manage or operate the  
16 facilities at which care of pregnant women is rendered, is the Emergency Medical Treatment  
17 and Active Labor Act, or "EMTALA"; and  
18

19 Whereas, EMTALA codifies that an "emergency medical condition" is defined to exist *upon the*  
20 *recognition of the threat* of loss of life or loss of function of any bodily system; and  
21

22 Whereas, It is incontrovertible that conditions including those such as ectopic pregnancies,  
23 premature rupture of membranes, and other conditions represent a clear danger to the life and  
24 health of the mother, *upon the recognition of these conditions*, even before the development of  
25 "unstable" vital signs such as tachycardia or hypotension; and  
26

27 Whereas, EMTALA not only clearly defines the obligations of the medical care team, but also  
28 supersedes any state laws to the contrary due to the "Supremacy Clause" of the United States  
29 Constitution; therefore be it  
30

31 RESOLVED, That our American Medical Association advocate for policies to ensure that all  
32 patients receive prompt, complete and unbiased emergency health care that is medically sound  
33 and evidence-based, in compliance with the federal Emergency Medical Treatment and Active  
34 Labor Act (EMTALA). (Directive to Take Action)

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

Received: 5/4/23



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234  
(A-23)

Introduced by: American Academy of Dermatology, Pennsylvania, The American Society of Dermatopathology, Society for Investigative Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery

Subject: Medicare Physician Fee Schedule Updates and Grassroots Campaign

Referred to: Reference Committee B

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Whereas, Since 1992, Medicare payment to physicians has been based on the Medicare Physician Fee Schedule (PFS), whether those services are provided in physician offices, hospitals, ambulatory surgical centers, skilled nursing facilities, hospices, outpatient dialysis facilities, clinical laboratories, or beneficiaries' homes. Payment to physicians for services provided in a physician's office is based on a single rate, while payment for services provided in other facilities is proportioned according to the resources available to the physician; and

Whereas, The required statutory update to the conversion factor of 0% for calendar year (CY) 2023, the expiration of the 3% supplemental increase to Medicare PFS for 2022, and a budget neutrality adjustment of 1.47%, the final Medicare PFS CF for CY 2023 decreased by 2% from CY 2022 to CY 2023 from \$34.60 to \$33.88. Despite this cut, Medicare stated "The CY 2023 Medicare PFS final rule is one of several rules that reflect a broader Administration-wide strategy to create a more equitable health care system that results in better accessibility, quality, affordability, and innovation;" and

Whereas, Payments and administrative burdens on physician practices are eroding physicians' ability to focus on patients, driving burnout among physicians generally, and threatening physicians ability to practice; and

Whereas, Our American Medical Association and myriad other medical organizations support HR 2474, "Strengthening Medicare for Patients and Providers Act"; therefore be it

RESOLVED, That our American Medical Association's top priority be to advocate for positive annual updates to the Medicare Physician Fee Schedule (PFS) to accurately account for annual inflation, cost of living, and practice expense increases (Directive to Take Action); and be it further

RESOLVED, That our AMA actively engage in an AMA-organized and sponsored national grassroots campaign that educates patients about how lack of sufficient positive updates to the physician fee schedule places physician practice survivability and access to quality health care at risk (Directive to Take Action); and be it further

RESOLVED, That this newly-created AMA grassroots campaign actively engage America's patients, as constituents, to use their influence to lobby Congress in favor of positive Medicare PFS updates to help ensure the survivability of physician practices and access to quality health care for all. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235  
(A-23)

Introduced by: American College of Emergency Physicians

Subject: EMS as an Essential Service

Referred to: Reference Committee B

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1 Whereas, Longer delays for ambulances for emergency and non-emergency calls for service is  
2 associated with an increase in mortality<sup>1</sup>; and  
3

4 Whereas, Delays for ambulances have been increasing in the past few years, in part due to  
5 increasing loss of workforce which started prior to the COVID-19 pandemic and has been  
6 exacerbated by the pandemic<sup>2</sup>; and  
7

8 Whereas, 70% of Emergency Medical Services (EMS) clinicians plan to leave the field in the  
9 next 4 years<sup>3</sup>; and  
10

11 Whereas, 26% of those leaving cited compensation as the reason for their leaving and 45% felt  
12 that this was the main problem impacting retention<sup>3</sup>; and  
13

14 Whereas, EMS clinician turnover is as high as 40% in 2022<sup>4</sup>, compared to almost half that rate  
15 within the publicly funded fire department based EMS model<sup>5</sup>; and  
16

17 Whereas, Every state defines fire departments and fire protections as an essential function of  
18 government and provides a funding mechanism for the same<sup>6</sup>; and  
19

20 Whereas, Only 11 states define EMS as an essential service, limiting funding and access to  
21 federal funds for the services that are provided<sup>6</sup>, indicating that declaring EMS as essential  
22 service alongside fire protection could help improve funding, salaries, and provider retention;  
23 therefore be it  
24

25 RESOLVED, That our American Medical Association recognize that the provision of Emergency  
26 Medical Services is an essential service of government and is best overseen by physicians with  
27 specialized training in medical direction for Emergency Medical Services (New HOD Policy);  
28 and be it further  
29

30 RESOLVED, That our AMA work with the American College of Emergency Physicians (ACEP),  
31 the National Registry of Emergency Medical Technicians (NREMT), the National Association of  
32 EMS Physicians (NAEMSP), the National Association of State EMS Officials (NASEMSO), and  
33 other relevant stakeholders to create model legislation at the state level to establish funding for  
34 Emergency Medical Services as an essential service (Directive to Take Action); and be it further  
35

36 RESOLVED, That our AMA advocate for federal funding of Emergency Medical Services as an  
37 essential service. (Directive to Take Action)

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

Received: 5/10/23

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## RELEVANT AMA POLICY

### On-Site Emergency Care H-130.976

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

Citation: BOT Rep. N, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

### Overcrowding and Hospital EMS Diversion H-130.945

It is the policy of the AMA:

- (1) that the overall capacity of the emergency health care system needs to be increased through facility and emergency services expansions that will reduce emergency department overcrowding and ambulance diversions; incentives for recruiting, hiring, and retaining more nurses; and making available additional hospital beds;
- (2) to advocate for increased public awareness as to the severity of the emergency department crisis, as well as the development and distribution of patient-friendly educational materials and a physician outreach campaign to educate patients as to when it is appropriate to go to the emergency department;
- (3) to support the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physician on-call coverage, and encourage the exchange of information among these groups;
- (4) that hospitals be encouraged to establish and use appropriate criteria to triage patients arriving at emergency departments so those with simpler medical needs can be redirected to other appropriate ambulatory facilities;
- (5) that hospitals be encouraged to create nurse-staffed and physician-supervised telephone triage programs to assist patients by guiding them to the appropriate facility; and
- (6) to work with the American Hospital Association and other appropriate organizations to encourage hospitals and their medical staffs to develop diversion policy that includes the criteria for diversion; monitor the frequency of diversion; identify the reasons for diversion; and develop plans to resolve and/or reduce emergency department overcrowding and the number of diversions.

Citation: CMS Rep. 1, A-02; Reaffirmed: BOT Rep. 3, I-02; Modified: BOT Rep. 15, I-04; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 3, A-11; Reaffirmed: CMS Rep. 1, A-21;

**Addressing Payment and Delivery in Rural Hospitals D-465.998**

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

Citation: CMS Rep. 9, A-21;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236  
(A-23)

Introduced by: American College of Cardiology

Subject: AMA Support for Nutrition Research

Referred to: Reference Committee B

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1 Whereas, The Office of Nutrition Research (ONR) focuses on advancing nutrition science to  
2 promote health, and to reduce the burden of diet-related diseases and nutrition health  
3 disparities. In January 2021, ONR was relocated to the National Institutes of Health (NIH) Office  
4 of the Director (OD) to better coordinate and lead research functions across NIH institutes and  
5 centers; and  
6

7 Whereas, Nutrition research has been chronically underfunded. A 2019 NIH analysis compared  
8 the amount of dedicated NIH funding for risk factors of death and disability and concluded that  
9 large disparities exist between the top causes of poor health and the research funding allocated  
10 to address them—with the largest gap existing for nutrition. Despite this pressing need for more  
11 investment, funding levels for nutrition research and training have remained flat since FY2015;  
12 and  
13

14 Whereas, The President's budget includes \$121 million to support nutrition research, including  
15 investments that will advance the goals of the White House National Strategy on Hunger,  
16 Nutrition, and Health. Resources will expand the efforts of the NIH Common Fund Community  
17 Partnerships to Advance Science for Society, and help to ensure diversity and inclusion in  
18 nutrition, health, and food security research. Funding will also allow NIH to focus on expanding  
19 and diversifying the nutrition science workforce and investing in creative new approaches to  
20 advance research regarding the prevention and treatment of diet-related diseases, including the  
21 Food is Medicine initiative; and  
22

23 Whereas, Poor nutrition is a major driver of diet-related diseases, including heart disease, type  
24 2 diabetes, obesity, hypertension, and some cancers, and has staggering costs to society. Diet-  
25 related diseases are the number one cause of death and disability in the United States. The  
26 combined health care spending and lost productivity from suboptimal diets costs the economy  
27 \$1.1 trillion each year. A strong investment in NIH ONR would expand and accelerate scientific  
28 discoveries that positively impact public health, health care costs, equity, the economy, national  
29 security, and the nation's resilience to new threats; and  
30

31 Whereas, The nutrition security crisis in this country is deeply inequitable, with people of color  
32 facing higher rates of diabetes, obesity, stroke, and heart disease than white people. Properly  
33 investing in nutrition research in this country is essential to understanding and combatting the  
34 drivers of this inequitable harm and to building a more diverse nutrition science workforce. Both  
35 of these steps are essential to improving health equity in this country; and  
36

37 Whereas, Diet-related illness also undermines our country's military readiness. A striking 77% of  
38 young adults are ineligible for military service, with obesity as the largest disqualifier; therefore  
39 be it

- 1 RESOLVED, That our American Medical Association seek national legislation in support of the
- 2 President's FY24 Budgetary request that the National Institutes of Health's (NIH's) Office of
- 3 Nutrition Research (ONR) receive at least \$121,000,000, as this level of funding would enable
- 4 ONR to secure the leadership, organizational structure, and resources to effectively fulfill its
- 5 important mission. (Directive to Take Action)

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

Received: 5/10/23

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237  
(A-23)

Introduced by: California, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, The Society of Thoracic Surgeons

Subject: Prohibiting Covenants Not-To-Compete in Physician Contracts

Referred to: Reference Committee B

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1 Whereas, Non-compete agreements are contracts whereby an employee agrees not to enter  
2 direct competition with their employer once the employment term is over, regardless of which  
3 party terminates the contract; and  
4

5 Whereas, While intention of such agreements is to reduce competition, it has also been shown  
6 to negatively impact wages and employment mobility; and  
7

8 Whereas, The Federal Trade Commission (FTC) has proposed banning non-compete contracts  
9 in order to reduce wage suppression and stimulate the flow of workers between employers, and  
10 increase competition, which could result in increased earnings for workers by \$250-\$290 billion  
11 annually<sup>1</sup>; and  
12

13 Whereas, The use of non-compete agreements has been extensive in the healthcare system,  
14 affecting 37-45% of physicians, including those in residency and fellowship training<sup>2,3</sup>; and  
15

16 Whereas, The elimination of non-compete contracts could lead to a reduction in consumer  
17 health care costs by approximately \$148 billion a year, increasing affordability and access to  
18 healthcare services for patients<sup>1</sup>; and  
19

20 Whereas, Allowing physicians to work for multiple hospitals can enhance the availability of  
21 specialist coverage in a community, improving patient access to care and reducing healthcare  
22 disparities; and  
23

24 Whereas, Recently graduating trainees entering the workforce are especially vulnerable to the  
25 negative effects of non-compete contracts, which can limit their opportunities for career  
26 advancement and restrict their ability to provide care in underserved areas; and  
27

28 Whereas, Although the Accreditation Council for Graduate Medical Education (ACGME)  
29 currently prohibits restrictive covenants as a contingency for residents or fellows participating  
30 within any GME training program, there are non-ACGME fellowship programs which require  
31 trainees to sign restrictive covenants as a condition for employment; and  
32

33 Whereas, During the COVID-19 pandemic physicians advocating for healthcare worker safety  
34 and adequate personal protective equipment (PPE) were threatened with termination, which  
35 due to non-compete clauses meant months or years of unemployment or geographic relocation;  
36 and



1 Whereas, When physicians are legally restrained from terminating a contract of employment,  
2 employers are not incentivized to create supportive work environment or respond to physician  
3 advocacy, further contributing to physician burnout; and  
4

5 Whereas, Some employers offer recruitment and retention incentives, such as sign-on bonuses,  
6 student loan reimbursement, moving expenses or housing fees that become “de facto” non-  
7 compete covenants because employers require these expenses to be repaid upon contract  
8 termination; and  
9

10 Whereas, Our AMA’s Code of Ethics E-11.2.3.1, *Restrictive Covenants*, recognizes that  
11 “Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit  
12 access to care” and further advises physicians not to enter agreements that “unreasonably  
13 restrict a physician’s right to practice medicine for a specified period of time or in a specified  
14 geographic area on termination of a contractual relationship”; and  
15

16 Whereas, Current AMA policy D-383.978, *Restrictive Covenants of Large Health Care Systems*,  
17 speaks to the need to “educate medical students, physicians-in-training and physicians entering  
18 employment contracts with large healthcare systems on the dangers of aggressive restrictive  
19 covenants”; and  
20

21 Whereas, The AMA has not supported elimination or prohibition of covenants not-to-compete,  
22 despite the overwhelming harm non-compete clauses bear in the current healthcare landscape  
23 and has been criticized for its “noncommittal approach” that fails to protect physicians  
24 (H-383.987, *Restrictive Covenants in Physician Contracts*); and  
25

26 Whereas, Covenants not-to-compete are already prohibited outright in several states including  
27 California, North Dakota, Oklahoma and Washington D.C; and additional states such as New  
28 Hampshire, Delaware, Massachusetts and Rhode Island ban non-compete covenants  
29 specifically for physicians, but they remain legal in 38 states; and  
30

31 Whereas, Many national specialty and state societies supported the Federal Trade  
32 Commission’s (FTC) recent proposed ban on non-compete agreements to protect employed  
33 physicians but also urged FTC to include non-profit hospital employers which comprise 58% of  
34 the nation’s hospitals (AHA); and  
35

36 Whereas, Non-compete bans 1) allow physicians the autonomy to advocate on behalf of their  
37 patients without inappropriate interference and protects the sanctity of the physician-patient  
38 relationship; 2) protect patient access to care, particularly in rural and underserved areas, by  
39 allowing physicians to change jobs but remain in those areas to care for their communities; and  
40 3) can discourage consolidation which can lead to increased health care costs; therefore be it  
41

42 RESOLVED, That our American Medical Association support policies, regulations, and  
43 legislation that prohibits covenants not-to-compete for all physicians in clinical practice who hold  
44 employment contracts with for-profit or non-profit hospital, hospital system, or staffing company  
45 employers (New HOD Policy); and be it further

46 RESOLVED, That our AMA oppose the use of restrictive covenants not-to-compete as a  
47 contingency of employment for any physician-in-training, regardless of the ACGME  
48 accreditation status of the residency/fellowship training program (New HOD Policy), and be it  
49 further

1 RESOLVED, That our AMA study and report back on current physician employment contract  
2 terms and trends with recommendations to address balancing legitimate business interests of  
3 physician employers while also protecting physician employment mobility and advancement,  
4 competition, and patient access to care - such recommendations to include the appropriate  
5 regulation or restriction of 1) Covenants not to compete in physician contracts with independent  
6 physician groups that include time, scope, and geographic restrictions; and 2) De facto non-  
7 compete restrictions that allow employers to recoup recruiting incentives upon contract  
8 termination. (Directive to Take Action)

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

Received: 5/10/23

#### REFERENCES

1. Federal Trade Commission, ed. FACT SHEET: FTC Proposes Rule to Ban Noncompete Clauses, Which Hurt Workers and Harm Competition. Federal Trade Commission | Protecting America's Consumers. [https://www.ftc.gov/system/files/ftc\\_gov/pdf/noncompete\\_nprm\\_fact\\_sheet.pdf](https://www.ftc.gov/system/files/ftc_gov/pdf/noncompete_nprm_fact_sheet.pdf). Published 2023. Accessed April 18, 2023.
2. Lavetti K, Simon C, White WD. The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians\*. Kurt J. Lavetti. [http://kurtlavetti.com/UIPNC\\_vf.pdf](http://kurtlavetti.com/UIPNC_vf.pdf). Published June 29, 2018. Accessed April 18, 2023.
3. Smith, EB Ending Physician Non-compete Agreements—Time for a National Solution. *JAMA Health Forum*. 2021;2(12):e214018

#### RELEVANT AMA POLICY

##### **Restrictive Covenants in Physician Contracts H-383.987**

Our AMA will provide guidance, consultation, and model legislation concerning the application of restrictive covenants to physicians upon request of state medical associations and national medical specialty societies.

Citation: BOT Rep. 13, A-16;

##### **Restrictive Covenants of Large Health Care Systems D-383.978**

Our AMA, through its Organized Medical Staff Section, will educate medical students, physicians-in-training, and physicians entering into employment contracts with large health care system employers on the dangers of aggressive restrictive covenants, including but not limited to the impact on patient choice and access to care.

Citation: Res. 026, A-19; Modified: Speakers Rep. 1, A-21

##### **Covenants Not to Compete D-265.988**

Our AMA will create a state restrictive covenant legislative template to assist state medical associations, national medical specialty societies and physician members as they navigate the intricacies of restrictive covenant policy at the state level.

Citation: BOT Rep. 06, I-20;

##### **E-11.2.3.1 Restrictive Covenants**

Competition among physicians is ethically justifiable when it is based on such factors as quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit access to care.

Physicians should not enter into covenants that:

- (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of time or in a specified geographic area on termination of a contractual relationship; and
- (b) Do not make reasonable accommodation for patients' choice of physician.

Physicians in training should not be asked to sign covenants not to compete as a condition of entry into any residency or fellowship program.

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238  
(A-23)

Introduced by: Arizona

Subject: Eliminate Mandatory Medicare Budget Cuts

Referred to: Reference Committee B

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1 Whereas, The 2023 Medicare payments are to cut physician pay; and

2  
3 Whereas, Medicare payments to physicians have not been consistent with inflation and have  
4 not increased in 20 years<sup>1</sup>; and

5  
6 Whereas, Practice costs and consumer prices have increased during that time frame; and

7  
8 Whereas, Medicare physician payments have declined 22% over the last two decades when  
9 adjusted for inflation<sup>2</sup>; therefore be it

10  
11 RESOLVED, That our American Medical Association continue to advocate for new legislation on  
12 Medicare physician payment reform. (Directive to Take Action)

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

Received: 5/9/23

## REFERENCES

1. U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, February 2022
2. U.S. Bureau of Labor Statistics, American Medical Association, Economic and Health Policy Research, September 2022

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239  
(A-23)

Introduced by: Arizona

Subject: Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians

Referred to: Reference Committee B

Whereas, Advanced Practice Providers (APP's: PA's and NP's) have an established scope of practice directly determined by the specialty of their supervisory physician and their practice site; and

Whereas, Advanced Practice Providers in collaboration with their supervisory physicians provide care commensurate with the specialty training and board certification of the physician; and

Whereas, Currently Advanced Practice Providers do not have any established standard for a residency or apprenticeship requirement or specialization process after graduation that aligns them with the specialty training of their supervisory physicians; and

Whereas, This absence of specialty designation for Advanced Practice Providers creates the following harms to the practice of medicine and the quality of care for our patients:

1. Advanced Practice Providers can completely change their professional specialty focus overnight creating major training requirements and costs for the practice that hires them.
2. Lower income physician specialties like primary care are disproportionately impacted by the frequent departure of APP's for higher income specialties.
3. Costly training periods for APP's can take a minimum of one year, for example, for primary care based specialties.
4. The current "non-specialty designated" APP system creates a financially exploitative system. Specialties with higher physician salaries unfairly lure away APP's from the practices of lower salaried physicians. Those practices are unable to compete with salaries offered by disparate higher income specialties.
5. Primary care practices, for example, are thus left with untenable training cost losses and exponentially high turnover in an already volatile and predatory market; and

Whereas, If residency and specialty training make sense for physicians, some type of established apprenticeship training program within established specialties must also make sense for APP's; and

Whereas, Current severe healthcare workforce shortages in the setting of an inflationary economy and reduced physician payments for our services, makes an alignment of APP salary and specialty competition particularly critical; therefore be it

RESOLVED, That our American Medical Association Board of Trustees study and report back at the 2023 Interim meeting on the economic impact to primary care and other lower tier income

1 medical specialties of specialty switching by Advanced Practice Providers (Directive to Take  
2 Action); and be it further

3  
4 RESOLVED, That our AMA Board of Trustees study and report back at the 2023 Interim  
5 meeting about possible options on how APP's can best be obligated to stay in a specialty tract  
6 that is tied to the specialty area of their supervising physician in much the same way their  
7 supervisory physicians are tied to their own specialty, with an intent for the study to look at how  
8 the house of medicine can create functional barriers that begin to make specialty switching by  
9 Advanced Practice Providers appropriately demanding. (Directive to Take Action)

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

Received: 5/9/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240  
(A-23)

Introduced by: Illinois

Subject: Attorneys' Retention of Confidential Medical Records and Controlled  
Medical Expert's Tax Returns After Case Adjudication

Referred to: Reference Committee B

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1 Whereas, Medical records are extremely confidential records governed by the Health Insurance  
2 Portability and Accountability Act of 1996 (HIPAA) and can only be disclosed under certain  
3 circumstances; and  
4

5 Whereas, It is recommended that any documentation that may be required in a personal injury  
6 or breach of contract dispute is retained for as long as necessary. "As long as necessary" will  
7 depend on the relevant statute of limitations in force in the state. In many cases, statutes of  
8 limitation are longer than any HIPAA record retention periods; and  
9

10 Whereas, The filing of a civil lawsuit provides the mechanism for the issuance of subpoenas for  
11 witnesses and subpoenas duces tecum to produce documents that often involve medical  
12 records; and  
13

14 Whereas, The Circuit Court of Cook County amended its Health Insurance Portability and  
15 Accountability Act (HIPAA) Protective Order following the Illinois Supreme Court's recent  
16 determination of an insurer's obligations with a plaintiff's protected health information (PHI). In  
17 short, PHI obtained by insurance companies during litigation cannot be used outside the  
18 litigation context, and it must be returned/destroyed at its conclusion. (*See Haage v. Zavala*,  
19 2021 IL 125918); and  
20

21 Whereas, The amended HIPAA Protective Order requires return or destruction of all records  
22 within 60 days of the close of the case. This prohibits parties, counsel, *and the parties'*  
23 *insurers* from using PHI for any purpose other than the litigation in which the order was entered;  
24 and  
25

26 Whereas, The American Bar Association is generally silent regarding attorney's retention of  
27 medical records after the case is adjudicated; and  
28

29 Whereas, Courts have required controlled expert witnesses to produce personal financial  
30 records, including federal 1099 tax forms related to legal work as well as personal income tax  
31 returns, even when they include information concerning the expert's spouse; and  
32

33 Whereas, In *Grant v. Rancour*, 2020 IL App (2d) 190802 (June 12, 2020), the court stated that:  
34 "Opposing parties may cross-examine an expert witness about the amount and percentage of  
35 his or her income generated as an expert witness, the frequency with which he or she testifies,  
36 and the frequency with which he or she testifies for a particular side."; and  
37

38 Whereas, Personal tax returns of medical experts obtained by attorneys should be afforded  
39 similar HIPPA type protections after the close of the case; and

Whereas, Attorney's prolonged retention of these confidential and private documents can only be utilized in an adversarial intent; therefore be it further

RESOLVED, That our American Medical Association advocate that attorney requests for controlled medical expert personal tax returns should be limited to 1099-MISC forms (miscellaneous income) and that entire personal tax returns (including spouse's) should not be forced by the court to be disclosed (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate through legislative or other relevant means the proper destruction by attorneys of medical records (as suggested by *Haage v. Zavala*, 2021 IL 125918) and medical expert's personal tax returns within sixty days of the close of the case. (Directive to Take Action)

Fiscal Note: TBD

Received: 5/5/23

#### REFERENCES

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2. <https://www.cdc.gov/phlp/publications/topic/hipaa.html>
3. <https://www.hipaajournal.com/hipaa-retention-requirements/>
4. *Haage v. Zavala*, 2021 IL 125918.
5. <https://www.americanbar.org/>
6. <https://www.clausen.com/cook-county-uses-hipaa-to-further-limit-discovery-and-use-of-litigants-medical-records/>
7. *Grant v. Rancour*, 2020 IL App (2d) 190802 (June 12, 2020)

#### RELEVANT AMA POLICY

##### Expert Witness Testimony H-265.994

(1) Regarding expert witnesses in clinical matters, as a matter of public interest the AMA encourages its members to serve as impartial expert witnesses.

(2) Our AMA is on record that it will not tolerate false testimony by physicians and will assist state, county and specialty medical societies to discipline physicians who testify falsely by reporting its findings to the appropriate licensing authority.

(3) Existing policy regarding the competency of expert witnesses and their fee arrangements (BOT Rep. SS, A-89) is reaffirmed, as follows:

(a) The AMA believes that the minimum statutory requirements for qualification as an expert witness in medical liability issues should reflect the following: (i) that the witness be required to have comparable education, training, and occupational experience in the same field as the defendant or specialty expertise in the disease process or procedure performed in the case; (ii) that the occupational experience include active medical practice or teaching experience in the same field as the defendant; (iii) that the active medical practice or teaching experience must have been within five years of the date of the occurrence giving rise to the claim; and (iv) that the witness be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association or by a board with equivalent standards.

(b) The AMA opposes payment of contingent fees for all types of medicolegal consultations, including management services provided by firms engaged in locating physician consultants. Where necessary, the AMA supports state legislation making it illegal for medicolegal consulting firms to take a contingent fee in personal injury litigation. Such arrangements threaten the integrity and the compensation goals of the civil justice system. Like the individual expert witness, the role of the medicolegal consulting firm which locates and supplies experts should be one of limited service to the judicial process. Contingent fee arrangements are plainly inconsistent with the scope of this responsibility.

(c) The AMA supports the right to cross examine physician expert witnesses on the following issues: (i) the amount of compensation received for the expert's consultation and testimony; (ii) the frequency of the physician's expert witness activities; (iii) the proportion of the physician's professional time devoted to and income derived from such activities; and (iv) the frequency with which he or she testified for either

plaintiffs or defendants. The AMA supports laws consistent with its model legislation on expert witness testimony.

Citation: (Sub. Res. 223, A-92; Appended: Sub. Res. 211, I-97; Reaffirmation A-99; Modified: BOT Rep. 8, I-04; Reaffirmed: Res. 2, I-05; Reaffirmed: BOT Rep. 10, A-15)



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241  
(A-23)

Introduced by: Illinois

Subject: Allow Viewing Access to Prescription Drug Monitoring Programs  
Through EHR for Clinical Medical Students and Residents

Referred to: Reference Committee B

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1 Whereas, The majority of physicians reported that prescription drug monitoring programs  
2 (PDMPs) improved their opioid prescribing by decreasing the amount administered and  
3 increasing comfort in prescribing<sup>2</sup>; and  
4

5 Whereas, A systematic review showed a significant correlation between appropriate utilization  
6 of PDMPs and reduced rate of opioid abuse<sup>3</sup>; and  
7

8 Whereas, Expanding accessibility of PDMPs may further amplify PDMPs effectiveness and  
9 allow the clinical care team to be more efficient, particularly in an academic setting<sup>4</sup>; and  
10

11 Whereas, Accessibility of PDMPs to front-line health care workers allows its utilization as a  
12 screening tool instead of postemptive verification<sup>4</sup>; and  
13

14 Whereas, Deficits of the PDMPs include ineffective data utilization, such as resistance to use of  
15 systems by providers experiencing an increased workload<sup>2,5</sup>; and  
16

17 Whereas, Medical and pharmaceutical students are afforded fewer patient loads and more  
18 patient-centered time than their resident and attending physician team members, allowing more  
19 focus on a patient's nuanced prescription history; and  
20

21 Whereas, Medical and pharmaceutical students have access to patient health information  
22 through electronic health record (EHR) in their clinical years, providing access to PDMPs will  
23 impart comprehensive job training in their role as future physicians; and  
24

25 Whereas, Our American Medical Association has existing policy (H-95.939, *Development and*  
26 *Promotion of Single National Prescription Drug Monitoring Program*) in support of a physician's  
27 ability to designate a delegate to check information on the Prescription Drug Monitor Program,  
28 depending on state law; and  
29

30 Whereas, Our AMA acknowledges that Prescription Drug Monitoring Program data is health  
31 information and promotes medical school training that incorporates safe prescribing practices,  
32 safe medication storage and disposal practices, and functional assessment of patients with  
33 chronic conditions in order for the future generation of physicians to contribute to positive  
34 solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths  
35 (H-95.945, *Prescription Drug Diversion, Misuse and Addiction*); therefore be it  
36

37 RESOLVED, That our American Medical Association amend Policy H-95.945, *Prescription Drug*  
38 *Diversion, Misuse and Addiction*, to include prescription drug monitoring program (PDMP)

- 1 viewing access as a mainstay of appropriate and comprehensive medical training for clinical
- 2 medical students and residents. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 5/5/23

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1. Lange J, Gaddis G, Varner E, Schmidt S, Cohen R, Schwarz E. Resident Access to the St. Louis County Prescription Drug Monitoring Program: Why PDMPs Matter and How to Gain Access. *Mo Med*. 2018 Nov-Dec;115(6):487-493. PMID: 30643325; PMCID: PMC6312172.
2. Lin DH, Lucas E, Murimi IB, Jackson K, Baier M, Frattaroli S, Gielen AC, Moyo P, Simoni-Wastila L, Alexander GC. Physician attitudes and experiences with Maryland's prescription drug monitoring program (PDMP). *Addiction*. 2017 Feb;112(2):311-319. doi: 10.1111/add.13620. Epub 2016 Nov 3. PMID: 27658522.
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#### RELEVANT AMA POLICY

##### **Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939**

Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.

Citation: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

##### **Prescription Drug Diversion, Misuse and Addiction H-95.945**

Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.

Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242  
(A-23)

Introduced by: Illinois

Subject: Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure

Referred to: Reference Committee B

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1 Whereas, Peer to peer reviews, the purpose of which is to determine if a patient should have a  
2 certain procedure, frequently involve physicians that are not of the same specialty as the  
3 requesting physician; and  
4

5 Whereas, Denials of necessary procedures benefiting the patient unfortunately occur during  
6 peer to peer reviews where the physician reviewer is not of the same specialty as the physician  
7 recommending a particular procedure; therefore be it  
8

9 RESOLVED, That our American Medical Association adopt policy in support of and cause to be  
10 introduced legislation requiring any peer to peer review require a physician from the same  
11 specialty as the physician requesting a procedure for their patient, be involved in the peer to  
12 peer phone call and decision process. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 5/5/23

### RELEVANT AMA POLICY

#### Managed Care H-285.998

(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.

(2) Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.

(3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.

(4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings. With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by

professional preparation to assume this leadership role.

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care.

Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.

A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions.

All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians.

In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.

Citation: Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02; Reaffirmation I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: CMS Rep. 04, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 4, A-21; Reaffirmation: A-22;

### **Approaches to Increase Payer Accountability H-320.968**

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: BOT Rep. M, I-90; Reaffirmed by Res. 716, A-95; Reaffirmed by CMS Rep. 4, A-95; Reaffirmation I-96; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmation I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-00; Reaffirmed in lieu of Res. 839, I-08; Reaffirmation A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmation: A-17; Reaffirmation: I-17; Reaffirmation: A-18; Reaffirmation: A-19; Reaffirmed: Res. 206, I-20; Reaffirmation: A-22;

### **Prior Authorization and Utilization Management Reform H-320.939**

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22;

### **Promoting Accountability in Prior Authorization D-285.960**

Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion; (2) advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

Citation: CMS Rep. 4, A-21;

### **Medical Necessity Determinations H-320.995**

- (1) Our AMA urges: (a) health insurance carriers and government health care financing agencies to rely on appropriate medical peer review programs for adjudication and resolution of all matters concerning quality or utilization of medical services requiring professional judgment, and (b) that peer review programs have as their goal both improved quality of care and more efficient delivery of medical service.
- (2) Our AMA urges health insurance carriers, government financing agencies, physicians and medical societies to explore ways of improving communications, such as the following: (a) In furtherance of past Association recommendations that policyholders be thoroughly and clearly informed as to the extent of their coverage, more detailed information explaining the "medical necessity" exclusion should be provided, especially when the exclusion refers more to the site of the service than to the service itself. (b) Insurers should develop formal protocols as to their methodology for determining "medical necessity," including distinctions between those instances where in-house medical expertise is considered sufficient and those where outside consultation is considered necessary; (c) Third party methodologies for determining "medical necessity" should be made available to medical societies and to individual physicians, as well as listings of those specific situations (such as the ordering of either experimental or outdated procedures or questionable hospital admissions) where additional data may be required; (d) In "medical necessity" decisions where the determination may be modified by additional medical evidence, there should be an opportunity for the treating physician to provide such evidence before a final decision not to pay is made.

Citation: CMS Rep. L, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation and Reaffirmed: Sub. Res. 713, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmation: A-18; Reaffirmation: A-22;

**Prescription Drug Diversion, Misuse and Addiction H-95.945**

Our AMA: (1) supports permanent authorization of and adequate funding for the National All Schedules Prescription Electronic Reporting (NASPER) program so that every state, district and territory of the US can have an operational Prescription Drug Monitoring Program (PDMP) for use of clinicians in all jurisdictions; (2) considers PDMP data to be protected health information, and thus protected from release outside the healthcare system unless there is a HIPAA exception or specific authorization from the individual patient to release personal health information, and recommends that others recognize that PDMP data is health information; (3) recommends that PDMP's be designed such that data is immediately available when clinicians query the database and are considering a decision to prescribe a controlled substance; (4) recommends that individual PDMP databases be designed with connectivity among each other so that clinicians can have access to PDMP controlled substances dispensing data across state boundaries; and (5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths.

Citation: Res. 223, A-12; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmation A-16;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243  
(A-23)

Introduced by: Illinois

Subject: Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony

Referred to: Reference Committee B

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1 Whereas, The use of expert witnesses has become an integral and indispensable aspect of  
2 American litigation, and it is often the side with the best expert who wins the day; and  
3

4 Whereas, Federal Rule of Evidence 702 provides: *Testimony by Expert Witnesses: A witness*  
5 *who is qualified as an expert by knowledge, skill, experience, training, or education may testify*  
6 *in the form of an opinion or otherwise if: (a) the expert's scientific, technical, or other specialized*  
7 *knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;*  
8 *(b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable*  
9 *principles and methods; and (d) the expert has reliably applied the principles and methods to*  
10 *the facts of the case; and*  
11

12 Whereas, Medical experts make up about 40% of testifying experts at the federal level; and  
13

14 Whereas, There are generally two standards that govern admissibility of expert testimony: The  
15 Frye Standard (1923) and the Daubert Standard (1993); and  
16

17 Whereas, The Frye standard or Frye test (or general acceptance test as it became to be known)  
18 is a test to determine the admissibility of scientific evidence providing that expert opinion based  
19 on a scientific technique is admissible only where the technique is generally accepted as  
20 reliable in the relevant scientific community. A court applying the Frye standard must determine  
21 whether or not the method by which that evidence was obtained was generally accepted by  
22 experts in the particular field in which it belongs; and  
23

24 Whereas, Under the Daubert standard, the factors that may be considered in determining  
25 whether the methodology is valid are: (1) whether the theory or technique in question can be  
26 and has been tested; (2) whether it has been subjected to peer review and publication; (3) its  
27 known or potential error rate; (4) the existence and maintenance of standards controlling its  
28 operation; and (5) whether it has attracted widespread acceptance within a relevant scientific  
29 community; and  
30

31 Whereas, The United States Supreme Court further clarified that an expert must "employ in the  
32 courtroom the same level of intellectual rigor that characterizes the practice of an expert in the  
33 relevant field;" and  
34

35 Whereas, In most jurisdictions (and all federal courts), the Frye standard has been superseded  
36 by the Daubert standard. States still following Frye include California, Illinois, Maryland,  
37 Minnesota, New Jersey, New York, Pennsylvania, and Washington (Florida switched in May  
38 2019); and



1 Whereas, In *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 147 (1999), the U.S. Supreme Court  
2 extended its Daubert reasoning to all expert testimony, not simply that which was considered  
3 “scientific,” and  
4

5 Whereas, The second sentence of Illinois Rule of Evidence 702 enunciates the core principles  
6 of the Frye test for admissibility of scientific evidence as set forth in *Donaldson v. Central Illinois*  
7 *Public Service Co.*, 767 N.E.2d 314 (Ill. 2002); and  
8

9 Whereas, A court applying the traditional (Frye) standard of care is less interested in the  
10 methodology underlying the expert’s opinion and more interested in the experience and  
11 education of the expert; and  
12

13 Whereas, By applying a Daubert analysis to an expert’s testimony on the standard of care, the  
14 testimony becomes a scientifically based testimony rather than an expert’s notion of what is  
15 common practice in the medical profession; and  
16

17 Whereas, Daubert challenges do present an opportunity to keep frivolous testimony out of a  
18 trial; and  
19

20 Whereas, Using a dataset of all medical malpractice payouts reported between 2004 and 2018  
21 to the U.S. Department of Health and Human Services, using a difference-in-differences  
22 approach to examine the effect of adopting the Daubert standard in state courts that previously  
23 adhered to the Frye standard, it was found that adopting Daubert is associated with a modest  
24 increase in settlement amounts (7.44% or \$25,578) and a decrease in the filing rate (.44 fewer  
25 claims filed per 100,000; mean filing rate in Daubert and Frye jurisdictions was 4.8 and 6.1,  
26 respectively; This result is statistically significant at the 5% level); and  
27

28 Whereas, The Daubert standard is a higher standard than the Frye standard for admissibility of  
29 expert witness testimony; therefore be it  
30

31 RESOLVED, That our American Medical Association advocate through legislative or other  
32 relevant means the use of the Daubert Standard to replace the Frye Standard for Expert  
33 Witness Testimony. (Directive to Take Action)

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

Received: 5/5/23

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2. Frye v. United States, 293 F. 1013 (D.C. Cir. 1923)
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10. Thatcher, Robert W., Cart J. Biver, and Duane M. North. "Quantitative EEG and the Frye and Daubert standards of admissibility." *Clinical Electroencephalography* 34.2 (2003): 39-53.
11. Joe S. Cecil, Ten Years of Judicial Gatekeeping Under Daubert, 95 Am. J. Pub. Health S74–S80 (2005)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 244  
(A-23)

Introduced by: American Association of Public Health Physicians

Subject: Recidivism

Referred to: Reference Committee B

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1 Whereas, Recidivism has constantly risen and is now 44% of those released from a correctional  
2 facility<sup>1</sup>; and  
3

4 Whereas, There are many factors causing recidivism including untreated mental health  
5 disorders, untreated substance use disorders, homelessness, and inadequate discharge  
6 planning by the correctional facility<sup>1,2</sup>; and  
7

8 Whereas, These factors result from insufficient personnel to treat mental health conditions  
9 during persons' incarceration; insufficient mental health care community workers; and  
10 insufficient substance use disorder treatment programs in correctional facilities<sup>1</sup>; and  
11

12 Whereas, There are insufficient mental health and drug rehabilitation programs and counselors  
13 in the community<sup>1</sup>; and  
14

15 Whereas, There is inadequate low-cost housing for persons recently released from a  
16 correctional facility<sup>2</sup>; and  
17

18 Whereas, There are insufficient shelters and rehabilitation facilities in the community; and  
19

20 Whereas, With proper post-release medical care, recidivism can be reduced; therefore be it  
21

22 RESOLVED, That our American Medical Association advocate and encourage federal, state,  
23 and local legislators and officials to increase the number of community mental health facilities to  
24 meet the need of indigent, homeless, and released previously incarcerated persons (Directive to  
25 Take Action); and be it further  
26

27 RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and  
28 officials to increase the number of community drug rehabilitation facilities to meet the needs of  
29 indigent, homeless, and released previously incarcerated persons (Directive to Take Action);  
30 and be it further  
31

32 RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and  
33 officials to ensure there are enough residential/rehabilitation facilities for formerly incarcerated  
34 persons to live (Directive to Take Action); and be it further  
35

36 RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and  
37 officials to ensure that correctional facilities have adequate well-trained personnel who can  
38 ensure that those incarcerated persons released from their facility are able to immediately have  
39 access to mental health, drug and residential rehabilitation facilities at an appropriate level  
40 (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA advocate and encourage federal, state, and local legislators and  
 2 officials to advocate prompt reinstatement in governmental medical programs and insurance for  
 3 those being released from incarceration facilities. (Directive to Take Action)

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

Received: 5/10/23

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2. The Impact of Limited Housing Opportunities on Formerly Incarcerated People in the Context of Addiction Recovery:  
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5507072/>
3. <https://www.legalreader.com/access-to-mental-health-care-greatly-reduces-recidivism-study-shows/>
4. <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/02/over-1-in-9-people-with-co-occurring-mental-illness-and-substance-use-disorders-arrested-annually>
5. <https://interrogatingjustice.org/challenges-after-release/homelessness-after-reentry-leads-to-higher-recidivism-rates/#:~:text=Unsheltered%20homelessness%20after%20reentry%20leads,system%20than%20the%20general%20public.>
6. <https://www.aamc.org/news-insights/out-prison-struggling-stay-healthy>
7. <https://www.forbes.com/health/mind/mental-health-statistics/>
8. <https://www.apa.org/pi/ses/resources/indicator/2019/04/incarcerated-women>
9. <https://naacp.org/resources/naacp-supports-comprehensive-approach-assisting-ex-offenders-re-entering-society-and>
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#### RELEVANT AMA POLICY

##### Standards of Care for Inmates of Correctional Facilities H-430.997

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

Citation: Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12; Modified: CSAPH Rep. 1, A-22;

##### Juvenile Justice System Reform H-60.919

Our AMA:

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to

public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.

6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.

7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.

8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

9. Will create a policy to establish minimal age of 14 years for juvenile justice jurisdiction in the United States.

10. Will develop model legislation to establish minimal age of 14 for juvenile justice jurisdiction in the United States.

Citation: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16; Appended: Res. 905, I-22;

#### **Access to Mental Health Services H-345.981**

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

(1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;

(2) improving public awareness of effective treatment for mental illness;

(3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;

(4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;

(5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and

(6) reducing financial barriers to treatment.

Citation: CMS Rep. 9, A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Reaffirmed: Res. 503, A-17; Reaffirmation: I-18;

#### **Medicaid Coverage of Adults in Psychiatric Hospitals H-345.976**

1. Our AMA will monitor the Medicaid Emergency Psychiatric Demonstration Project established by the Patient Protection and Affordable Care Act for consistency with AMA policy, especially the impact on access to psychiatric care and treatment of substance use disorders.

2. Our AMA supports the evolution of psychiatrist-supervised mental health care homes.

3. Our AMA encourages states that maintain low numbers of inpatient psychiatric beds per capita to strive to offer more comprehensive community based outpatient psychiatric services.

Citation: CMS Rep. 3, A-11; Reaffirmed: CMS Rep. 1, A-21;

#### **Community-Based Treatment Centers H-160.963**

Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities.

Citation: BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21;

#### **Support for Health Care Services to Incarcerated Persons D-430.997**

Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;

(2) encourage all correctional systems to support NCCHC accreditation;

- (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
- (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
- (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
- (6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep. 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19;

#### **Statement of Principles on Mental Health H-345.999**

- (1) Tremendous strides have already been made in improving the care and treatment of patients with psychiatric illness, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat psychiatric illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
- (2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.
- (3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
- (4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.

Citation: A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19;

#### **Increasing Detection of Mental Illness and Encouraging Education D-345.994**

- 1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
- 2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Citation: Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmed: Res. 425, A-22;

#### **Physicians, Psychotherapy and Mental Health Care H-345.996**

Our AMA supports efforts to inform physicians, the public and third party payers that physicians in the private sector are at the forefront of mental health care in their office practices and provide significant amounts of direct and preventive mental health services to the public.

Citation: Res. 17, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21;

#### **Maintaining Mental Health Services by States H-345.975**

Our AMA:

- 1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;

2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
  3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
  4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
  5. will take these resolves into consideration when developing policy on essential benefit services.
- Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22;

#### **Mental Health Crisis Interventions H-345.972**

Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities; and (5) supports: (a) increased research on non-violent de-escalation tactics for law enforcement encounters with people who have mental illness and/or developmental disabilities; and (b) research of fatal encounters with law enforcement and the prevention thereof.

Citation: Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21; Reaffirmed: BOT Rep. 2, I-21; Appended: Res. 408, A-22;

#### **Parity for Mental Health and Substance Use Disorders in Health Insurance Programs H-185.974**

1. Our AMA supports parity of coverage for mental, health, and substance use disorders.
2. Our AMA supports federal legislation, standards, policies, and funding that enforce and expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C and D).
3. Our AMA supports federal legislation, standards, policies, and funding that require Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance use disorder care, consistent with nationally recognized medical professional organization level of care criteria for mental health or substance use disorders.

Citation: Res. 212, A-96; Reaffirmation A-97; Reaffirmed: Res. 215, I-98; Reaffirmation A-99; Reaffirmed: BOT Action in response to referred for decision Res. 612, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmation A-02; Reaffirmation I-03; Modified: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmation A-15; Modified: Res. 113, A-16; Modified: Res. 216, I-22;

#### **Increased Funding for Substance Use Disorder Treatment H-95.973**

Our AMA (1) urges Congress to substantially increase its funding for substance use disorder treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the substance use disorder treatment system.

Citation: Res. 116, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20;

#### **Referral of Patients to Substance Use Disorder Treatment Programs H-95.991**

Our AMA urges its members to acquaint themselves with the various substance use disorder treatment programs available for the medical treatment of alcohol and drug use and, where appropriate, to refer their patients to them promptly.

Citation: Res. 31, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20;

### **Drug Abuse in the United States - Treatment Effectiveness And Capacity - A Preliminary Report H-95.969**

Given the need throughout the health care delivery field for more effective and efficient forms of treatment, it is important to investigate the potential for better patient-treatment matching in treating alcohol and drug abusers. Researchers usually try to isolate each element of treatment in order to study it scientifically. In practice, however, several treatment approaches are typically used simultaneously or sequentially. In general, there have been too few well-controlled studies of combined interventions to permit final conclusions about their overall effectiveness in alcohol and drug abuse patients. The available findings are somewhat unimpressive, however, given the scope and intensity of the many combined treatment programs. One reason for the lack of impressive findings may have to do with patient characteristics which determine the amount of change which will occur with any treatment, and perhaps the degree to which additional treatment will result in additional measurable change. In highly motivated good-prognosis patients, for example, one well-chosen intervention - or even standard treatment - may produce maximal amounts of change, making the impact of additional interventions unmeasurable and, by implication, unnecessary. In poor-prognosis patients, on the other hand, the overall amount of change possible may be very limited, making a significant difference between one or many interventions difficult to demonstrate. Finding patient variables (i.e., prior drinking pattern, psychiatric morbidity) that are strongly predictive of treatment outcome may help identify patients expected to benefit least - and most - from multiple interventions. The AMA believes immediate attention should be given to all of these areas of urgently needed action, and commits itself to continued participation in the formulation, dissemination, and evaluation of the national responses to the problems of alcohol and drug abuse.

Citation: BOT Rep. Y, A-90; Reaffirmed: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07; Reaffirmed: CSAPH Rep. 01, A-17;

### **Disease Prevention and Health Promotion in Correctional Institutions H-430.989**

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

Citation: CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Alt. Res. 404, I-20;

### **Disclosure of Drug Use and Addiction Treatment History in Public Assistance Programs H-270.966**

Our AMA opposes: a) requiring that housing applicants consent to the disclosure of medical information about alcohol and other drug abuse treatment as a condition of renting or receiving Section 8 assistance; and b) requiring applicants and/or beneficiaries of Temporary Assistance for Needy Families (TANF, "welfare") and/or the Supplemental Nutrition Assistance Program (SNAP, "food stamps") to disclose medical information, including alcohol and other drug use or treatment for addiction, or to deny assistance from these programs based on substance use status.

Citation: Res. 245, A-97; Reaffirmed: BOT Rep. 33, A-07; Modified: Res. 203, A-16;

### **Survey of Addiction Treatment Centers' Availability H-95.926**

Our AMA: (1) encourages the Substance Abuse and Mental Health Services Administration (SAMHSA) to use its national surveys to increase the information available on the type of insurance (e.g., Medicaid, Medicare, private insurance) accepted by substance use disorder treatment programs listed in SAMHSAs treatment locators; (2) encourages physicians who are authorized to provide medication assisted treatment to opt in to be listed publicly in SAMHSAs treatment locators; and (3) encourages SAMHSA to include private and group practice physicians in its online treatment locator for addiction treatment facilities.

Citation: CMS Rep. 04, A-17;

**Eradicating Homelessness H-160.903**

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) supports the use of physician-led, team-based street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
- (5) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (6) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (7) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
- (8) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (9) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (10) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
- (11) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods;
- (12) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.
- (13) encourages medical schools to implement physician-led, team-based Street Medicine programs with student involvement.

Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22; Appended: Res. 931, I-22;

**Increased Funding for Drug-Related Programs H-95.980**

The AMA supports the expansion of those drug rehabilitation programs which provide an environment for medical and other professional counseling, education and behavior change, and voluntary HIV testing for persons at risk for HIV.

Citation: Res. 35, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18;



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245  
(A-23)

Introduced by: Association for Clinical Oncology

Subject: Biosimilar/Interchangeable Terminology

Referred to: Reference Committee B

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1 Whereas, Biosimilars are a type of biologic medication that is safe and effective for treating  
2 many illnesses; and  
3

4 Whereas, A biosimilar and its original biologic have no clinically meaningful differences in terms  
5 of quality, safety, and efficacy; and  
6

7 Whereas, Biosimilars and biologics have the same treatment risks and benefits<sup>1</sup>; and  
8

9 Whereas, Biosimilars may be available at a lower cost than the original biologic reference  
10 product and studies show that savings improve when biosimilars are used in place of reference  
11 biologics during the treatment of cancer malignancies, resulting in savings to the Medicare  
12 program and decreased out-of-pocket costs for patients; and  
13

14 Whereas, An interchangeable product is not superior in quality to a biosimilar and would have to  
15 meet the same regulatory requirements as a biosimilar; and  
16

17 Whereas, Interchangeability is simply a legislative term that has created confusion about the  
18 inherent lack of clinically meaningful difference among biosimilars; and  
19

20 Whereas, If a biosimilar is equivalent in structure, function, safety, and efficacy to the reference  
21 product, by definition the two are interchangeable; and  
22

23 Whereas, Despite the Food and Drug Administration's (FDA) efforts to provide clarity on the  
24 meaning of "interchangeable" (a new legislative term), including the release of guidance on  
25 interchangeability, confusion and misinformation remain; and  
26

27 Whereas, By creating a divide between a biosimilar and an interchangeable biosimilar for  
28 regulatory purposes at the pharmacy level, the United States further exacerbates clinician and  
29 patient education and access barriers<sup>2</sup>; therefore be it  
30

31 RESOLVED, That our American Medical Association repeal policy H-125.976, *Biosimilar*  
32 *Interchangeability Pathway* (Rescind HOD Policy); and be it further  
33

34 RESOLVED, That our AMA advocate for state and federal laws and regulations that support  
35 patient and physician choice of biosimilars and remove the "interchangeable" designation from  
36 the FDA's regulatory framework. (Directive to Take Action)

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

Received: 5/10/23

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2. Gladys Rodriguez et. al, ASCO Policy Statement on Biosimilar and Interchangeable Products in Oncology. *JCO Oncology Practice*. April 07, 2023. <https://ascopubs.org/doi/pdf/10.1200/OP.22.00783?role=tab>

## RELEVANT AMA POLICY

### **Biosimilar Interchangeability Pathway H-125.976**

Our AMA will: (1) strongly support the pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug; and (2) issue a request to the FDA that the agency finalize the biosimilars interchangeability pathway outlined in its draft guidance Considerations in Demonstrating Interchangeability With a Reference Product with all due haste, so as to allow development and designation of interchangeable biosimilars to proceed, allowing transition to an era of less expensive biologics that provide safe, effective, and accessible treatment options for patients.

Citation: Res. 523, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 246  
(A-23)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Modification of CMS Interpretation of Stark Law

Referred to: Reference Committee B

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1 Whereas, The physician self-referral law, commonly referred to as the Stark Law (42 U.S.C.  
2 1395nn):

- 3 1. Prohibits a physician from making referrals for certain designated health services  
4 payable by Medicare to an entity with which he or she (or an immediate family member)  
5 has a financial relationship (ownership, investment, or compensation), unless an  
6 exception applies;
- 7 2. Prohibits the entity from presenting or causing to be presented claims to Medicare (or  
8 billing another individual, entity, or third-party payer) for those referred services; and
- 9 3. Establishes a number of specific exceptions and grants the Secretary the authority to  
10 create regulatory exceptions for financial relationships that do not pose a risk of program  
11 or patient abuse<sup>1</sup>; and  
12

13 Whereas, Exceptions under the Stark law include in-office ancillary services so that physicians  
14 can furnish designated health services to practice patients; and  
15

16 Whereas, Medically integrated pharmacy services increase patient adherence and allow  
17 physicians to trust that their patients receive intended drug treatment with appropriate  
18 instructions<sup>2,3</sup>; and  
19

20 Whereas, Many physician practices have in-office pharmacies as part of the delivery of health  
21 care; and  
22

23 Whereas, Physician office pharmacies have been able to have a trusted surrogate pick up  
24 prescriptions on behalf of a patient when the patient is unable to come into the office for  
25 whatever reason, including illness or lack of transportation; and  
26

27 Whereas, Physician office pharmacies have been able to mail or otherwise send a prescription  
28 securely to a patient when the patient is unable to come into the office for whatever reason,  
29 including illness or lack of transportation; and  
30

31 Whereas, A set of frequently asked questions (FAQs) issued by the Center for Medicare &  
32 Medicaid Services (CMS)<sup>4</sup> states that the delivery of a medicine to a patient using the Postal  
33 Service, a commercial package service, or by a trusted surrogate violates the in-office exception  
34 of the Stark Law, because that the drug was not dispensed to the patient in the physician office  
35 because the patient was not physically present; and  
36

37 Whereas, CMS guidance may have a negative impact on timely access to treatment for patients  
38 and may increase the administrative burden for physicians; therefore be it

1 RESOLVED, That our American Medical Association request that the Center for Medicare &  
 2 Medicaid Services retract the determination that delivery of medicine to a patient using the  
 3 Postal Service, a commercial package service, or by a trusted surrogate violates the in-office  
 4 exception of the Stark Law (Directive to Take Action); and be it further

5  
 6 RESOLVED, That our AMA advocate for legislation to clarify that a surrogate may deliver  
 7 medicine dispensed at a physician-owned pharmacy without being in violation of the Stark Law  
 8 if the Center for Medicare & Medicaid Services does not change its position on disallowing the  
 9 delivery of medicine to a patient using the Postal Service or a commercial package service.  
 10 (Directive to Take Action)

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

Received: 5/10/23

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2. Iuga A, & McGuire M. Adherence and health care costs. *Risk Manag Healthc Policy*. 2014; 7: 35–44.
3. May B. ASCO/NCODA Release Standards for Medically Integrated Dispensing of Oral Anticancer Drugs. *The ASCO Post*. December 25, 2019. <https://ascopost.com/issues/december-25-2019/asconcorda-release-standards-for-medically-integrated-dispensing-of-oral-anticancer-drugs/>
4. Center for Medicare & Medicaid Services. Physician Self-Referral Law Frequently Asked Questions. (2021). <https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Downloads/FAQs-Physician-Self-Referral-Law.pdf>

#### RELEVANT AMA POLICY

##### **Physician Ownership and Referral for Imaging Services D-270.995**

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

Citation: (Res. 235, A-04; Reaffirmed in lieu of Res. 901, I-05; Reaffirmed: BOT Rep. 10, A-15; Reaffirmed in lieu of Res. 213, A-15)

##### **Access to In-Office Administered Drugs H-330.884**

1. Our American Medical Association will advocate that physician access to in-office administered drugs, including drugs dispensed by pharmacies, be preserved.  
 2. Our AMA will work with the Center for Medicare & Medicaid Services, The Joint Commission, America's Health Insurance Plans, Federation of State Medical Boards, National Association of Boards of Pharmacy, and other involved stakeholders to improve and support patient access to in-office administered drugs.

3. Our AMA will advocate for coverage for in-office administered drugs and related delivery services for patients who are physically unable to self-administer the drug.

Citation: Res. 702, A-15; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation: A-18; Reaffirmation: I-18;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 247  
(A-23)

Introduced by: Albert L. Hsu, MD, Delegate

Subject: Assessing the Potentially Dangerous Intersection Between AI and Misinformation

Referred to: Reference Committee B

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1 Whereas, Our American Medical Association has extensive policy on Augmented Intelligence  
2 (AI), including H-480.939, H-480.940, 11.2.1, H-295.857; and  
3

4 Whereas, In AMA policy H-480.939, *Augmented Intelligence in Health Care*, “our AMA will  
5 advocate that

6 1. Oversight and regulation of health care AI systems must be based on risk of harm and  
7 benefit accounting for a host of factors, including but not limited to: intended and reasonably  
8 expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI  
9 system methods; level of automation; transparency; and, conditions of deployment.

10 7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best  
11 positioned to know the AI system risks and best positioned to avert or mitigate harm do so  
12 through design, development, validation, and implementation. Our AMA will further  
13 advocate:

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

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

20 c. Health care AI systems that are subject to non-disclosure agreements concerning flaws,  
21 malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and  
22 the party initiating or enforcing the gag clause assumes liability for any harm”; and  
23

24 Whereas, In AMA policy H-480-940, *Augmented Intelligence in Health Care*, “our AMA has a  
25 unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine  
26 benefits patients, physicians, and the health care community. To that end our AMA will seek to:

27 1. Leverage its ongoing engagement in digital health and other priority areas for improving  
28 patient outcomes and physicians’ professional satisfaction to help set priorities for health  
29 care AI.

30 2. Identify opportunities to integrate the perspective of practicing physicians into the  
31 development, design, validation, and implementation of health care AI.

32 3. Promote development of thoughtfully designed, high-quality, clinically validated health  
33 care AI that:

34 a. is designed and evaluated in keeping with best practices in user-centered design,  
35 particularly for physicians and other members of the health care team;

36 b. is transparent;

37 c. conforms to leading standards for reproducibility;

- d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
  - e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promises and limitations of health care AI.
  5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI"; and

Whereas, In AMA policy 11.2.1, "Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings;" and

Whereas, AI may have the potential to augment medical and public health misinformation; and

Whereas, AI may have the potential to propagate negative anonymous cyberspace evaluations of physicians; therefore be it

RESOLVED, That our American Medical Association study the potential for AI to augment medical and public health misinformation, as well as the potential to augment cyber-libel, cyber-slander, cyber-bullying, and dissemination of internet misinformation about physicians; and that our AMA propose appropriate state and federal regulations and legislative remedies, with a report back at the 2023 Annual meeting. (Directive to Take Action)

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

Received: 5/10/23

## RELEVANT AMA POLICY

### **Anonymous Cyberspace Evaluations of Physicians D-478.980**

Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.

Citation: (BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 717, A-12; Reaffirmation A-14)

**Medical and Public Health Misinformation in the Age of Social Media D-440.915**

Our AMA: (1) encourages social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information; (2) encourages social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms; (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and (4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

Citation: Res. 421, A-21; Reaffirmed: BOT Rep. 15, A-22;

**Augmented Intelligence in Health Care H-480.939**

Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
  - a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
  - b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so

through design, development, validation, and implementation. Our AMA will further advocate:

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

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

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

8. Our AMA, national medical specialty societies, and state medical associations—

- a. Identify areas of medical practice where AI systems would advance the quadruple aim;

- b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;

- c. Outline new professional roles and capacities required to aid and guide health care AI systems; and

- d. Develop practice guidelines for clinical applications of AI systems.

9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)

10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Citation: BOT Rep. 21, A-19; Reaffirmation: A-22;

### **Augmented Intelligence in Medical Education H-295.857**

Our AMA encourages:

- (1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;

- (2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;

- (3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;

- (4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;

- (5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;

- (6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;

- (7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;

- (8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;

- (9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and

- (10) close collaboration with and oversight by practicing physicians in the development of AI applications.

Citation: CME Rep. 04, A-19;



### **Augmented Intelligence in Health Care H-480.940**

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
  - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
  - b. is transparent;
  - c. conforms to leading standards for reproducibility;
  - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
  - e. safeguards patients and other individuals privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18;

#### **E.11.2.1 Professionalism in Health Care Systems**

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations and the profession should:

- (a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients.
- (b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.
- (c) Ensure that all such tools:
  - (i) are designed in keeping with sound principles and solid scientific evidence.

a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.

b. Practice guidelines, formularies, and similar tools should be based on best available evidence and developed in keeping with ethics guidance.

c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.

(ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;

(iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;

(iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.

(d) Encourage, rather than discourage, physicians (and others) to:

(i) provide care for patients with difficult to manage medical conditions;

(ii) practice at their full capacity, but not beyond.

(e) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.

(f) Ensure that the use of financial incentives and other tools is routinely monitored to:

(i) identify and address adverse consequences;

(ii) identify and encourage dissemination of positive outcomes.

All physicians should:

(g) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.

(h) Advocate for changes in how the delivery of care is organized to promote access to high-quality care for all patients.

Issued: 2016; Amended: 2021; Amended: 2022

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 248  
(A-23)

Introduced by: Indiana

Subject: Supervised Consumption Sites

Referred to: Reference Committee B

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1 Whereas, Supervised Consumption Sites (also known as overdose prevention sites, safe  
2 injection sites, harm reduction centers, etc.), are sites where people can use controlled  
3 substances while being monitored by staff; and  
4

5 Whereas, Such government-sanctioned sites are now operating in New York City, D.B.A. Insite,  
6 North America's first legal supervised sites having more than 100 sites around the world, and  
7 Vancouver's Insite averaged 312 injection room visits per day in 2019; and  
8

9 Whereas, Only a few such sites now operate in the U.S. and may soon expand without much  
10 knowledge or concern by the medical community; and  
11

12 Whereas, It is reported that the U.S. Department of Justice is evaluating the establishment of  
13 such sites and conferring with regulators about appropriate guardrails; and  
14

15 Whereas, AMA policy H-95.925, *Pilot Implementation of Supervised Injection Facilities*, supports  
16 the development and implementation of "pilot supervised injection facilities", but the current  
17 preferred terms for these sites is "overdose prevention site" or "harm reduction center";  
18 therefore be it  
19

20 RESOLVED, That our American Medical Association seek information and consider policy and  
21 legislation regarding the federal legalization of overdose prevention sites (Directive to Take  
22 Action); and be it further  
23

24 RESOLVED, That our AMA amend policy H-95.925, *Pilot Implementation of Supervised*  
25 *Injection Facilities*, to replace the references to "supervised injection facilities" with "overdose  
26 prevention sites". (Modify Current HOD Policy)

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

Received: 5/10/23

### RELEVANT AMA POLICY

#### **Pilot Implementation of Supervised Injection Facilities H-95.925**

Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.

Citation: Res. 513, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 249  
(A-23)

Introduced by: Indiana

Subject: Restrictions on Social Media Promotion of Drugs

Referred to: Reference Committee B

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1 Whereas, Many of our youth have access and exposure to social media outlets that have great  
2 potential to influence our young people regarding drugs; and  
3

4 Whereas, A recent study published in the Journal of Studies on Alcohol and Drug reported on  
5 popular alcohol videos on the social networking site TikTok and noted - 98% of the videos  
6 expressed pro-alcohol sentiment; nearly half were guide videos demonstrating drink recipes;  
7 61% depicted consuming multiple drinks quickly; 69% conveyed positive experiences; 55%  
8 contained humor; nearly half associated alcohol with camaraderie but only 4% of the videos  
9 depicted alcohol with negative associations; and  
10

11 Whereas, Similar results could be anticipated with social media networks with other drugs;  
12 therefore be it  
13

14 RESOLVED, That our American Medical Association seek policy and legislation that would limit  
15 social media's promotion and dissemination of corporate advertisement on usage of commercial  
16 and illicit drugs to our youth. (Directive to Take Action)

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

Received: 5/10/23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 250  
(A-23)

Introduced by: Indiana

Subject: Medicare Budget Neutrality

Referred to: Reference Committee B

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1 Whereas, Medicare physician payments have not had regular positive updates; and

2  
3 Whereas, Medical practice expenses have gone up significantly every year; and

4  
5 Whereas, Medicare physician payments have lagged behind and have not kept up with inflation  
6 and practice costs; and

7  
8 Whereas, Every year physicians must advocate to prevent a Medicare payment cut; and

9  
10 Whereas, Other health care entities like the hospitals and insurance companies are not subject  
11 to budget neutrality; and

12  
13 Whereas, The physician payments are subject to budget neutrality, which results in a  
14 threatened pay cut every year; therefore be it

15  
16 RESOLVED, That our American Medical Association reaffirm its position supporting removal of  
17 budget neutrality for Medicare physician payments, which would result in regular positive  
18 updates for physicians so that the payments can keep up with inflation and practice expenses.  
19 (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 5/10/23

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 251  
(A-23)

Introduced by: Maryland

Subject: Federal Government Oversight of Augmented Intelligence

Referred to: Reference Committee B

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1 Whereas, Safety of patients is of physicians' utmost concern; and

2  
3 Whereas, The applications for augmented intelligence have grown exponentially in the last  
4 decade; and

5  
6 Whereas, There may be positive applications for improved human health such as in PTSD or  
7 pain management; and

8  
9 Whereas, Without appropriate oversight, the developing applications could also have  
10 detrimental impacts to human health; and

11  
12 Whereas, The U.S. Food and Drug Administration (FDA) protects public health by  
13 regulating human drugs and biological products, animal drugs, medical devices, tobacco  
14 products, food (including animal food), cosmetics, and electronic products that emit radiation;  
15 and

16  
17 Whereas, The U.S. Department of Agriculture (USDA) protects public health by regulating food,  
18 agriculture, natural resources, rural development, nutrition, and related issues based on public  
19 policy, the best available science, and effective management; and

20  
21 Whereas, There is no federal agency at present which is charged with oversight of augmented  
22 intelligence and social media and their effect on health; therefore be it

23  
24 RESOLVED, That our American Medical Association study and develop recommendations on  
25 how to best protect public health by regulation and oversight of the development and  
26 implementation of augmented intelligence and its applications in the healthcare arena. (Directive  
27 to Take Action)

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

Received: 5/1/23

## RELEVANT AMA POLICY

### Augmented Intelligence in Health Care H-480.939

Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit

accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.

2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.

3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.

4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.

5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:

- a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.

- b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.

7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:

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

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

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

8. Our AMA, national medical specialty societies, and state medical associations—

- a. Identify areas of medical practice where AI systems would advance the quadruple aim;

- b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;

- c. Outline new professional roles and capacities required to aid and guide health care AI systems; and

- d. Develop practice guidelines for clinical applications of AI systems.

9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)

10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Citation: BOT Rep. 21, A-19; Reaffirmation: A-22;

#### **Augmented Intelligence in Health Care H-480.940**

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to:

- 1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.

2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
  3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
    - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
    - b. is transparent;
    - c. conforms to leading standards for reproducibility;
    - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
    - e. safeguards patients and other individuals' privacy interests and preserves the security and integrity of personal information.
  4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
  5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
- Citation: BOT Rep. 41, A-18;

### **Augmented Intelligence in Medical Education H-295.857**

Our AMA encourages:

- (1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;
  - (2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;
  - (3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;
  - (4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;
  - (5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;
  - (6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;
  - (7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;
  - (8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;
  - (9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and
  - (10) close collaboration with and oversight by practicing physicians in the development of AI applications.
- Citation: CME Rep. 04, A-19;



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 252  
(A-23)

Introduced by: Maryland

Subject: Strengthening Patient Privacy

Referred to: Reference Committee B

---

1 Whereas, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established  
2 the Privacy Rule in order to protect the use and transmission of “individually identifiable health  
3 information” and now sets the federal guideline and industry-wide standard for privacy and  
4 security of protected health information (PHI)<sup>1</sup>; and  
5

6 Whereas, In recognition of the increasing adoption and potential utility of health information in  
7 life sciences research, policy assessment, health operations studies, and more, the Privacy  
8 Rule permits a covered entity to use and disclose health information if it is de-identified or does  
9 not provide a reasonable basis to identify an individual<sup>1</sup>; and  
10

11 Whereas, Since federal HIPAA regulations do not regulate de-identified health information as it  
12 is not considered PHI, thereby allowing for its unrestricted use and distribution by covered  
13 entities<sup>2</sup>; and  
14

15 Whereas, A systematic literature review revealed that anonymization of PHI does not eliminate  
16 the risk data re-identification risk and that different de-identification techniques have different re-  
17 identification risks<sup>3</sup>; and  
18

19 Whereas, Re-identification of de-identified datasets is possible and third party data brokers such  
20 as McKinsey have been shown to leverage complex algorithms and data triangulation in order  
21 to re-identify patient data without ever having documented consent from the individuals<sup>4</sup>; and  
22

23 Whereas, Sweeney demonstrated that publicly and semi-publicly available health data from  
24 various agencies including the Agency for Healthcare Research and Quality, when linked to  
25 publicly available data from the US census summary, could potentially allow for re-identification  
26 of all unique hospitalized patients, although risk of re-identification varied widely depending on  
27 the identifiers studied<sup>5</sup>; and  
28

29 Whereas, Current de-identification practices of prescription records in Canada, similar to ones in  
30 the U.S., were found to have a high likelihood of re-identification with other publicly available  
31 information if stronger de-identification measures were not implemented<sup>6</sup>; and  
32

33 Whereas, A machine learning algorithm successfully reidentified 85.6% of adults’ physical  
34 activity data and demographic to individual-specific health record numbers with previously  
35 recorded physical activity data<sup>7</sup>; and  
36

37 Whereas, The previously outlined information highlights the growing concerns of re-identification  
38 of patient’s protected health information using de-identified datasets and publicly available  
39 information<sup>9,10</sup>; and

Whereas, AMA Principles of Medical Ethics 3.1.1, *Privacy in Health Care*, calls upon physicians to "protect patient privacy in all settings to the greatest extent possible" and AMA policy H-480.940, *Augmented Intelligence in Health Care*, calls upon the AMA to "safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information" in the context of AI; therefore be it

RESOLVED, That our American Medical Association study the modern threats to patient privacy, especially in the context of augmented intelligence, and generate recommendations to guide AMA advocacy in this area for the betterment of patient rights. (Directive to Take Action)

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

Received: 5/1/23

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#### RELEVANT AMA POLICY

##### 3.1.1 Privacy in Health Care

Protecting information gathered in association with the care of the patient is a core value in health care. However, respecting patient privacy in other forms is also fundamental, as an expression of respect for patient autonomy and a prerequisite for trust.

Patient privacy encompasses a number of aspects, including personal space (physical privacy), personal data (informational privacy), personal choices including cultural and religious affiliations (decisional privacy), and personal relationships with family members and other intimates (associational privacy).

Physicians must seek to protect patient privacy in all settings to the greatest extent possible and should:

- (a) Minimize intrusion on privacy when the patient's privacy must be balanced against other factors.
- (b) Inform the patient when there has been a significant infringement on privacy of which the patient would otherwise not be aware.
- (c) Be mindful that individual patients may have special concerns about privacy in any or all of these areas.

##### Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
  - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
  - b. is transparent;
  - c. conforms to leading standards for reproducibility;
  - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
  - e. safeguards patients and other individuals privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 253  
(A-23)

Introduced by: New York

Subject: Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)

Referred to: Reference Committee B

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1 Whereas, Physicians provide a great deal of work outside the tradition patient visit, including  
2 asynchronous remote care – such as phone calls, coordination of care with subspecialists and  
3 pharmacists, electronic messaging, and review of laboratory data (outside of face to face and  
4 remote visit); and  
5

6 Whereas, The volume of asynchronous remote work continues to increase, and was  
7 accelerated in 2020-2022 during the COVID-19 pandemic<sup>1</sup>; and  
8

9 Whereas, Uncompensated work is a significant contributor to physician burnout and a driver of  
10 the loss of primary care workforce and shortages in care<sup>1,2</sup>; and  
11

12 Whereas, Access to care coordination is greatly impacted by social determinants of health, and  
13 disparities or inequities exist in patient access to care coordination<sup>3,4</sup>; and  
14

15 Whereas, Care coordination by physicians involves frequent and ongoing contact with home  
16 health and care management services, usually on days other than the actual clinical office visit,  
17 and using separate electronic systems outside of the physician's electronic health record<sup>4-6</sup>;  
18 and  
19

20 Whereas, The Centers for Medicare & Medicaid Services (CMS) and private insurers have  
21 reimbursed for some aspects of care coordination, but these reimbursements are likely to end  
22 with, or shortly after, the end of the COVID-19 public health emergency declaration<sup>7</sup>; therefore  
23 be it  
24

25 RESOLVED, That our American Medical Association create a policy stating that payors should  
26 compensate physicians for asynchronous (outside the day of a patient visit) non-visit or remote  
27 care, such phone calls, electronic messaging, and review of laboratory data (New HOD Policy);  
28 and be it further  
29

30 RESOLVED, That our AMA advocate for expansion of Current Procedural Terminology (CPT)  
31 codes 99441-99445 into telemedicine parity law, that will include reimbursement similar to other  
32 CPT codes. (Directive to Take Action)

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

Received: 5/10/23

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**RELEVANT AMA POLICY****Evolving Impact of Telemedicine H-480.974**

Our AMA:

- (1) will evaluate relevant federal legislation related to telemedicine;
- (2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
- (3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
- (4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
- (5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
- (6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
- (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
- (8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
- (9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association ([www.americantelemed.org](http://www.americantelemed.org)) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

Citation: CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 254  
(A-23)

Introduced by: American College of Surgeons, American Academy of Otolaryngology –  
Head and Neck Surgery, American Academy of Orthopaedic Surgeons,  
American Academy of Ophthalmology, American Society of Plastic Surgeons

Subject: Eliminating the Party Statement Exception in Quality Assurance Proceedings

Referred to: Reference Committee B

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1 Whereas, Quality Assurance (QA) is an essential, legally required process for the practice of  
2 surgery and medicine; and  
3

4 Whereas, Proceedings and records from QA meetings, including Morbidity and Mortality  
5 conferences, have been protected from discovery (QAP; QA Privilege) for nearly 50 years by  
6 provisions in the Education Law (§ 6527(3)) and the Public Health Law (§2805-m(2)); and  
7

8 Whereas, QA meetings allow physicians to identify best practices and improve the delivery of  
9 health care services; and  
10

11 Whereas, Comments made during a QA meeting by a person who is a named party in a  
12 malpractice case may be discoverable and do not benefit from the same protections (known as  
13 a *party-statement exception, PSE*); and  
14

15 Whereas, A recent legal case, Siegel v. Snyder 202 A.D. 3d 125, 161 N.Y.S.3d 159 (2nd Dept,  
16 2021), has challenged the quality-assurance privilege in committee meeting minutes or  
17 materials in which a speaker is not identified; and  
18

19 Whereas, The recent decision in Siegel v. Snyder 202 A.D. 3d 125, 161 N.Y.S.3d 159 (2nd  
20 Dept, 2021) sets a new precedent of discoverability of QA meeting minutes when each speaker  
21 in a QA meeting fails to be identified; and  
22

23 Whereas, New York physicians or institutions currently seeking to assert a QA privilege now  
24 have the burden of demonstrating that the QA committee meeting minutes were not party  
25 statements subject to disclosure; and  
26

27 Whereas, In response to the decision of this case and the PSE, professional organizations  
28 representing hospitals have suggested limiting the involvement of named parties in QA efforts;  
29 and  
30

31 Whereas, In response to the decision of this case and the PSE, a growing number of New York  
32 medical centers have limited the involvement of named parties in QA efforts; and  
33

34 Whereas, Widespread knowledge of the recent judicial interpretation of the PSE discourages  
35 open, transparent reporting and discussion of opportunities for improvement in patient care; and  
36

37 Whereas, In response to diminished QA proceedings, the educational and performance  
38 improvement value of QA conferences is eroding; and

1 Whereas, The PSE creates inappropriate adverse incentives for plaintiffs to name residents,  
2 departmental leaders and QA officers as parties to legal proceedings for the sole purpose of  
3 discovery; therefore be it  
4

5 RESOLVED, That our American Medical Association reaffirm the importance of meaningful  
6 Quality Assurance proceedings that are unhindered by legal discovery concerns (New HOD  
7 Policy); and be it further  
8

9 RESOLVED, That our AMA strongly support and advocate for eliminating the Party Statement  
10 Exception to confidentiality at Quality Assurance meetings in all applicable laws. (Directive to  
11 Take Action)

Fiscal Note: Minimal - less than \$1,000

Received: 5/10/23

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<https://casetext.com/case/siegel-v-snyder>

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 255  
(A-23)

Introduced by: Georgia

Subject: Correctional Medicine

Referred to: Reference Committee B

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1 Whereas, Detained and/or incarcerated patients have the right to medical neutrality from their  
2 treating physician regardless of their status as a detained or incarcerated person<sup>1</sup>; and  
3

4 Whereas, Detained and/or incarcerated persons have the right to speak with their provider  
5 confidentially<sup>1</sup>; and  
6

7 Whereas, Detained and/or incarcerated persons have the right to removal of physical restraints  
8 for the purpose of a physical exam at the discretion of the treating physician<sup>3</sup>; and  
9

10 Whereas, Detained and/or incarcerated persons have the right to medical care at a facility that  
11 has a protocol for and supports ongoing quality improvement of medical care for the  
12 incarcerated patient<sup>1</sup>; and  
13

14 Whereas, Detained and/or incarcerated persons have the right to privacy and protection from  
15 inquiry regarding charges, conviction, or duration of sentence unless immediately pertinent to  
16 patient care<sup>1</sup>; and  
17

18 Whereas, Detained and/or incarcerated persons have the right to informed consent; to be  
19 adequately informed of diagnoses, treatment options, risks and alternatives, and follow-up plans  
20 with respect to educational status and literacy as necessary<sup>1</sup>; and  
21

22 Whereas, Detained and/or incarcerated persons have the right to refuse care, diagnostic  
23 testing, nutrition, laboratory studies, medications, and procedures, for as long as the patient  
24 has medical decision making capacity as deemed by the treating physician or is not at  
25 immediate risk of harm to self or others<sup>4</sup>; and  
26

27 Whereas, Detained and/or incarcerated persons have the right to timely administration of all  
28 interventions and necessary consultations while in the emergency department as deemed by  
29 the attending physician<sup>1</sup>; and  
30

31 Whereas, Detained and/or incarcerated persons have the right to make their healthcare  
32 decisions independent of law enforcement officials when competent, and to appoint an  
33 appropriate surrogate medical decision-maker in the event they become incompetent. Wardens,  
34 sheriffs, guards, police officers, prison administrators, and other law enforcement officials are  
35 not eligible medical decision-makers<sup>2</sup>; and  
36

37 Whereas, Detained and/or incarcerated persons have the right to consultation by their medical  
38 decision-maker according to state laws regardless of the policies of law enforcement or carceral  
39 institutions<sup>1</sup>; now therefore be it



- 1 RESOLVED, That our American Medical Association work with interested parties and key stake
- 2 holders, including the American College of Emergency Physicians, to develop model federal
- 3 legislation requiring health care facilities to inform patients in custody about their rights as a
- 4 patient under applicable federal and state law. (Directive to Take Action)

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

Received: 5/9/23

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 256  
(A-23)

Introduced by: American Society for Surgery of the Hand, American Association  
of Hand Surgery

Subject: Regulating Misleading AI Generated Advice to Patients

Referred to: Reference Committee B

Whereas, A generative pretrained transformer (GPT) is an AI tool that produces text resembling human writing, allowing users to interact with AI almost as if they are communicating with another person; and

Whereas, GPT is prone to errors and omissions that can fail at simple tasks, such as basic arithmetic, or insidiously commit errors that go unnoticed without scrutiny by subject matter experts; and

Whereas, Patients might benefit from using GPT as a medical resource; however, unless its advice is filtered through health care practitioners, false or misleading information could endanger their safety; and

Whereas, When consumers directly ask AI for emotional support or medical advice, they act outside the patient-physician relationship, and few guardrails exist; and

Whereas, Most health care laws do not apply in the consumer context, however, the Federal Trade Commission (FTC) could designate false and misleading AI-generated medical advice as *unfair or deceptive business practices* that violate the FTC act, and the US Food and Drug Administration could hold software developers responsible if GPT makes false medical claims; therefore be it

RESOLVED, That our American Medical Association commence a study of the benefits and unforeseen consequences to the medical profession of GPTs, with report back to the HOD at the 2023 interim meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA consider working with the Federal Trade Commission and other appropriate organizations to protect patients from false or misleading AI-generated medical advice (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage physicians to educate our patients about the benefits and risks of consumers facing generative pretrained transformers. (New HOD Policy)

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

Received: 4/2/23

**REFERENCES**

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