

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(A-23)

Introduced by: American College of Preventive Medicine

Subject: Prediabetes as a Major Health Concern for Chronic Disease Prevention

Referred to: Reference Committee D

1 Whereas, Approximately 96 million Americans or 1 in 3 people have prediabetes¹; and

2
3 Whereas, 80% of adults are not aware they have prediabetes and remain undetected²; and

4
5 Whereas, 1 out of 4 Americans aged 12 to 18 years in the United States have prediabetes,
6 placing younger generations at risk for developing type 2 diabetes and heart disease in the
7 future³; and

8
9 Whereas, Historically marginalized and excluded populations in the United States are
10 disproportionately affected by prediabetes and type 2 Diabetes including Black Americans,
11 Hispanic/Latino Americans, American Indians, Pacific Islanders, and Asian Americans²; and

12
13 Whereas, The United States Preventive Services Task Force (USPSTF) recommends adults
14 aged 35 to 70 years who have certain risk factors including overweight or obesity should be
15 screened for prediabetes and type 2 diabetes by physicians and receive referrals to valuable
16 preventive interventions⁴; and

17
18 Whereas, The Centers for Disease Control and Prevention estimates approximately 210,000
19 children and adolescents living in the United States under the age of 20 years have diabetes
20 and of that group 23,000 children and adolescents have type 2 diabetes⁵; and

21
22 Whereas, Healthy People 2030 reports 2 in 5 adults and 1 in 5 children have obesity and
23 therefore are at risk of developing severe medical conditions including type 2 diabetes⁶; and

24
25 Whereas, Non-Hispanic Black and Hispanic adults and children have a higher incidence of
26 obesity when compared to other racial groups⁷; and

27
28 Whereas, About 10% of Americans living with prediabetes will advance to a diabetes diagnosis
29 within a year⁸; and

30
31 Whereas, Other risk factors related to prediabetes include “older age, physical inactivity,
32 unhealthy diet, and genetic predisposition⁸”, and therefore lifestyle choices related to physical
33 activity levels, weight management and choosing not to smoke decrease the risk of diabetes-
34 related complications, while also monitoring A1C, blood pressure and cholesterol levels⁹; and

35
36 Whereas, Those living with prediabetes can also delay or prevent diabetes through engaging in
37 lifestyle prevention strategies and services which manage “psychological, social, and
38 motivational obstacles⁸”; and

Whereas, The United States healthcare system spends an estimated \$327 billion per year on diabetes-related medical expenses and reduced productivity¹⁰; and

Whereas, The average American living with diabetes spends an estimated \$16,750 per year on medical expenses, with \$9,600 per year on diabetes-related medical expenses¹⁰; and

Whereas, Healthcare providers should carefully review appropriateness of glucagon-like peptide-1 (GLP-1) receptor agonist therapy as shortages within this drug class have recently emerged^{11,12}; and

Whereas, The American College of Preventive Medicine (ACPM) in partnership with the American College of Lifestyle Medicine (ACLM) developed the Lifestyle Medicine Core Competencies Program for healthcare providers to address various modalities of lifestyle medicine in relation to prediabetes and diabetes care management including nutrition, physical activity, sleep health, health and wellness coaching, emotional wellness and weight management¹³; and

Whereas, Structured lifestyle change programs focused on healthy eating, physical activity and lowering medical expenses, such as Diabetes Self-Management Education and Support (DSMES)¹⁴, the National Diabetes Prevention Program (NDPP)¹⁵ and the Childhood Obesity Intervention Cost-Effectiveness Study (CHOICES)¹⁶, can prevent or delay the onset of obesity, prediabetes and type 2 diabetes^{14,15,16}; and

Whereas, 1 in 4 people who take insulin reported associated costs effecting their ability to consistently and/or correctly take the medication¹⁷; and

Whereas, Advocacy efforts are needed to continue to lower the cost of diabetes management through reducing excessive insulin costs and limiting medical-related copayments¹⁷; therefore be it

RESOLVED, That our American Medical Association acknowledge prediabetes as a major health concern for chronic disease prevention in the United States and support development of physician and patient focused education, increased access to care and continued advocacy for local, state, and nation-wide policy change within a diversity, equity, inclusion, and accessibility framework. (Directive to Take Action)

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

Received: 5/31/23

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RELEVANT AMA POLICY

Strategies to Increase Diabetes Awareness D-440.935

Our AMA will organize a series of activities for the public in collaboration with health care workers and community organizations to bring awareness to the severity of diabetes and measures to decrease its incidence.

Citation: Res. 412, A-13

Support Efforts to Improve Access to Diabetes Self-Management Training Services H-160.899

Our AMA: (1) will actively support regulatory and legislative actions that will mitigate barriers to Diabetes Self-Management Training (DSMT) utilization; and (2) will support outreach efforts to foster increased reliance on DSMT by physician practices in order to improve quality of diabetes care.

Citation: Res. 119, A-17

National Diabetes Education Program H-440.861

Our AMA formally endorses the work of the National Diabetes Education Program (NDEP), a joint venture of the National Institutes of Health, the Centers for Disease Control and Prevention, and over 200 organizations, and will seek inclusion in the NDEP Steering Committee to help guide the development of diabetes educational materials in line with existing AMA policy.

Citation: BOT Action in response to referred for decision Res. 604, I-07; Reaffirmed: CSAPH Rep. 01, A-17

Ensuring the Best In-School Care for Children with Diabetes H-60.932

Our AMA policy is that physicians, physicians-in-training, and medical students should serve as advocates for pediatric patients with diabetes to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections.

Citation: CSAPH Rep. 4, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Genomic-Based Approaches to the Risk Assessment, Management and Prevention of Type 2 Diabetes H-440.838

Our AMA encourages continued research into the potential of genomic information to improve risk assessment, management and prevention of type 2 diabetes, and will report back on important advances as appropriate.

Citation: (CSAPH Rep. 2, A-14)

Expansion of National Diabetes Prevention Program H-440.844

Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers.

Citation: Sub. Res. 911, I-12; Reaffirmed: CSAPH Rep. 1, A-22

Obesity as a Major Health Concern H-440.902

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.

Citation: Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002
(A-23)

Introduced by: New York

Subject: Withdraw and Amend Virtual Credit Card Policy

Referred to: Reference Committee G

1 Whereas, Our American Medical Association has previously adopted resolutions on Virtual
2 Credit Card Payments (VCC) (H-190.955); and
3

4 Whereas, Our AMA has previously adopted a position that VCC is an allowed payment method;
5 therefore it be
6

7 RESOLVED, That our American Medical Association withdraw or amend any of its policy
8 statements that VCCs are 'legal' or 'not illegal' (Directive to Take Action); and be it further
9

10 RESOLVED, That our AMA advocate on behalf of the physicians and plainly state that in no
11 circumstance is advisable or beneficial for medical practices to get paid by VCCs. (Directive to
12 Take Action)

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

Received: 6/1/23

REFERENCES

<https://www.beckersasc.com/asc-transactions-and-valuation-issues/private-practice-physicians-drop-to-26.html>

RELEVANT AMA POLICY

Virtual Credit Card Payments H-190.955

1. Our American Medical Association will educate its members about the use of virtual credit cards by third party payers, including the costs of accepting virtual credit card payments from third party payers, the beneficiaries of the administrative fees paid by the physician practice inherent in accepting such payments and the lower cost alternative of electronic funds transfer via the Automated Clearing House.
2. Our AMA will advocate for advance disclosure by third-party payers of transaction fees associated with virtual credit cards and any rebates or other incentives awarded to payers for utilizing virtual credit cards.
3. Our AMA supports transparency, fairness, and provider choice in payers' use of virtual credit card payments, including: advanced physician consent to acceptance of this form of payment; disclosure of transaction fees; clear information about how the provider can opt out of this payment method at any time; and prohibition of payer contracts requiring acceptance of virtual credit card payments for network inclusion.

Citation: (Sub. Res. 704, A-15)

Physician Credit Card Payments by Health Insurance Companies D-190.972

Our AMA will consider legislation on behalf of physicians that any credit card transaction/bank fees are paid by the insurer and not the health care provider.

Citation: (Res. 225, I-14)

CMS Administrative Requirements D-190.970

Our AMA will: (1) forcefully advocate that the Centers for Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative simplification requirements thoroughly and offers transparency in its processes and decisions as required by the Administrative Procedure Act (APA); (2) forcefully advocate that the CMS resolve all complaints related to the non-compliant payment methods including opt-out virtual credit cards, charging processing fees for electronic claims and other illegal electronic funds transfer (EFT) fees; (3) communicate its strong disapproval of the failure by the CMS Office of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements as required by the law and its failure to impose financial penalties for non-compliance by health plans; and (4) through legislation, regulation or other appropriate means, advocate for the prohibition of health insurers charging physicians and other providers to process claims and make payment.

Citation: Res. 229, I-21; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1003
(A-23)

Introduced by: New York

Subject: Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion

Referred to: Reference Committee G

1 Whereas, Our American Medical Association has previously affirmed its strategic plan to embed
2 equity, diversity, and inclusion as its guiding principles; and
3

4 Whereas, Many healthcare tasks are outsourced by health plans to lower-cost countries in
5 vastly different time zones, including India, Pakistan, Philippines, among others; likewise, many
6 revenue cycle management (RCM) duties, >70% are outsourced to the same countries by
7 medical practices, including hospitals and physician practices. Surveys suggest that 85-90% of
8 calls are answered by insurance representatives in non-US time zones; and
9

10 Whereas, Studies have shown that night shift work has adverse health effects; and
11

12 Whereas, Provider outsourced RCM staff and health plan outsourced staff work in the same
13 time zone, separated from the US by around 12 hours. Both provider RCM outsourced staff and
14 health plan outsourced staff work night shifts during US business hours while mostly interacting
15 with each other; and
16

17 Whereas, Common sense suggests that it would be advantageous for outsourced staff to work
18 in their local time zone as much as possible, and that would be the preferred option for most;
19 and
20

21 Whereas, Outsourced workers in low-cost outsourced countries are relatively under-privileged;
22 therefore it be
23

24 RESOLVED, That our American Medical Association advocate that health plans that outsource
25 their customer service facing operations to foreign countries in time zones separated by more
26 than 4 hours from the US should implement 16 or 24-hour availability for their support services
27 staffed by outsourced employees to allow local day shift work schedules for their own
28 outsourced employees in different time zones and provider employees located in similar time
29 zones (Directive to Take Action); and be it further
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31 RESOLVED, That our AMA support national legislation that calls on health plans that outsource
32 their customer service facing operations to foreign countries in time zones separated by more
33 than 4 hours from the US to implement 16 or 24-hour availability for their support services
34 staffed by outsourced employees to allow local day shift work schedules for their own
35 outsourced employees in different time zones and provider employees located in similar time
36 zones (New HOD Policy); and be it further
37

38 RESOLVED, That our AMA advocate for fair treatment of outsourced employees in vastly
39 different time zones by health plans. (Directive to Take Action)

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

Received: 6/5/23

RELEVANT AMA POLICY

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;

Remuneration for Physician Services H-385.951

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmation: A-22;

Prior Authorization Reform D-320.982

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.
Citation: Res. 704, A-19; Reaffirmation: A-22;

Light Pollution: Adverse Health Effects of Nighttime Lighting H-135.932

Our AMA:

1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This

effect can be minimized by using dim red lighting in the nighttime bedroom environment.

3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.

4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.

Citation: CSAPH Rep. 4, A-12; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 1, A-22;

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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1004
(A-23)

Introduced by: Oregon

Subject: Treatment of Overweight and Obesity

Referred to: Reference Committee B

Whereas, The prevalence of overweight and obesity in the United States is approaching 50%¹ and together they account for at least \$174 billion in annual excess health care spending²; and

Whereas, Obesity is a major contributor to serious chronic diseases such as diabetes, hypertension, and degenerative joint disease and thus a major contributor to poor health outcomes³; and

Whereas, Evidence-based medicine recognizes obesity as a chronic disease resulting from both genetic and environmental factors rather than from moral failure⁴; and

Whereas, The best available evidence suggests that modifications of diet and exercise are unlikely to result in long-term benefits; and

Whereas, The treatment of obesity has progressed to the point where an individualized approach utilizing appropriate combinations of behavioral, surgical, and pharmacological interventions⁵ is considered the standard of care⁶; and

Whereas, Newer pharmacological treatments include medications that are very expensive⁷ and whose cost in the United States exceeds that in other countries; and

Whereas, Currently, third-party payors, including Medicare, many state Medicaid programs, and many commercial insurance companies do not cover these and other established medications for weight loss consequently resulting in inequities in care and disparities in outcomes; therefore be it

RESOLVED, That our American Medical Association join in efforts to convince Congress to address the affordability and accessibility of evidence-based, prevention and treatment of obesity across the United States. (Directive to Take Action)

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

Received: 6/6/23

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3. Obesity Clinical Guidance. <https://www.aafp.org/family-physician/patient-care/clinical-recommendations/clinical-guidance-obesity.html>. AAFP: Clinical Guidance: Obesity and Healthy Lifestyle: Clinical Guidance and Practice Resources. Date accessed: March 15, 2023. Date published: February 28, 2023.

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6. Foster, D., Sanchez-Collins, S., & Cheskin, L. J. (2017). Multidisciplinary Team-Based Obesity Treatment in Patients With Diabetes: Current Practices and the State of the Science. *Diabetes spectrum : a publication of the American Diabetes Association*, 30(4), 244–249. <https://doi.org/10.2337/ds17-0045>.
7. Anti-obesity medications are set to skyrocket this year. But how will we afford them? <https://www.usatoday.com/story/news/health/2023/02/19/anti-obesity-medications-cost/11069886002/>. USA Today. Date accessed: March 15, 2023. Date published: February 20, 2023.

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;

REFERRAL CHANGES AND OTHER REVISIONS

2023 Annual Meeting

WITHDRAWN RESOLUTIONS

- Resolution 708 - UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures (American College of Gastroenterology)

REFERRAL CHANGES

- Resolution 255 - Correctional Medicine, has been reassigned to Reference Committee D and is now Resolution 432
- Resolution 504 - Regulating Misleading AI Generated Advice to Patients, has been reassigned to Reference Committee B and is now Resolution 256
- Resolution 506 - Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development, has been reassigned to Reference Committee F and is now Resolution 609

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- Resolution 220 - Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations (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, American College of Radiology)
- Resolution 223 - Protecting Access to Gender Affirming Care (The Endocrine Society, American Association of Clinical Endocrinology, American Society for Reproductive Medicine, American College of Obstetrics and Gynecology, American Academy of Pediatrics, Medical Student Section)
- Resolution 224 - Advocacy Against Obesity-Related Bias by Insurance Providers (American Society for Metabolic and Bariatric Surgery, Society of American Gastrointestinal and Endoscopic Surgeons, Obesity Medicine Association)
- Resolution 254 - Eliminating the Party Statement Exception in Quality Assurance Proceedings (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, Urological Caucus, New York)
- Resolution 257 - AMA Efforts on Medicare Payment Reform (Texas, Florida, Pennsylvania, American Academy of Dermatology, American Contact Dermatitis Society, American Society for Dermatologic Surgery Association, Arizona, California, Indiana, Mississippi, New Jersey, New York, Oklahoma, South Carolina, American Academy of Ophthalmology, American Society of Plastic Surgeons, American Society of Regional Anesthesia and Pain, Private Practice Physicians Section, International Medical Graduates Section)
- Resolution 319 - Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement (Minority Affairs Section, National Medical Association, Medical Student Section)

REFERRAL CHANGES AND OTHER REVISIONS

2023 Annual Meeting

- Resolution 606 – AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates (Georgia, Mississippi, Oklahoma, New Jersey, Alabama, Virginia, Delaware, Arkansas)
- Resolution 607 - Enabling Sections of the American Medical Association (Matthew D. Gold, M.D., Delegate, Organized Medical Staff Section)

* Additional sponsors underlined.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials (A-23)

Presented by: Roxanne Tyroch, MD, Chair

Saturday, June 10, 2023

1 Mister Speaker, Members of the House of Delegates:

2 3 (1) LATE RESOLUTIONS

4
5 The Committee on Rules and Credentials met Friday, June 9, to discuss Late Resolutions
6 1001, 1002, 1003, and 1004. The sponsors of the late resolutions met with the committee and
7 were given the opportunity to present for the committee's consideration the reason the
8 resolution could not be submitted in a timely fashion and the urgency of consideration by the
9 House of Delegates at this meeting.

10
11 Recommended for acceptance:

- 12
13 • Late 1001 – Prediabetes as a Major Health Concern for Chronic Disease Prevention

14
15 Recommended against acceptance:

- 16
17 • Late 1002 – Withdraw and Amend Virtual Credit Card Policy
18 • Late 1003 – Outsourcing of Administrative and Clinical Work to Different Time Zones –
19 An Issue of Equity, Diversity, and Inclusion
20 • Late 1004 – Treatment of Overweight and Obesity

21 22 (2) REAFFIRMATION RESOLUTIONS

23
24 The Speakers asked the Committee on Rules and Credentials to review the recommendations
25 for placing resolutions introduced at this meeting of the House of Delegates on the
26 Reaffirmation Calendar. Reaffirmation of existing policy means that the policies reaffirmed
27 remain active policies within the AMA policy database and therefore are part of the body of
28 policy that can be used in setting the AMA's agenda. It also resets the sunset clock, so such
29 policies will remain viable for 10 years from the date of reaffirmation. The Committee
30 recommends that current policy be reaffirmed in lieu of the following resolutions (current policy
31 and AMA activities are listed in the Appendix to this report):

- 32
33 • Resolution 005 – Providing Culturally and Religiously Sensitive Attire Options at
34 Hospitals for Patients and Employees
35 • Resolution 102 – Reforming the Medicare Part B "Buy and Bill" Process to Encourage
36 Biosimilar Use
37 • Resolution 103 – Movement Away from Employer-Sponsored Health Insurance
38 • Resolution 104 – Support for Medicare Expansion to Wheelchair Accessibility Home
39 Modifications as Durable Medical Equipment
40 • Resolution 105 – Studying Population-Based Payment Policy Disparities
41 • Resolution 108 – Sustainable Reimbursement for Community Practices

- Resolution 109 – Improved Access to Care for Patients in Custody of Protective Services
- Resolution 110 – Long-Term Care Coverage for Dementia Patients
- Resolution 111 – Potential Negative Consequences of ACOs
- Resolution 112 – Removal of Barriers to Care for Lung Cancer Screening in Medicaid
- Resolution 113 – Cost of Insulin
- Resolution 114 – Physician and Trainee Literacy of Healthcare Costs
- Resolution 115 – Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer
- Resolution 116 – Medicare Coverage of OTC Nicotine Replacement Therapy
- Resolution 117 – Payment for Physicians Who Practice Street Medicine
- Resolution 201 – Pharmacists Prescribing for Urinary Tract Infections
- Resolution 207 – Ground Ambulance Services and Surprise Billing
- Resolution 210 – The Health Care Related Effects of Recent Changes to the US Mexico
- Resolution 212 – Marijuana Product Safety
- Resolution 213 – Telemedicine Services and Health Equity
- Resolution 214 – Advocacy and Action for a Sustainable Medical Care System
- Resolution 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
- Resolution 219 – Repealing the Ban on Physician-Owned Hospitals
- Resolution 220 – Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations
- Resolution 222 – Physician Ownership of Hospital Blocked by the ACA
- Resolution 223 – Protecting Access to Gender Affirming Care
- Resolution 224 – Advocacy Against Obesity-Related Bias by Insurance Providers
- Resolution 227 – Reimbursement for Postpartum Depression Prevention
- Resolution 229 – Firearm Regulation for Persons Charged with or Convicted of a Violent Offense
- Resolution 231 – Equitable Interpreter Services and Fair Reimbursement
- Resolution 232 – Supervised Injection Facilities (SIFs) Allowed by Federal Law
- Resolution 233 – Dobbs-EMTALA Medical Emergency
- Resolution 234 – Medicare Physician Fee Schedule Updates and Grassroots Campaign
- Resolution 238 – Eliminate Mandatory Medicare Budget Cuts
- Resolution 242 – Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting
- Resolution 243 - Replacing the Frye Standard for the Daubert Standard in Expert Witness
- Resolution 244 – Recidivism
- Resolution 245 – Biosimilar Interchangeable Terminology
- Resolution 246 – Modification of CMS Interpretation of Stark Law
- Resolution 248 – Supervised Consumption Sites
- Resolution 249 – Restrictions on Social Media Promotion of Drugs
- Resolution 250 – Medicare Budget Neutrality
- Resolution 252 – Strengthening Patient Privacy
- Resolution 253 – Appropriate Compensation for Non-Visit Care (Remote or Care of
- Resolution 254 – Eliminating the Party Statement Exception in Quality Assurance Proceedings
- Resolution 313 – Filtering International Medical Graduates During Residency or Fellowship Applications
- Resolution 315 – Prohibit Discriminatory ERAS® Filters In NRMP Match
- Resolution 317 – Supporting Childcare for Medical Resident

- Resolution 425 – Examining Policing Through a Public Health Lens
- Resolution 426 – Accurate Abortion Reporting with Demographics by the Center for Disease Control
- Resolution 431 - Qualified Immunity Reform
- Resolution 510 – Comparative Effectiveness Research
- Resolution 515 – Regulate Kratom and Ban Over-The-Counter Sales
- Resolution 516 – Fasting is Not Required for Lipid Analysis
- Resolution 522 – Approval Authority of the FDA
- Resolution 523 – Reducing Youth Abuse of Dextromethorphan
- Resolution 524 – Ensuring Access to Reproductive Health Services Medications
- Resolution 701 – Reconsideration of the Birthday Rule
- Resolution 702 – Providing Reduced Parking for Patients
- Resolution 703 – Tribal Health Program Electronic Health Record Modernization
- Resolution 705 – Aging and Dementia Friendly Health Systems
- Resolution 711 – Doctors’ Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs
- Resolution 713 – Redesigning the Medicare Hospice Benefit
- Resolution 714 – Improving Hospice Program Integrity
- Resolution 715 – Published Metrics for Hospitals and Hospital Systems
- Resolution 716 – Transparency and Accountability of Hospitals and Hospital Systems
- Resolution 717 – Improving Patient Access to Supplemental Oxygen Therapies
- Resolution 718 – Insurance Coverage of FDA Approved Medications and Devices
- Resolution 722 – Expanding Protections of End-of-Life Care
- Resolution 723 – Vertical Consolidation in Health Care – Markets or Monopolies

Mister Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Jerry P. Abraham, MD; Robert H. Emmick, Jr., MD; Christopher Garofalo, MD; Carlos Latorre, MD; Christopher Libby, MD; and Christopher McAdams, MD; and on behalf of the committee those who appeared before the committee.

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APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 005 – Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees

- Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949
- Support of Human Rights and Freedom H-65.965
- Civil Rights & Medical Professionals E-9.5.4
- Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease H-440.856

Resolution 102 – Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use

- Cuts in Medicare Outpatient Infusion Services D-330.960
- Pharmaceutical Costs H-110.987
- Biosimilar Interchangeability Pathway H-125.976
- Abbreviated Pathway for Biosimilar Approval H-125.980
- Reference Pricing H-185.935
- Medicare Reimbursements for Medications H-330.917

Resolution 103 – Movement Away from Employer-Sponsored Health Insurance

- Options to Maximize Coverage under the AMA Proposal for Reform H-165.823
- Health Insurance Affordability H-165.828
- Individual Health Insurance H-165.920

Resolution 104 – Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment

- Health Care for Older Patients H-25.999
- Support for Housing Modification Policies H-160.890

Resolution 105 – Studying Population-Based Payment Policy Disparities

- Planning and Delivery of Health Care Services H-160.975
- US Physician Shortage H-200.954
- Principles of and Actions to Address Primary Care Workforce H-200.949
- Access to Care by Medicaid Patients H-290.989

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 108 – Sustainable Reimbursement for Community Practices

- The Preservation of the Private Practice of Medicine D-405.988
- Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976
- Health Care Access for Medicaid Patients H-385.921
- Physician Payment Reform H-390.849

Resolution 109 – Improved Access to Care for Patients in Custody of Protective Services

- Alternative Payment Models and Vulnerable Populations D-385.952
- Health Plan Initiatives Addressing Social Determinants of Health H-165.822
- Medicaid - Towards Reforming the Program H-290.997
- Improving Risk Adjustment in Alternative Payment Models H-385.907

Resolution 110 – Long-Term Care Coverage for Dementia Patients

- Senior Care H-25.993
- Financing of Long-Term Services and Supports H-280.945
- Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options D-280.982
- Ensuring Medicare Coverage for Long Term Care D-280.985
- Policy Directions for the Financing of Long-Term Care H-280.991

Resolution 111 – Potential Negative Consequences of ACOs

- Health Care Reform Physician Payment Models D-385.963
- Accountable Care Organization Principles H-160.915
- Physician-Focused Alternative Payment Models H-385.913
- Alternative Payment Models and Vulnerable Populations D-385.952
- Improving Risk Adjustment in Alternative Payment Models H-385.907
- Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk) D-385.953
- Prospective Payment Model Best Practices for Independent Private Practice H-385.904

Resolution 112 – Removal of Barriers to Care for Lung Cancer Screening in Medicaid

- Lung Cancer Screening to be Considered Standard Care H-185.936

Resolution 113 – Cost of Insulin

- Insulin Affordability H-110.984
- Incorporating Value into Pharmaceutical Pricing H-110.986
- Pharmaceutical Costs H-110.987
- Cost Sharing Arrangements for Prescription Drugs H-110.990
- Strategies to Address Rising Health Care Costs H-155.960

Resolution 114 – Physician and Trainee Literacy of Healthcare Costs

- Controlling Cost of Medical Care H-155.966
- Price Transparency D-155.987
- Management and Leadership for Physicians D-295.316
- Patient Information and Choice H-373.998

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 115 – Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer

- Symptomatic and Supportive Care for Patients with Cancer H-55.999
- Health Insurance Market Regulation H-165.856
- Status Report on the Uninsured H-185.964

Resolution 116 – Medicare Coverage of OTC Nicotine Replacement Therapy

- Health Plan Coverage for Over-the-Counter Drugs H-185.956
- Health Insurance and Reimbursement for Tobacco Cessation and Counseling H-490.916

Resolution 117 – Payment for Physicians Who Practice Street Medicine

- Eradicating Homelessness H-160.903

Resolution 201 – Pharmacists Prescribing for Urinary Tract Infections

- Practicing Medicine by Non-Physicians H-160.949
- Evaluation of the Expanding Scope of Pharmacists' Practice D-35.987
- Drug Initiation or Modification by Pharmacists H-160.928
- Combating Antimicrobial Resistance through Education H-100.973

Resolution 207 – Ground Ambulance Services and Surprise Billing

- Out-of-Network Care H-285.904
- Billing Procedures for Emergency Care H-130.978
- Medicare Balance Billing D-390.986
- Balance Billing H-385.991

Resolution 210 – The Health Care Related Effects of Recent Changes to the US Mexico Border

- Immigration Status is a Public Health Issue D-350.975
- Patient and Physician Rights Regarding Immigration Status H-315.966
- Financial Impact of Immigration on the American Health System H-160.920
- Financial Impact of Immigration on American Health System D-160.988

Resolution 212 – Marijuana Product Safety

- Cannabis Legalization for Medicinal Use D-95.969
- Cannabis and Cannabinoid Research H-95.952
- Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
- Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936
- Taxes on Cannabis Products H-95.923

Resolution 213 – Telemedicine Services and Health Equity

- Addressing Equity in Telehealth H-480.937
- Coverage of and Payment for Telemedicine H-480.946

Resolution 214 – Advocacy and Action for a Sustainable Medical Care System

- Physician Payment Reform H-390.849
- Sequestration D-390.946

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 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

- Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
- Physician Assistants and Nurse Practitioners H-160.947
- Physician Assistants H-35.989
- Models/Guidelines for Medical Health Care Teams H-160.906
- AMA Support for States in Their Development of Legislation to Support Physician-Led, Team Based Care D-35.982
- Practicing Medicine by Non-Physicians H-160.949

Resolution 219 – Repealing the Ban on Physician-Owned Hospitals
by the following policy:

- Hospital Consolidation H-215.960

Resolution 220 – Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations

- Importance of Clinical Research H-460.930
- Prevent Medicare Advantage Plans from Limiting Care D-285.959
- Medicare Advantage Policies H-330.878

Resolution 222 – Physician Ownership of Hospital Blocked by the ACA

- Hospital Consolidation H-215.960

Resolution 223 – Protecting Access to Gender Affirming Care

- Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
- Medical Spectrum of Gender D-295.312
- Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824
- Affirming the Medical Spectrum of Gender H-65.962
- Discriminatory Policies that Create Inequities in Health Care H-65.963

Resolution 224 – Advocacy Against Obesity-Related Bias by Insurance Providers

- Addressing Obesity D-440.954

Resolution 227 – Reimbursement for Postpartum Depression Prevention

- Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
- Preventive Services H-425.997
- Value of Preventive Services H-460.894

Resolution 229 – Firearm Regulation for Persons Charged with or Convicted of a Violent Offense

- Violence as a Public Health Issue H-515.979
- Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 231 – Equitable Interpreter Services and Fair Reimbursement

- Certified Translation and Interpreter Services D-385.957
- Physician Reimbursement for Interpreter Services D-385.946
- Interpreters in the Context of the Patient-Physician Relationship H-160.924
- Patient Interpreters H-385.928
- Interpreter Services and Payment Responsibilities H-385.917
- Appropriate Reimbursement for Language Interpretive Services D-160.992
- Use of Language Interpreters D-385.978
- Discrimination Against Physicians by Health Care Plans H-285.985
- Interpreters For Physician Visits D-90.999
- Availability and Payment for Medical Interpreters Services in Medical Practices H-385.929
- Support for Standardized Interpreter Training D-300.976

Resolution 232 – Supervised Injection Facilities (SIFs) Allowed by Federal Law

- Pilot Implementation of Supervised Injection Facilities H-95.925

Resolution 233 – Dobbs-EMTALA Medical Emergency

- Opposition to Criminalization of and Civil Liability for Pregnancy Loss as the Result of Medically Necessary Care D-160.911
- Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era D-5.998
- Preserving Access to Reproductive Health Services D-5.999

Resolution 234 – Medicare Physician Fee Schedule Updates and Grassroots Campaign

- Physician Payment Reform H-390.849
- Sequestration D-390.946

Resolution 238 – Eliminate Mandatory Medicare Budget Cuts

- Physician Payment Reform H-390.849
- Sequestration D-390.946

Resolution 242 – Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure

- Managed Care H-285.998

Resolution 243 – Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony

- 9.7.1 Medical Testimony

Resolution 244 – Recidivism

- Community-Based Treatment Centers H-160.963
- Increased Funding for Drug-Related Programs H-95.980
- Inhalant Abuse H-95.962

Resolution 245 – Biosimilar Interchangeable Terminology

- Biosimilar Interchangeability Pathway H-125.976

Resolution 246 – Modification of CMS Interpretation of Stark Law

- Access to In-Office Administered Drugs H-330.884

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 248 – Supervised Consumption Sites

- Pilot Implementation of Supervised Injection Facilities H-95.925

Resolution 249 – Restrictions on Social Media Promotion of Drugs

- Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965
- Medical and Public Health Misinformation in the Age of Social Media D-440.915
- Prevention of Drug-Related Overdose D-95.987
- Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988

Resolution 250 – Medicare Budget Neutrality

- Physician Payment Reform H-390.849
- Sequestration D-390.946

Resolution 252 – Strengthening Patient Privacy

- Patient Privacy and Confidentiality H-315.983
- Supporting Improvements to Patient Data Privacy D-315.968
- Integration of Mobile Health Applications and Devices into Practice H-480.943

Resolution 253 – Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)

- Addressing Equity in Telehealth H-480.937
- Audio-Only Telehealth for Risk Adjusted Payment Models D-480.962

Resolution 254 – Eliminating the Party Statement Exception in Quality Assurance Proceedings

- Legal Protections for Peer Review H-375.962

Resolution 313 – Filtering International Medical Graduates During Residency or Fellowship Applications

- Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
- Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310-945

Resolution 315 – Prohibit Discriminatory ERAS® Filters In NRMP Match

- Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
- Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process D-310-945

Resolution 317 – Supporting Childcare for Medical Residents

- Supporting Child Care for Health Care Professionals D-200.974

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 425 – Examining Policing Through a Public Health Lens

- Improving the Accuracy of Death Certificates H-85.981
- Policing Reform D-65.987
- Policing Reform H-65.954

Resolution 426 – Accurate Abortion Reporting with Demographics by the Center for Disease Control

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

Resolution 431 - Qualified Immunity Reform

- Policing Reform D-65.987
- Policing Reform H-65.954

Resolution 510 – Comparative Effectiveness Research

- Comparative Effectiveness Research D-460.973
- Comparative Effectiveness Research H-460.909

Resolution 515 – Regulate Kratom and Ban Over-The-Counter Sales

- Kratom and its Growing Use Within the United States H-95.934
- Dietary Supplements and Herbal Remedies H-150.954
- Addressing Emerging Trends in Illicit Drug Use H-95.940

Resolution 516 – Fasting is Not Required for Lipid Analysis

- Prevention of Coronary Artery Disease H-425.990
- Medical Evaluations of Healthy Persons H-425.994

Resolution 522 – Approval Authority of the FDA

- Supporting Access to Mifepristone (Mifeprex) H-100.948
- FDA H-100.992
- Food and Drug Administration H-100.980

Resolution 523 – Reducing Youth Abuse of Dextromethorphan

- Harmful Drug Use in the United States - Strategies for Prevention H-95.978

Resolution 524 – Ensuring Access to Reproductive Health Services Medications

- Supporting Access to Mifepristone (Mifeprex) H-100.948
- FDA H-100.992
- Food and Drug Administration H-100.980

Resolution 701 – Reconsideration of the Birthday Rule

- Expanding Choice in the Private Sector H-165.881
- Individual Health Insurance H-165.920
- Health System Reform Legislation H-165.838

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 702 – Providing Reduced Parking for Patients

- Non-Emergency Patient Transportation Systems H-130.954
- Voluntary Health Care Cost Containment H-155.998
- Health Promotion and Disease Prevention H-425.993
- Resident and Fellows' Bill of Rights H-310.912

Resolution 703 – Tribal Health Program Electronic Health Record Modernization

- Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987
- Maintenance Payments for Electronic Health Records D-478.975
- Improving Health Care of American Indians H-350.976
- Indian Health Service H-350.977
- Principles for Hospital Sponsored Electronic Health Records D-478.973

Resolution 705 – Aging and Dementia Friendly Health Systems

- Alzheimer's Disease H-25.991
- Physicians and Family Caregivers: Shared Responsibility H-210.980
- Health Care for Older Patients H-25.999
- A Guide for Best Health Practices for Seniors Living in Retirement Communities H-25.987
- Senior Care H-25.993

Resolution 711 – Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs

- Preserving Access to Reproductive Health Services D-5.999
- Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era D-5.998

Resolution 713 – Redesigning the Medicare Hospice Benefit

- Hospice Care H-85.955
- Hospice Coverage and Underutilization H-85.966
- End-of-Life Care H-85.949
- Good Palliative Care H-70.915
- Concurrent Hospice and Curative Care H-85.951
- Support for the Quadruple Aim H-405.955
- Plan for Continued Progress Toward Health Equity H-180.944

Resolution 714 – Improving Hospice Program Integrity

- Fraud and Abuse Within the Medicare System H-175.981
- Health Care Fraud and Abuse Update H-175.984

Resolution 715 – Published Metrics for Hospitals and Hospital Systems

- Physician Satisfaction D-405.985
- Capturing Physician Sentiments of Hospital Quality D-215.988
- Due Diligence for Physicians and Practices Joining and ACO with Risk Based Models (Up Side and Down Side Risk) D-385.953
- Factors Causing Burnout H-405.948
- Physician Burnout D-405.972

APPENDIX – RESOLUTIONS RECOMMENDED FOR REAFFIRMATION OF CURRENT POLICY IN LIEU OF THE RESOLUTIONS WITH REAFFIRMED POLICY AND AMA ACTIVITIES

Resolution 716 – Transparency and Accountability of Hospitals and Hospital Systems

- Hospital Medical Staff Relationships – Dispute Resolution H-225.979
- Affirmatively Protecting the Safety and Dignity of Physicians and Trainees as Workers D-515.977
- Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951
- Factors Causing Burnout H-405.948

Resolution 717 – Improving Patient Access to Supplemental Oxygen Therapies

- Managed Care H-285.998

Resolution 718 – Insurance Coverage of FDA Approved Medications and Devices

- Drug Availability H-100.991
- Status Report on the Uninsured H-185.964

Resolution 722 – Expanding Protections of End-of-Life Care

- Hospice Care H-85.955
- Hospice Coverage and Underutilization H-85.966
- End-of-Life Care H-85.949
- Good Palliative Care H-70.915
- Concurrent Hospice and Curative Care H-85.951

Resolution 723 – Vertical Consolidation in Health Care – Markets or Monopolies

- Hospital Consolidation H-215.960
- Health System Consolidation D-215.984
- Health Care Entity Consolidation D-383.980

SUMMARY OF FISCAL NOTES (A-23)

BOT Report(s)

- 01 Annual Report: none
- 02 New Specialty Organizations Representation in the House of Delegates: Minimal
- 03 2022 Grants and Donations: Informational report
- 04 AMA 2024 Dues: none
- 05 Update on Corporate Relationships: Informational report
- 06 Redefining AMA's Position on ACA and Healthcare Reform: Informational report
- 07 AMA Performance, Activities, and Status in 2022: Informational report
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023: Informational report
- 09 Council on Legislation Sunset Review of 2013 House Policies: Modest
- 10 American Medical Association Health Equity Annual Report: Informational report
- 11 HPSA and MUA Designation For SNFs: Modest
- 12 Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners: Minimal
- 13 Delegate Apportionment and Pending Members: Minimal
- 14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations: \$274,962
- 15 National Cancer Research Patient Identifier: Minimal
- 16 Informal Inter-Member Mentoring: Informational report
- 17 AMA Public Health Strategy: --
- 18 Making AMA Meetings Accessible: none
- 19 Medical Community Voting in Federal and State Elections: Informational report
- 20 Surveillance Management System for Organized Medicine Policies and Reports: --
- 21 Specialty Society Representation in the House of Delegates -
Five-Year Review: Minimal

CC&B Report(s)

- 01 AMA Bylaws and Gender Neutral Language and Miscellaneous Update: Minimal

CEJA Opinion(s)

- 01 Amendment to Opinion 4.2.7, "Abortion": Informational report
- 02 Amendment to Opinion E-10.8, "Collaborative Care": Informational report
- 03 Pandemic Ethics and the Duty of Care: Informational report

CEJA Report(s)

- 01 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions: Minimal
- 02 Ethical Principles for Physicians In Private Equity Owned Practices: Minimal
- 03 Short-term Medical Service Trips: Minimal
- 04 Responsibilities to Promote Equitable Care: Minimal
- 05 CEJA's Sunset Review of 2013 House Policies: Minimal
- 06 Use of De-identified Patient Information D-315.969: Informational Report
- 07 Use of Social Media for Product Promotion and Compensation: Informational report
- 08 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report: Informational report

SUMMARY OF FISCAL NOTES (A-23)

CLRPD Report(s)

- 01 Demographic Characteristics of the House of Delegates and AMA Leadership: Informational report
- 02 A Primer on the Medical Supply Chain: Informational report

CME Report(s)

- 01 Council on Medical Education Sunset Review of 2013 House of Delegates' Policies: Minimal
- 02 Financing Medical Education: Minimal
- 03 Financial Burdens and Exam Fees for International Medical Graduates: Minimal
- 04 Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance: Not yet determined
- 05 Support for Institutional Policies for Personal Days for Undergraduate Medical Students: Not yet determined
- 06 Modifying Financial Assistance Eligibility Criteria for Medical School Applicants: Minimal
- 07 Management and Leadership Training in Medical Education: Minimal
- 08 Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict: Minimal
- 09 The Impact of Midlevel Providers on Medical Education: Minimal

CMS Report(s)

- 01 Council on Medical Service Sunset Review of 2013 House Policies: Minimal
- 02 Medicare Coverage of Dental, Vision, and Hearing Services: Minimal
- 03 Private Insurer Payment Integrity: Minimal
- 04 Bundled Payments and Medically Necessary Care: Minimal
- 05 Prescription Drug Dispensing Policies: Minimal
- 06 Health Care Marketplace Plan Selection: Informational report
- 07 Reporting Multiple Services Performed During a Single Patient Encounter: Minimal
- 08 Impact of Integration and Consolidation on Patients and Physicians: Minimal
- 09 Federally Qualified Health Centers and Rural Health Care: Minimal

CSAPH Report(s)

- 01 Oppose Scheduling of Gabapentin: Minimal
- 02 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices: Minimal
- 03 Regulation and Control of Self-Service Labs: Minimal
- 04 School Resource Officer Violence De-Escalation Training and Certification: Minimal
- 05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers: Minimal
- 06 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections: Minimal
- 07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders: Minimal
- 08 Sunset Review of 2013 HOD Policies: Minimal

HOD Comm on Compensation of the Officers

- 01 Report of the HOD Committee on the Compensation of the Officers: \$0

Joint Report(s)

- CCB/CLRPD 01 Joint Council Report: Sunset Review of 2013 House Policies: Minimal

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

- 001 Opposing Mandated Reporting of LGBTQ+ Status: Minimal
- 002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports: Minimal
- 003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation: Modest
- 004 Amending Policy H-525.988, "Sex and Gender Differences in Medical Research": Minimal
- 005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees: Minimal
- 006 Ensuring Privacy as Large Retail Settings Enter Healthcare: Modest
- 007 Independent Medical Evaluation: Modest
- 008* Study on the Criminalization of the Practice of Medicine: Modest
- 009* Racism - A Threat to Public Health: Modest
- 010* Advocating for Increased Support to Physicians in Family Planning and Fertility: Modest
- 011* Rights of the Developing Baby: Modest
- 012* Viability of the Newborn: Modest
- 013* Serial (Repeated) Sperm Donors: Modest
- 014* Redressing the Harms of Misusing Race in Medicine: Modest
- 015* Report Regarding the Criminalization of Providing Medical Care: Modest
- 016# Supporting Efforts to Strengthen Medical Staffs Through Collective Bargaining and/or Unionization: \$50k Develop program, including education
- 017# Establishing a Formal Definition of "Employed Physician": Minimal
- 018# Confidentiality of Sexual Orientation and Gender Identity Data: Minimal
 - 101 Updating Physician Job Description for Disability Insurance: \$57,817 Study the most effective approach to developing specialty-specific job descriptions that reflect the true physical and cognitive demands of each given specialty for use in the Occupational Information System under development by the Social Security Admini
 - 102 Reforming the Medicare Part B "Buy and Bill" Process to Encourage Biosimilar Use: Modest
 - 103 Movement Away from Employer-Sponsored Health Insurance: Minimal
 - 104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment: Minimal
 - 105 Studying Population-Based Payment Policy Disparities: Modest
 - 106 Billing for Traditional Healing Services: Modest
 - 107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use: Modest
 - 108 Sustainable Reimbursement for Community Practices: Modest
 - 109 Improved Access to Care For Patients in Custody of Protective Services: Modest
 - 110 Long-Term Care Coverage for Dementia Patients: Modest
 - 111* Potential Negative Consequences of ACOs: Modest
 - 112* Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs: Modest
 - 113* Cost of Insulin: Modest
 - 114* Physician and Trainee Literacy of Healthcare Costs: Modest
 - 115* Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer: Modest
 - 116* Medicare Coverage of OTC Nicotine Replacement Therapy: Modest
- 117# Payment for Physicians who Practice Street Medicine: Modest
- 118# Advancing Acute Care at Home: Moderate
- 119# Rescinding the Medicare Three-Day Hospital Inpatient Requirement for Nursing Home Admission: Modest
- 120# Supporting Permanent Reimbursement of Acute Hospital Care at Home: Modest
- 201 Pharmacists Prescribing for Urinary Tract Infections: Modest

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

- 202 Support for Mental Health Courts: Minimal
- 203 Drug Policy Reform: Modest
- 204 Supporting Harm Reduction: Modest
- 205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness: Minimal
- 206 Tribal Public Health Authority: Modest
- 207 Ground Ambulance Services and Surprise Billing: Minimal
- 208 Medicaid Managed Care for Indian Health Care Providers: Modest
- 209 Purchased and Referred Care Expansion: Modest
- 210 The Health Care Related Effects of Recent Changes to the US Mexico Border: Minimal
- 211 Amending Policy H-80.999, "Sexual Assault Survivors", to Improve Knowledge and Access to No-cost Rape Test Kits: Minimal
- 212 Marijuana Product Safety: Modest
- 213 Telemedicine Services and Health Equity: Resolve 1 Modest. Resolve 2 Minimal.
- 214 Advocacy and Action for a Sustainable Medical Care System: Modest
- 215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud: Minimal
- 216 Improved Foster Care Services for Children: Modest
- 217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools: Minimal
- 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: Modest
- 219 Repealing the Ban on Physician-Owned Hospitals: Modest
- 220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations: Modest
- 221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool: Minimal
- 222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA): Modest
- 223 Protecting Access to Gender Affirming Care: Modest
- 224 Advocacy Against Obesity-Related Bias by Insurance Providers: Modest
- 225* Regulation of "Cool/Non-Menthol" Tobacco Products: Minimal
- 226* Vision Qualifications for Driver's License: Modest
- 227* Reimbursement for Postpartum Depression Prevention: Modest
- 228* Reducing Stigma for Treatment of Substance Use Disorder: Minimal
- 229* Firearm Regulation for Persons Charged with or Convicted of a Violent Offense: Modest
- 230* Address Disproportionate Sentencing for Drug Offenses: Modest
- 231* Equitable Interpreter Services and Fair Reimbursement: Modest
- 232* Supervised Injection Facilities (SIFs) Allowed by Federal Law: Minimal
- 233* Dobbs - EMTALA Medical Emergency: Modest
- 234* Medicare Physician Fee Schedule Updates and Grassroots Campaign: Modest
- 235* EMS as an Essential Service: Modest
- 236* AMA Support for Nutrition Research: Modest
- 237* Prohibiting Covenants Not-To-Compete in Physician Contracts: Modest
- 238* Eliminate Mandatory Medicare Budget Cuts: Modest
- 239* Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians: Modest

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

- 240* Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication: Modest
- 241* Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents: Minimal
- 242* Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure: Minimal
- 243* Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony: Modest
- 244* Recidivism: Modest
- 245* Biosimilar/Interchangeable Terminology: Modest
- 246* Modification of CMS Interpretation of Stark Law: Modest
- 247* Assessing the Potentially Dangerous Intersection Between AI and Misinformation: Modest
- 248* Supervised Consumption Sites: Modest
- 249* Restrictions on Social Media Promotion of Drugs: Modest
- 250* Medicare Budget Neutrality: Minimal
- 251* Federal Government Oversight of Augmented Intelligence: Modest
- 252* Strengthening Patient Privacy: Modest
- 253* Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination): Modest
- 254* Eliminating the Party Statement Exception in Quality Assurance Proceedings: Minimal
- 255* Moved to Reference Committee D - Now Resolution 432: Modest
- 256* Regulating Misleading AI Generated Advice to Patients: Modest
- 257# AMA Efforts on Medicare Payment Reform: \$1 million to \$8 million. AMA will implement the called for actions: Media and grassroots campaign, potential fly-in, providing reports, etc. Spend would be based on political opportunity and scaled appropriately, which is why a range is given for the fiscal note.
- 258# Adjustments to Hospice Dementia Enrollment Criteria: Modest
- 259# Strengthening Supplemental Nutrition Assistance Program (SNAP): Modest
- 260# Advocate to the Centers for Medicare and Medicaid Services and The Joint Commission to Redefine the Term "Provider" and Not Delete the Term "Licensed Independent Practitioner": Modest
- 261# Physician Owned Hospitals: \$100K - Comprehensive external study
- 262# Alignment of Specialty Designations for Advanced Practice Providers With Their Supervising Physicians: \$200K - Research and task force implementation.
- 263# Elimination of Non-Compete Clauses in Employment Contracts: Modest
 - 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education: Minimal
 - 302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations: Modest
 - 303 Medical School Management of Unmatched Medical Students: Modest
 - 304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement: Modest
 - 305 Indian Health Service Graduate Medical Education: Minimal
 - 306 Increased Education and Access to Fertility Resources for U.S. Medical Students: Modest
 - 307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents: Minimal
 - 308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants: Minimal
 - 309 Against Legacy Preferences as a Factor in Medical School Admissions: Modest
 - 310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation: Modest
 - 311 Residency Application Support for Students of Low-Income Backgrounds: Minimal
 - 312 Indian Health Service Licensing Exemptions: Modest
 - 313 Filtering International Medical Graduates During Residency or Fellowship Applications: Modest

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

- 314 Support for International Medical Graduates from Turkey: Modest
- 315* Prohibit Discriminatory ERAS® Filters In NRMP Match: Minimal
- 316* Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges: Modest
- 317* Supporting Childcare for Medical Residents: Minimal
- 318* Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions: Minimal
- 319* Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement: Minimal
- 320* Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession: Minimal
- 321* Corporate Compliance Consolidation: Modest
- 322* Disclosure of Compliance issues and Creating a National Database of Joint Leadership: Minimal
- 323# Amend Policy D-275.948, "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training": Minimal
- 401 Metered Dose Inhalers and Greenhouse Gas Emissions: Modest
- 402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance: Minimal
- 403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Minimal
- 404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers: Modest
- 405 Amendment to AMA Policy "Firearms and High-Risk Individuals H-145.972" to Include Medical Professionals as a Party Who Can Petition the Court: Minimal
- 406 Increase Employment Services Funding for People with Disabilities: Minimal
- 407 Addressing Inequity in Onsite Wastewater Treatment: Minimal
- 408 School-to-Prison Pipeline: Minimal
- 409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training: Modest
- 410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs: Minimal
- 411 Protecting Workers During Catastrophes: Modest
- 412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal: Minimal
- 413 Supporting Intimate Partner and Sexual Violence Safe Leave: Minimal
- 414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population: Minimal
- 415 Environmental Health Equity in Federally Subsidized Housing: Modest
- 416 New Policies to Respond to the Gun Violence Public Health Crisis: Modest
- 417 Treating Social Isolation and Loneliness as a Social Driver of Health: Modest
- 418 Increasing the Availability of Automated External Defibrillators: Minimal
- 419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System: Minimal
- 420 Foster Health Care: Minimal
- 421 Prescribing Guided Physical Activity for Depression and Anxiety: Modest
- 422 National Emergency for Children: Minimal
- 423 Reducing Sodium Intake to Improve Public Health: \$25,107,941 Policy changes, ad campaign, and educational material
- 424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home: Minimal
- 425* Examining Policing Through a Public Health Lens: Minimal
- 426* Accurate Abortion Reporting with Demographics by the Center for Disease Control: Minimal
- 427* Minimizing the Influence of Social Media on Gun Violence: Developing educational content - \$50,070
- 428* Mattress Safety in the Hospital Setting: Modest
- 429* Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System: Initiating a public health campaign - \$43,166
- 430* Teens and Social Media: Minimal

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

- 431* Qualified Immunity Reform: Minimal
- 432# Correctional Medicine: Modest
- 433# Upholding Scientifically and Medically Valid Practices for Blood Transfusions: Minimal
- 434# Improving Hazardous Chemical Transport Regulations for Public Health Protections: Minimal
- 435# Stand Your Ground Laws: Modest
- 501 AMA Study of Chemical Castration in Incarceration: Modest
- 502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures: Minimal
- 503 Increasing Diversity in Stem Cell Biobanks and Disease Models: Minimal
- 504 Moved to Reference Committee B - Now Resolution 256: Modest
- 505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations: Minimal
- 506 Moved to Reference Committee F - Now Resolution 609: Approximately \$47,000 for identifying, recruiting, promoting, and facilitating industry-physician relationships through the Physician Innovation Network regarding AI.
- 507 Recognizing the Burden of Rare Disease: Minimal
- 508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses: Minimal
- 509 Addressing Medical Misinformation Online: Minimal
- 510 Comparative Effectiveness Research: Modest
- 511 Regulation of Phthalates in Adult Personal Sexual Products: Minimal
- 512 Wheelchairs on Airplanes: Minimal
- 513 Substance Use History is Medical History: Minimal
- 514 Adolescent Hallucinogen-Assisted Therapy Policy: Modest
- 515 Regulate Kratom and Ban Over-The-Counter Sales: Minimal
- 516 Fasting is Not Required for Lipid Analysis: Approximately \$50k for the development of CME-accredited interactive e-learning including staff costs and external vendor contracting
- 517* Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States: Modest
- 518* Defending NIH funding of Animal Model Research From Legal Challenges: Modest
- 519* Rescheduling or Descheduling Testosterone: Minimal
- 520* Supporting Access to At-Home Injectable Contraceptives: Minimal
- 521* Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs: Minimal
- 522* Approval Authority of the FDA: Modest
- 523* Reducing Youth Abuse of Dextromethorphan: Modest
- 524* Ensuring Access to Reproductive Health Services Medications: Modest
- 525# Decriminalizing and Destigmatizing Perinatal Substance Use Treatment: Minimal
- 601 Solicitation using the AMA Brand: Minimal
- 602 Supporting the Use of Gender-Neutral Language: Up to \$23K to review all current AMA policies and compile a report with recommendations for HOD consideration
- 603 Environmental Sustainability of AMA National Meetings: Implementation of this initiative will be a multi-million dollar undertaking due to the need for consultants to develop a plan, project management to implement measures, potential reduction of in-person meetings and travel, and the ongoing purchase of carbon credits to offset areas where AMA may not be able to reduce emissions, including, among others, utilities in rented AMA office space. Measuring and reporting on compliance will contribute to significant annual costs thereafter. It is currently impossible to provide more precise cost information given the myriad factors involved.
- 604 Speakers Task Force to Review and Modernize the Resolution Process: Modest
- 605 Equity and Justice Initiatives for International Medical Graduates: Approximately \$44K for a one-time update of the health equity strategic plan, plus ~\$24k annually to produce the requested forum

SUMMARY OF FISCAL NOTES (A-23)

Resolution(s)

- 606* AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates: This policy would result in AMA being responsible for approximately \$8.1 million annually based on current AMA travel policy, estimated average costs for airfare and travel, and current number of delegates and alternate delegates
- 607* Enabling Sections of the American Medical Association: Space permitting within currently contracted venues, the incremental daily cost of expanding an AMA Section meeting beyond one day is ~\$10-\$12K per meeting, per section
- 608* Supporting Carbon Offset Programs for Travel for AMA Conferences: Implementation of this initiative will be a multi-million dollar undertaking due to the need for consultants to develop a plan, project management to implement measures, potential reduction of in-person meetings and travel, and the ongoing purchase of carbon credits to offset AMA emissions, including, among others, making mitigation efforts accessible to attendees. Measuring and reporting on compliance will contribute to significant annual costs thereafter. It is currently impossible to provide more precise cost information given the myriad factors involved.
- 609* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development: Approximately \$47,000 for identifying, recruiting, promoting, and facilitating industry-physician relationships through the Physician Innovation Network regarding AI.
- 610# NIH Public Access Plan: Minimal
- 701 Reconsideration of the Birthday Rule: Minimal
- 702 Providing Reduced Parking for Patients: Minimal
- 703 Tribal Health Program Electronic Health Record Modernization: Minimal
- 704 Interrupted Patient Sleep: Minimal
- 705 Aging and Dementia Friendly Health Systems: Modest
- 706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis: Modest
- 707 Expediting Repairs for Power and Manual Wheelchairs: Modest
- 708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures: Modest
- 709 Hospital Bans on Trial of Labor After Cesarean: Modest
- 710* Protect Patients with Medical Debt Burden: Modest
- 711* Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs: Modest
- 712* Medical Bankruptcy – A Unique Feature in the USA: Modest
- 713* Redesigning the Medicare Hospice Benefit: Modest
- 714* Improving Hospice Program Integrity: Modest
- 715* Published Metrics for Hospitals and Hospital Systems: Minimal
- 716* Transparency and Accountability of Hospitals and Hospital Systems: Minimal
- 717* Improving Patient Access to Supplemental Oxygen Therapies: Modest
- 718* Insurance Coverage of FDA Approved Medications and Devices: Modest
- 719* Care Partner Access to Medical Records: Modest
- 720* Prior Authorization Costs, AMA Update to CMS: Modest
- 721* Use of Artificial Intelligence for Prior Authorization: Modest
- 722* Expanding Protections of End-Of-Life Care: Modest
- 723# Vertical Consolidation in Health Care – Markets or Monopolies: Modest
- 724# Rural Hospital Payment Models: Modest
- 725# The Economics of Prior Authorization: Modest
- 726# Proper Use of Overseas Virtual Assistants in Medical Practice: Moderate
- 727# Health System Consolidation: \$200K - Efforts to implement new study

SUMMARY OF FISCAL NOTES (A-23)

Minimal - less than \$1,000

Modest - between \$1,000 - \$5,000

Moderate - between \$5,000 - \$10,000

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

**ORDER OF BUSINESS
SECOND SESSION**

**Saturday, June 10, 2023
12:30 PM**

1. Call to Order by the Speaker - Bruce A. Scott, MD

2. Report of the Rules and Credentials Committee - Roxanne Tyroch, MD, Chair

3. Presentation, Correction and Adoption of Minutes of the November 2022 Interim Meeting

4. Acceptance of Business

Report(s) of the Board of Trustees - Sandra Adamson Fryofer, MD, Chair

- 01 Annual Report (F)
- 02 New Specialty Organizations Representation in the House of Delegates (Amendments to C&B)
- 03 2022 Grants and Donations (Info. Report)
- 04 AMA 2024 Dues (F)
- 05 Update on Corporate Relationships (Info. Report)
- 06 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
- 07 AMA Performance, Activities, and Status in 2022 (Info. Report)
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023 (Info. Report)
- 09 Council on Legislation Sunset Review of 2013 House Policies (B)
- 10 American Medical Association Health Equity Annual Report (Info. Report)
- 11 HPSA and MUA Designation For SNFs (B)
- 12 Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners (B)
- 13 Delegate Apportionment and Pending Members (F)
- 14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations (G)
- 15 National Cancer Research Patient Identifier (Amendments to C&B)
- 16 Informal Inter-Member Mentoring (Info. Report)
- 17 AMA Public Health Strategy (D)
- 18 Making AMA Meetings Accessible (F)
- 19 Medical Community Voting in Federal and State Elections (Info. Report)
- 20 Surveillance Management System for Organized Medicine Policies and Reports (F)
- 21 Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)

Report(s) of the Council on Constitution and Bylaws - Kevin C. Reilly, Sr., MD, Chair

- 01 AMA Bylaws and Gender Neutral Language and Miscellaneous Update (Amendments to C&B)

Report(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair

- 01 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions (Amendments to C&B)
- 02 Ethical Principles for Physicians In Private Equity Owned Practices (Amendments to C&B)
- 03 Short-term Medical Service Trips (Amendments to C&B)
- 04 Responsibilities to Promote Equitable Care (Amendments to C&B)
- 05 CEJA's Sunset Review of 2013 House Policies (Amendments to C&B)
- 06 Use of De-identified Patient Information D-315.969 (Info. Report)
- 07 Use of Social Media for Product Promotion and Compensation (Info. Report)
- 08 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report (Info. Report)

Opinion(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair

- 01 Amendment to Opinion 4.2.7, "Abortion" (Info. Report)
- 02 Amendment to Opinion E-10.8, "Collaborative Care" (Info. Report)
- 03 Pandemic Ethics and the Duty of Care (Info. Report)

Report(s) of the Council on Long Range Planning and Development - Edmond B. Cabbabe, MD, Chair

- 01 Demographic Characteristics of the House of Delegates and AMA Leadership (Info. Report)
- 02 A Primer on the Medical Supply Chain (Info. Report)

Report(s) of the Council on Medical Education - John P. Williams, MD, Chair

- 01 Council on Medical Education Sunset Review of 2013 House of Delegates' Policies (C)
- 02 Financing Medical Education (C)
- 03 Financial Burdens and Exam Fees for International Medical Graduates (C)
- 04 Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance (C)
- 05 Support for Institutional Policies for Personal Days for Undergraduate Medical Students (C)
- 06 Modifying Financial Assistance Eligibility Criteria for Medical School Applicants (C)
- 07 Management and Leadership Training in Medical Education (C)
- 08 Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict (C)
- 09 The Impact of Midlevel Providers on Medical Education (C)

Report(s) of the Council on Medical Service - Lynn L. C. Jeffers, MD, Chair

- 01 Council on Medical Service Sunset Review of 2013 House Policies (G)
- 02 Medicare Coverage of Dental, Vision, and Hearing Services (A)
- 03 Private Insurer Payment Integrity (A)
- 04 Bundled Payments and Medically Necessary Care (A)
- 05 Prescription Drug Dispensing Policies (G)
- 06 Health Care Marketplace Plan Selection (Info. Report)
- 07 Reporting Multiple Services Performed During a Single Patient Encounter (A)
- 08 Impact of Integration and Consolidation on Patients and Physicians (G)
- 09 Federally Qualified Health Centers and Rural Health Care (G)

Report(s) of the Council on Science and Public Health - Noel N. Deep, MD, Chair

- 01 Oppose Scheduling of Gabapentin (E)
- 02 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices (E)
- 03 Regulation and Control of Self-Service Labs (E)
- 04 School Resource Officer Violence De-Escalation Training and Certification (D)
- 05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers (D)
- 06 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections (D)
- 07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders (D)
- 08 Sunset Review of 2013 HOD Policies (D)

Report(s) of the HOD Committee on Compensation of the Officers - Ray C. Hsiao, MD, Chair

- 01 Report of the HOD Committee on the Compensation of the Officers (F)

Joint Report(s)

- CCB/CLRPD 01 Joint Council Report: Sunset Review of 2013 House Policies (F)

--EXTRACTION OF INFORMATIONAL REPORTS--

Resolutions

- 001 Opposing Mandated Reporting of LGBTQ+ Status (Amendments to C&B)
- 002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports (Amendments to C&B)
- 003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation (Amendments to C&B)
- 004 Amending Policy H-525.988, "Sex and Gender Differences in Medical Research" (Amendments to C&B)
- 005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees (Amendments to C&B)
- 006 Ensuring Privacy as Large Retail Settings Enter Healthcare (Amendments to C&B)
- 007 Independent Medical Evaluation (Amendments to C&B)
- 008* Study on the Criminalization of the Practice of Medicine (Amendments to C&B)
- 009* Racism - A Threat to Public Health (Amendments to C&B)

010* Advocating for Increased Support to Physicians in Family Planning and Fertility (Amendments to C&B)

011* Rights of the Developing Baby (Amendments to C&B)

012* Viability of the Newborn (Amendments to C&B)

013* Serial (Repeated) Sperm Donors (Amendments to C&B)

014* Redressing the Harms of Misusing Race in Medicine (Amendments to C&B)

015* Report Regarding the Criminalization of Providing Medical Care (Amendments to C&B)

016# Supporting Efforts to Strengthen Medical Staffs Through Collective Bargaining and/or Unionization (Amendments to C&B)

017# Establishing a Formal Definition of “Employed Physician” (Amendments to C&B)

018# Confidentiality of Sexual Orientation and Gender Identity Data (Amendments to C&B)

101 Updating Physician Job Description for Disability Insurance (A)

102 Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use (A)

103 Movement Away from Employer-Sponsored Health Insurance (A)

104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment (A)

105 Studying Population-Based Payment Policy Disparities (A)

106 Billing for Traditional Healing Services (A)

107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use (A)

108 Sustainable Reimbursement for Community Practices (A)

109 Improved Access to Care For Patients in Custody of Protective Services (A)

110 Long-Term Care Coverage for Dementia Patients (A)

111* Potential Negative Consequences of ACOs (A)

112* Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs (A)

113* Cost of Insulin (A)

114* Physician and Trainee Literacy of Healthcare Costs (A)

115* Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer (A)

116* Medicare Coverage of OTC Nicotine Replacement Therapy (A)

117# Payment for Physicians who Practice Street Medicine (A)

118# Advancing Acute Care at Home (A)

119# Rescinding the Medicare Three-Day Hospital Inpatient Requirement for Nursing Home Admission (A)

120# Supporting Permanent Reimbursement of Acute Hospital Care at Home (A)

201 Pharmacists Prescribing for Urinary Tract Infections (B)

202 Support for Mental Health Courts (B)

203 Drug Policy Reform (B)

204 Supporting Harm Reduction (B)

205 Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness (B)

206 Tribal Public Health Authority (B)

207 Ground Ambulance Services and Surprise Billing (B)

208 Medicaid Managed Care for Indian Health Care Providers (B)

209 Purchased and Referred Care Expansion (B)

210 The Health Care Related Effects of Recent Changes to the US Mexico Border (B)

211 Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-cost Rape Test Kits (B)

212 Marijuana Product Safety (B)

213 Telemedicine Services and Health Equity (B)

214 Advocacy and Action for a Sustainable Medical Care System (B)

215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud (B)

216 Improved Foster Care Services for Children (B)

217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools (B)

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 (B)

219 Repealing the Ban on Physician-Owned Hospitals (B)

- 220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations (B)
- 221 Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool (B)
- 222 Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA) (B)
- 223 Protecting Access to Gender Affirming Care (B)
- 224 Advocacy Against Obesity-Related Bias by Insurance Providers (B)
- 225* Regulation of “Cool/Non-Menthol” Tobacco Products (B)
- 226* Vision Qualifications for Driver’s License (B)
- 227* Reimbursement for Postpartum Depression Prevention (B)
- 228* Reducing Stigma for Treatment of Substance Use Disorder (B)
- 229* Firearm Regulation for Persons Charged with or Convicted of a Violent Offense (B)
- 230* Address Disproportionate Sentencing for Drug Offenses (B)
- 231* Equitable Interpreter Services and Fair Reimbursement (B)
- 232* Supervised Injection Facilities (SIFs) Allowed by Federal Law (B)
- 233* Dobbs - EMTALA Medical Emergency (B)
- 234* Medicare Physician Fee Schedule Updates and Grassroots Campaign (B)
- 235* EMS as an Essential Service (B)
- 236* AMA Support for Nutrition Research (B)
- 237* Prohibiting Covenants Not-To-Compete in Physician Contracts (B)
- 238* Eliminate Mandatory Medicare Budget Cuts (B)
- 239* Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians (B)
- 240* Attorneys’ Retention of Confidential Medical Records and Controlled Medical Expert’s Tax Returns After Case Adjudication (B)
- 241* Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents (B)
- 242* Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure (B)
- 243* Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony (B)
- 244* Recidivism (B)
- 245* Biosimilar/Interchangeable Terminology (B)
- 246* Modification of CMS Interpretation of Stark Law (B)
- 247* Assessing the Potentially Dangerous Intersection Between AI and Misinformation (B)
- 248* Supervised Consumption Sites (B)
- 249* Restrictions on Social Media Promotion of Drugs (B)
- 250* Medicare Budget Neutrality (B)
- 251* Federal Government Oversight of Augmented Intelligence (B)
- 252* Strengthening Patient Privacy (B)
- 253* Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination) (B)
- 254* Eliminating the Party Statement Exception in Quality Assurance Proceedings (B)
- 255* Moved to Reference Committee D - Now Resolution 432 (B)
- 256* Regulating Misleading AI Generated Advice to Patients (B)
- 257# AMA Efforts on Medicare Payment Reform (B)
- 258# Adjustments to Hospice Dementia Enrollment Criteria (B)
- 259# Strengthening Supplemental Nutrition Assistance Program (SNAP) (B)
- 260# Advocate to the Centers for Medicare and Medicaid Services and The Joint Commission to Redefine the Term “Provider” and Not Delete the Term “Licensed Independent Practitioner” (B)
- 261# Physician Owned Hospitals (B)
- 262# Alignment of Specialty Designations for Advanced Practice Providers With Their Supervising Physicians (B)
- 263# Elimination of Non-Compete Clauses in Employment Contracts (B)
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education (C)
- 302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations (C)
- 303 Medical School Management of Unmatched Medical Students (C)

- 304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement (C)
- 305 Indian Health Service Graduate Medical Education (C)
- 306 Increased Education and Access to Fertility Resources for U.S. Medical Students (C)
- 307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents (C)
- 308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants (C)
- 309 Against Legacy Preferences as a Factor in Medical School Admissions (C)
- 310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation (C)
- 311 Residency Application Support for Students of Low-Income Backgrounds (C)
- 312 Indian Health Service Licensing Exemptions (C)
- 313 Filtering International Medical Graduates During Residency or Fellowship Applications (C)
- 314 Support for International Medical Graduates from Turkey (C)
- 315* Prohibit Discriminatory ERAS® Filters In NRMP Match (C)
- 316* Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges (C)
- 317* Supporting Childcare for Medical Residents (C)
- 318* Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions (C)
- 319* Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement (C)
- 320* Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession (C)
- 321* Corporate Compliance Consolidation (C)
- 322* Disclosure of Compliance issues and Creating a National Database of Joint Leadership (C)
- 323# Amend Policy D-275.948, “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training” (C)
- 401 Metered Dose Inhalers and Greenhouse Gas Emissions (D)
- 402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance (D)
- 403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers (D)
- 404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers (D)
- 405 Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972” to Include Medical Professionals as a Party Who Can Petition the Court (D)
- 406 Increase Employment Services Funding for People with Disabilities (D)
- 407 Addressing Inequity in Onsite Wastewater Treatment (D)
- 408 School-to-Prison Pipeline (D)
- 409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training (D)
- 410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs (D)
- 411 Protecting Workers During Catastrophes (D)
- 412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal (D)
- 413 Supporting Intimate Partner and Sexual Violence Safe Leave (D)
- 414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population (D)
- 415 Environmental Health Equity in Federally Subsidized Housing (D)
- 416 New Policies to Respond to the Gun Violence Public Health Crisis (D)
- 417 Treating Social Isolation and Loneliness as a Social Driver of Health (D)
- 418 Increasing the Availability of Automated External Defibrillators (D)
- 419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System (D)
- 420 Foster Health Care (D)
- 421 Prescribing Guided Physical Activity for Depression and Anxiety (D)
- 422 National Emergency for Children (D)
- 423 Reducing Sodium Intake to Improve Public Health (D)
- 424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home (D)
- 425* Examining Policing Through a Public Health Lens (D)
- 426* Accurate Abortion Reporting with Demographics by the Center for Disease Control (D)

427* Minimizing the Influence of Social Media on Gun Violence (D)
428* Mattress Safety in the Hospital Setting (D)
429* Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System (D)
430* Teens and Social Media (D)
431* Qualified Immunity Reform (D)
432# Correctional Medicine (D)
433# Upholding Scientifically and Medically Valid Practices for Blood Transfusions (D)
434# Improving Hazardous Chemical Transport Regulations for Public Health Protections (D)
435# Stand Your Ground Laws (D)
501 AMA Study of Chemical Castration in Incarceration (E)
502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures (E)
503 Increasing Diversity in Stem Cell Biobanks and Disease Models (E)
504 Moved to Reference Committee B - Now Resolution 256 (E)
505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations (E)
506 Moved to Reference Committee F - Now Resolution 609 (E)
507 Recognizing the Burden of Rare Disease (E)
508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses (E)
509 Addressing Medical Misinformation Online (E)
510 Comparative Effectiveness Research (E)
511 Regulation of Phthalates in Adult Personal Sexual Products (E)
512 Wheelchairs on Airplanes (E)
513 Substance Use History is Medical History (E)
514 Adolescent Hallucinogen-Assisted Therapy Policy (E)
515 Regulate Kratom and Ban Over-The-Counter Sales (E)
516 Fasting is Not Required for Lipid Analysis (E)
517* Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States (E)
518* Defending NIH funding of Animal Model Research From Legal Challenges (E)
519* Rescheduling or Descheduling Testosterone (E)
520* Supporting Access to At-Home Injectable Contraceptives (E)
521* Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs (E)
522* Approval Authority of the FDA (E)
523* Reducing Youth Abuse of Dextromethorphan (E)
524* Ensuring Access to Reproductive Health Services Medications (E)
525# Decriminalizing and Destigmatizing Perinatal Substance Use Treatment (E)
601 Solicitation using the AMA Brand (F)
602 Supporting the Use of Gender-Neutral Language (F)
603 Environmental Sustainability of AMA National Meetings (F)
604 Speakers Task Force to Review and Modernize the Resolution Process (F)
605 Equity and Justice Initiatives for International Medical Graduates (F)
606* AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates (F)
607* Enabling Sections of the American Medical Association (F)
608* Supporting Carbon Offset Programs for Travel for AMA Conferences (F)
609* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development (F)
610# NIH Public Access Plan (F)
701 Reconsideration of the Birthday Rule (G)
702 Providing Reduced Parking for Patients (G)
703 Tribal Health Program Electronic Health Record Modernization (G)
704 Interrupted Patient Sleep (G)
705 Aging and Dementia Friendly Health Systems (G)
706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis (G)
707 Expediting Repairs for Power and Manual Wheelchairs (G)

- 708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures (G)
- 709 Hospital Bans on Trial of Labor After Cesarean (G)
- 710* Protect Patients with Medical Debt Burden (G)
- 711* Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs (G)
- 712* Medical Bankruptcy – A Unique Feature in the USA (G)
- 713* Redesigning the Medicare Hospice Benefit (G)
- 714* Improving Hospice Program Integrity (G)
- 715* Published Metrics for Hospitals and Hospital Systems (G)
- 716* Transparency and Accountability of Hospitals and Hospital Systems (G)
- 717* Improving Patient Access to Supplemental Oxygen Therapies (G)
- 718* Insurance Coverage of FDA Approved Medications and Devices (G)
- 719* Care Partner Access to Medical Records (G)
- 720* Prior Authorization Costs, AMA Update to CMS (G)
- 721* Use of Artificial Intelligence for Prior Authorization (G)
- 722* Expanding Protections of End-Of-Life Care (G)
- 723# Vertical Consolidation in Health Care – Markets or Monopolies (G)
- 724# Rural Hospital Payment Models (G)
- 725# The Economics of Prior Authorization (G)
- 726# Proper Use of Overseas Virtual Assistants in Medical Practice (G)
- 727# Health System Consolidation (G)

--Memorial Resolutions--

5. Report of the Committee on Rules and Credentials - Roxanne Tyroch, MD, Chair

- Late Resolutions

- Proposed Reaffirmations

6. Unfinished Business and Announcements

contained in the Handbook Addendum

** contained in the Sunday Tote*

ORDER OF BUSINESS

Reference Committee A (A-23)
Scott H. Pasichow, MD, MPH, Chair

June 10, 2023
Grand Hall K/L

Hyatt Regency Hotel
Chicago, IL

1. Council on Medical Service Report 02 – Medicare Coverage of Dental, Vision, and Hearing Services
2. Council on Medical Service Report 03 – Private Insurer Payment Integrity
3. Council on Medical Service Report 04 – Bundled Payments and Medically Necessary Care
4. Council on Medical Service Report 07 – Reporting Multiple Services Performed During a Single Patient Encounter
5. Resolution 101 – Updating Physician Job Description for Disability Insurance
6. *Resolution 102 – Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use*
7. *Resolution 103 – Movement Away from Employer-Sponsored Health Insurance*
8. *Resolution 105 – Studying Population-Based Payment Policy Disparities*
9. *Resolution 109 – Improved Access to Care for Patients in Custody of Protective Services*
10. *Resolution 104 – Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment*
11. Resolution 106 – Billing for Traditional Healing Services
12. Resolution 107 – Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use
13. *Resolution 108 – Sustainable Reimbursement for Community Practices*
14. *Resolution 111 – Potential Negative Consequences of ACOs*
15. *Resolution 110 – Long-Term Care Coverage for Dementia Patients*

Amendments and supplemental materials MUST be sent to AMARefComA@gmail.com. Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee A hearing.

Note: Items in italics were originally placed on the reaffirmation consent calendar or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will **not** be discussed in the hearing, and these items will **not** be considered by the reference committee.

A Zoom webinar link is provided here: https://zoom.us/webinar/register/WN_PkOPhCpNTS6O6FL1RGxPcw. This link is view-only. Testimony cannot be accepted via Zoom.

16. *Resolution 112 – Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs*
17. *Resolution 113 – Cost of Insulin*
18. *Resolution 114 – Physician and Trainee Literacy of Healthcare Costs*
19. *Resolution 116 – Medicare Coverage of OTC Nicotine Replacement Therapy*
20. *Resolution 115 – Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer*
21. *Resolution 117 – Payment for Physicians Who Practice Street Medicine*
22. Resolution 118 – Advancing Acute Care at Home
Resolution 120 – Supporting Permanent Reimbursement of Acute Hospital Care at Home
23. Resolution 119 – Rescinding the Medicare Three-Day Hospital Inpatient Requirement for Nursing Home Admission

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ORDER OF BUSINESS

Reference Committee B (Annual 2023 Meeting)
Richard Geline, MD, Chair

June 10, 2023
1:30 pm CST
Regency Ballroom A/B

Zoom Link:

https://zoom.us/webinar/register/WN_H2rmGlpQSFqoVyzc0NWgdw

Items in italics are currently slated for reaffirmation or are a late resolution that needs to be approved for consideration.

1. BOT Report 9 – Council on Legislation Sunset Review of 2013 House Policies
2. BOT Report 11 – HPSA and MUA Designation for SNFs
3. BOT Report 12 – Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners
4. *Resolution 201 – Pharmacists Prescribing for Urinary Tract Infections*
5. *Resolution 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*
6. Resolution 235 – EMS as an essential service
7. Resolution 239 – Creating an AMA Taskforce Dedicated to the Alignment of Specialty Designations for Advanced Practice Providers with their Supervising Physicians
Resolution 262 - Alignment of Specialty Designations for Advanced Practice Providers With Their Supervising Physicians
8. Resolution 260 - Advocate to the Centers for Medicare and Medicaid Services and The Joint Commission to Redefine the Term “Provider” and Not Delete the Term “Licensed Independent Practitioner”
9. Resolution 202 – Support for Mental Health Courts
10. Resolution 203 – Drug Policy Reform
11. Resolution 204 – Supporting Harm Reduction
12. *Resolution 212 – Marijuana Product Safety*
13. Resolution 217 – Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools
14. Resolution 221 – Fentanyl Test Strips as a Harm Reduction and Overdose-Prevention Tool
15. Resolution 225 – Regulation of “Cool/Non-Menthol” Tobacco Products
16. Resolution 228 – Reducing Stigma for Treatment of Substance Use Disorder
17. Resolution 230 – Address Disproportionate Sentencing for Drug Offenses

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Participants with technical issues should email HODMeetingSupport@ama-assn.org (please include a phone number); someone will contact you back as soon as possible to assist. For urgent issues during the meeting, the HOD Hotline: 800-337-1599, will be available for assistance. Please note that unless there is a widespread technical difficulty, proceedings will continue.

18. *Resolution 232 – Supervised Injection Facilities (SIFs) Allowed by Federal Law*
Resolution 248 – Supervised Consumption Sites
19. *Resolution 241 – Allow Viewing Access to Prescription Drug Monitoring Programs Through EHR for Clinical Medical Students and Residents*
20. *Resolution 244 – Recidivism*
21. *Resolution 249 – Restrictions on Social Media Promotion of Drugs*
22. *Resolution 205 – Amending H-160.903, Eradicating Homelessness, to Reduce Evictions and Prevent Homelessness*
23. *Resolution 206 – Tribal Public Health Authority*
24. *Resolution 208 – Medicaid Managed Care for Indian Health Care Providers*
25. *Resolution 209 – Purchased and Referred Care Expansion*
26. *Resolution 207 – Ground Ambulance Services and Surprise Billing*
27. *Resolution 210 – The Health Care Related Effects of Recent Changes to the US Mexico Border*
28. *Resolution 211 – Amending Policy H-80.999, “Sexual Assault Survivors”, to Improve Knowledge and Access to No-cost Rape Test Kits*
29. *Resolution 213 – Telemedicine Services and Health Equity*
30. *Resolution 253 – Appropriate Compensation for Non-Visit Care (Remote or Care of Coordination)*
31. *Resolution 214 – Advocacy and Action for a Sustainable Medical Care System*
Resolution 234 – Medicare PFS Updates and Grassroots Campaign
Resolution 238 – Eliminate Mandatory Medicare Budget Cuts
Resolution 250 – Medicare Budget Neutrality
Resolution 257 – AMA Efforts on Medicare Payment Reform
32. *Resolution 215 – Supporting Legislative and Regulatory Efforts against Fertility Fraud*
33. *Resolution 216 – Improved Foster Care Services for Children*
34. *Resolution 219 – Repealing the Ban on Physician-Owned Hospitals*
Resolution 222 – Physician Ownership of Hospitals Blocked by the Affordable Care Act (ACA)
Resolution 261 – Physician Owned Hospitals
35. *Resolution 246 – Modification of CMS Interpretation of Stark Law*
36. *Resolution 220 – Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations*
37. *Resolution 223 – Protecting Access to Gender Affirming Care*
38. *Resolution 224 – Advocacy Against Obesity-Related Bias by Insurance Providers*
Late Resolution 1004 - Treatment of Overweight and Obesity
39. *Resolution 226 – Vision Qualifications for Driver’s License*
40. *Resolution 227 – Reimbursement for Postpartum Depression Prevention*
41. *Resolution 229 – Firearm Regulation for Persons Charged with or Convicted of a Violent Offense*
42. *Resolution 231 – Equitable Interpreter Services and Fair Reimbursement*
43. *Resolution 233 – Dobbs - EMTALA Medical Emergency*
44. *Resolution 236 – AMA Support for Nutrition Research*

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45. Resolution 259 – Strengthening Supplemental Nutrition Assistance Program
46. Resolution 237 – Prohibiting Covenants Not-to-Compete in Physician Contracts
Resolution 263 - Elimination of Non-Compete Clauses in Employment Contracts
47. Resolution 240 – Attorneys’ Retention of Confidential Medical Records and Controlled Medical Expert’s Tax Returns After Case Adjudication
48. *Resolution 242 – Peer to Peer Reviewer Must be of Same Specialty as Physician Requesting Procedure*
49. *Resolution 243 – Replacing the Frye Standard for the Daubert Standard in Expert Witness Testimony*
50. *Resolution 245 – Biosimilar/Interchangeable Terminology*
51. Resolution 247– Assessing the Potentially Dangerous Intersection Between AI and Misinformation
Resolution 251 – Federal Government Oversight of Augmented Intelligence
Resolution 256 – Regulating Misleading AI Generated Advice to Patients
52. *Resolution 252 – Strengthening Patient Privacy*
53. *Resolution 254 – Eliminating the Party Statement Exception in Quality Assurance Proceedings*
54. Resolution 258 – Adjustments to Hospice Dementia Enrollment Criteria

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ORDER OF BUSINESS

Reference Committee C (2023 Annual Meeting)

David T. Walsworth, MD, Chair

Saturday, June 10, 2023

1:30 – 5:30 pm CST

Regency Ballroom C

Zoom link below

1. Council on Medical Education Report 01 – Council on Medical Education Sunset Review of 2013 House of Delegates’ Policies
2. Resolution 321 – Corporate Compliance Consolidation
3. Resolution 322 – Disclosure of Compliance issues and Creating a National Database of Joint Leadership
4. Council on Medical Education Report 09 – The Impact of Midlevel Providers on Medical Education (Resolution 201-A-22)
5. Council on Medical Education Report 02 – Financing Medical Education (Resolution 306-A-22)
6. Council on Medical Education Report 06 – Modifying Financial Assistance Eligibility Criteria for Medical School Applicants
7. Resolution 319 – Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement
8. Resolution 320 – Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession
9. Resolution 309 – Against Legacy Preferences as a Factor in Medical School Admissions
10. Council on Medical Education Report 04 – Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance (Resolution 309-A-22, Resolve 2
11. Council on Medical Education Report 05 – Support for Institutional Policies for Personal Days for Undergraduate Medical Students (Resolution 314-A-22)
12. Resolution 304 – Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement
13. Resolution 306 – Increased Education and Access to Fertility Resources for U.S. Medical Students
14. Resolution 301 – Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
15. Resolution 310 – Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation
16. *Resolution 317 – Supporting Childcare for Medical Residents*
17. Resolution 305 – Indian Health Service Graduate Medical Education

18. Resolution 307 – Amending AMA Policy H-295.858, “Access to Confidential Health Services for Medical Students and Physicians” to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents
19. Resolution 316 – Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges
20. Resolution 308 – Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
21. Resolution 311 – Residency Application Support for Students of Low-Income Backgrounds
22. Resolution 303 – Medical School Management of Unmatched Medical Students
23. Resolution 302 – Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and Other Relevant Associations or Organizations
24. *Resolution 315 – Prohibit Discriminatory ERAS® Filters In NRMP Match*
25. *Resolution 313 – Filtering International Medical Graduates During Residency or Fellowship Applications*
26. Council on Medical Education Report 03 – Financial Burdens and Exam Fees for International Medical Graduates (Resolution 305-A-22)
27. Council on Medical Education Report 08 – Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict
28. Resolution 314 – Support for International Medical Graduates from Turkey
29. Resolution 312 – Indian Health Service Licensing Exemptions
30. Council on Medical Education Report 07 – Management and Leadership Training in Medical Education
31. Resolution 318 – Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions
32. Resolution 323 - Amend Policy D-275.948, “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”

Items in *italics* were placed on the Reaffirmation Consent Calendar. At the beginning of this hearing, the chair will identify those items that were not extracted and therefore will not be discussed in this hearing.

Amendments and supplemental material for Reference Committee C must be sent to meded@ama-assn.org.

Links to related Ref Com C information:

- Zoom link to hearing (view only): https://zoom.us/webinar/register/WN_Nh63DKUtRbq_RmJPnLsx2w
- Handbook and addendum: <https://www.ama-assn.org/system/files/a23-handbook-refcom-c.pdf>
- Online members forum: <https://www.ama-assn.org/forums/house-delegates/ref-comm-c>
- Preliminary document summarizing online testimony: <https://www.ama-assn.org/house-delegates/annual-meeting/business-ama-house-delegates-annual-meeting>

For technical assistance, contact HODMeetingSupport@ama-assn.org or call 800-337-1599.

ORDER OF BUSINESS

Reference Committee on Amendments to Constitution and Bylaws (A-23)
Brandi Ring, MD, Chair

Saturday, June 10, 2023

1:30pm – 5:00pm, Grand Hall I/J, East Tower, Ballroom Level

[Zoom Meeting Link](#) (view only)

1. BOT Report 02 - New Specialty Organizations Representation in the House of Delegates
2. BOT Report 15 - National Cancer Research Patient Identifier
3. BOT Report 21 - Specialty Society Representation in the House of Delegates - Five-Year Review
4. CCB Report 01 - AMA Bylaws and Gender Neutral Language and Miscellaneous Update
5. CEJA Report 01- Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
6. CEJA Report 02 - Ethical Principles for Physicians In Private Equity Owned Practices
7. CEJA Report 03 - Short-term Medical Service Trips
8. CEJA Report 04 - Responsibilities to Promote Equitable Care
9. CEJA Report 05 - CEJA's Sunset Review of 2013 House Policies
10. Resolution 001 - Opposing Mandated Reporting of LGBTQ+ Status
11. Resolution 002 - Exclusion of Race and Ethnicity in the First Sentence of Case Reports
12. Resolution 003 - Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation

Note: During the reference committee hearing, supplemental material may be sent to AMARefComCB@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. AMENDMENTS MUST BE EMAILED. This email address is NOT intended as a means to provide testimony, which should only be presented in on the Online Member Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

Items in *italics* were placed on the Reaffirmation Consent Calendar. At the beginning of this hearing, the chair will identify those items that were not extracted and therefore will not be discussed in this hearing.

Participants with technical issues should email HODMeetingSupport@ama-assn.org (please include a phone number); someone will contact you back as soon as possible to assist. For urgent issues during the meeting, the HOD Hotline: 800-337-1599, will be available for assistance. Please note that unless there is a widespread technical difficulty, proceedings will continue.

13. Resolution 004 - Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"
14. *Resolution 005 - Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees*
15. *Resolution 006 - Ensuring Privacy as Large Retail Settings Enter Healthcare*
16. Resolution 007 - Independent Medical Evaluation
17. Resolution 008 - Study on the Criminalization of the Practice of Medicine; and Resolution 015 - Report Regarding the Criminalization of Providing Medical Care
18. Resolution 009 - Racism - A Threat to Public Health
19. Resolution 010 - Advocating for Increased Support to Physicians in Family Planning and Fertility
20. Resolution 011 - Rights of the Developing Baby
21. Resolution 012 - Viability of the Newborn
22. Resolution 013 – Serial (Repeated) Sperm Donors
23. Resolution 014 – Redressing the Harms of Misusing Race in Medicine
24. Resolution 016 - Supporting Efforts to Strengthen Medical Staffs Through Collective Bargaining and/or Unionization
25. Resolution 017 - Establishing a Formal Definition of "Employed Physician"
26. Resolution 018 - Confidentiality of Sexual Orientation and Gender Identity Data

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ORDER OF BUSINESS

Reference Committee D (June 2023 Meeting)

Cynthia C. Romero, MD, Chair

June 10, 2023

Regency Ballroom D

1:00 pm – 5:30 pm Local Time (CDT)

Zoom link below (view only)

1. Board of Trustees Report 17 - AMA Public Health Strategy
2. Council on Science and Public Health Report 8 - Council on Science and Public Health Sunset Review of 2013 House Policies
3. Council on Science and Public Health Report 5 - Increasing Public Umbilical Cord Blood Donation in Transplant Centers
4. Council on Science and Public Health Report 7 - Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders and Indications for Metabolic and Bariatric Surgery
5. Council on Science and Public Health Report 4 - School Resource Officer Violence De-escalation Training and Certification
Resolution 408 - School-to-Prison Pipeline
6. Council on Science and Public Health Report 6 - Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections
Resolution 432 - Correctional Medicine
7. Resolution 403 - Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
8. Resolution 429 - Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System
9. Resolution 402 - Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance
10. Resolution 404 - Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers
11. Resolution 414 - Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population
12. Resolution 406 - Increase Employment Services Funding for People with Disabilities
13. Resolution 410 - Formal Transitional Care Program for Children and Youth with Special Health Care Needs
14. Resolution 433 - Upholding Scientifically and Medically Valid Practices for Blood Transfusions
15. Resolution 418 - Increasing the Availability of Automated External Defibrillators
16. Resolution 409 - Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training
17. Resolution 428 - Mattress Safety in the Hospital Setting

Items in *italics* were placed on the Reaffirmation Consent Calendar. At the beginning of this hearing, the chair will identify those items that were not extracted and therefore will not be discussed in this hearing.

Zoom link to hearing (view only webinar): https://zoom.us/webinar/register/WN_AGE_noEjR6yLK1JP91TzDw

During the reference committee hearing, supplemental material may be sent to ReferenceCommitteeD@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

18. Resolution 411 - Protecting Workers During Catastrophes
19. Resolution 412 - Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal
20. Resolution 413 - Supporting Intimate Partner and Sexual Violence Safe Leave
- Resolution 424 - Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home
21. Resolution 420 - Foster Health Care
22. Resolution 419 - Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System
23. Resolution 422 - National Emergency for Children
24. Resolution 417 - Treating Social Isolation and Loneliness as a Social Driver of Health
25. Resolution 421 - Prescribing Guided Physical Activity for Depression and Anxiety
26. *Resolution 425 - Examining Policing Through a Public Health Lens*
- Resolution 431 - Qualified Immunity Reform*
27. Resolution 430 - Teens and Social Media
28. Resolution 427 - Minimizing the Influence of Social Media on Gun Violence
29. Resolution 405 - Amendment to AMA Policy "Firearms and High-Risk Individuals H-145.972" to Include Medical Professionals as a Party Who Can Petition the Court
30. Resolution 416 - New Policies to Respond to the Gun Violence Public Health Crisis
31. Resolution 435 - Stand Your Ground Laws
32. Resolution 401 - Metered Dose Inhalers and Greenhouse Gas Emissions
33. Resolution 407 - Addressing Inequity in Onsite Wastewater Treatment
34. Resolution 415 - Environmental Health Equity in Federally Subsidized Housing
35. Resolution 434 - Improving Hazardous Chemical Transport Regulations for Public Health Protections
36. Resolution 423 - Reducing Sodium Intake to Improve Public Health
37. *Resolution 426 - Accurate Abortion Reporting with Demographics by the Center for Disease Control*

Items in *italics* were placed on the Reaffirmation Consent Calendar. At the beginning of this hearing, the chair will identify those items that were not extracted and therefore will not be discussed in this hearing.

Zoom link to hearing (view only webinar): https://zoom.us/webinar/register/WN_AGE_noEjR6yLK1JP91TzDw

During the reference committee hearing, supplemental material may be sent to ReferenceCommitteeD@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

ORDER OF BUSINESS

A-23 Reference Committee E
Jean Hausheer, MD, Chair

June 11, 2023, 8:00 AM – 12:00 PM

Grand Ballroom

Hyatt Regency

Livestream (via Zoom) available here: https://zoom.us/webinar/register/WN_fyBgvIDeTXaVFLALurM53w

1. CSAPH Report 1 - Oppose Scheduling of Gabapentin
2. CSAPH Report 2 - Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices
3. CSAPH Report 3 - Regulation and Control of Self-Service Labs
4. Resolution 509 - Addressing Medical Misinformation Online
5. Resolution 502 - Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
6. Resolution 508 - Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
7. Resolution 505 - Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations
Resolution 525 - Decriminalizing and Destigmatizing Perinatal Substance Use Treatment
8. Resolution 513 - Substance Use History is Medical History
9. Resolution 521 - Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs
10. Resolution 514 - Adolescent Hallucinogen-Assisted Therapy Policy
11. Resolution 512 - Wheelchairs on Airplanes
12. Resolution 501 - AMA Study of Chemical Castration in Incarceration
13. Resolution 511 - Regulation of Phthalates in Adult Personal Sexual Products
14. *Resolution 523* - Reducing Youth Abuse of Dextromethorphan*
15. *Resolution 515* - Resolution to Regulate Kratom and Ban Over-The-Counter Sales**
16. Resolution 519 - Rescheduling or Descheduling Testosterone
17. Resolution 518 - Defending NIH funding of Animal Model Research From Legal Challenges
18. Resolution 520 - Supporting Access to At-Home Injectable Contraceptives
19. *Resolution 522* - Approval Authority of the FDA*
Resolution 524 - Ensuring Access to Reproductive Health Services Medications*
20. *Resolution 510* - Comparative Effectiveness Research*
21. *Resolution 516* - Fasting is Not Required for Lipid Analysis*
22. Resolution 507 - Recognizing the Burden of Rare Disease
23. Resolution 503 - Increasing Diversity in Stem Cell Biobanks and Disease Models
24. Resolution 517 - Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States

** - indicates items placed on the Reaffirmation Consent Calendar for consideration. If extracted, items will be heard in the order listed.*

During the reference committee hearing, supplemental material may be sent to ReferenceCommitteeE@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should only be presented in on the Online Member Forum or orally to the committee. This address is only operational for the duration of the reference committee hearing.

ORDER OF BUSINESS

Reference Committee F (A-23)
Cheryl Gibson Fountain, MD, Chair

June 10, 2023
Grand Ballroom

Hyatt Regency Chicago
Chicago

Zoom Link: https://zoom.us/webinar/register/WN_xt9mZJV2Rr-ZCm1crSFFwQ

FINANCIAL

1. Board of Trustees Report 1 – Annual Report
2. Board of Trustees Report 4 – AMA 2024 Dues
3. Report of the House of Delegates Committee on Compensation of the Officers

HOUSE OF DELEGATES

4. Resolution 606 – AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates
5. Board of Trustees Report 13 – Delegate Apportionment and Pending Members
6. Board of Trustees Report 18 – Making AMA Meetings Accessible
7. Board of Trustees Report 20 – Surveillance Management System for Organized Medicine Policies and Reports
8. Resolution 604 – Speakers Task Force to Review and Modernize the Resolution Process
9. Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 – Joint Council Sunset Review of 2013 House Policies
10. Resolution 602 – Supporting the Use of Gender-Neutral Language

OPERATIONS

11. Resolution 601 – Solicitation Using the AMA Brand
12. Resolution 605 – Equity and Justice Initiatives for International Medical Graduates
13. Resolution 607 – Enabling Sections of the American Medical Association

Note: Items in *italics* were originally placed on the reaffirmation consent calendar, were recommended against consideration, or were late items. At the beginning of the reference committee hearing, the chair will identify those items that will not be discussed in the hearing, and these items will NOT be considered by the reference committee.

During the reference committee hearing, supplemental materials should be sent to referencecommittee@gmail.com. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, supporting documents, and the like. This email address is not intended as a means to provide testimony, which should be presented orally to the committee, and will only accept supplemental material for the duration of the reference committee hearing.

ENVIRONMENTAL

- 14. Resolution 603 – Environmental Sustainability of AMA National Meetings
- 15. Resolution 608 – Supporting Carbon Offset Programs for Travel for AMA Conferences

MISCELLANEOUS

- 16. Resolution 609 – Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
- 17. Resolution 610 – NIH Public Access Plan

ORDER OF BUSINESS

Reference Committee G (A-23)
Ezequiel Silva, III, MD, Chair

June 11, 2023
Grand Hall K/L

Hyatt Regency Hotel
Chicago, IL

1. Board of Trustees Report 14 – Advocacy of Private Practice Options for Health Care Operations in Large Corporations
2. Council on Medical Service Report 01 – Council on Medical Service Sunset Review of 2013 House Policies
3. Council on Medical Service Report 05 – Prescription Drug Dispensing Policies
4. Council on Medical Service Report 08 – Impact of Integration and Consolidation on Patients and Physicians
Resolution 723 – Vertical Consolidation in Health Care – Markets or Monopolies
Resolution 727 – Health System Consolidation Revisited
5. Council on Medical Service Report 09 – Federally Qualified Health Centers and Rural Health Care
6. *Resolution 701 – Reconsideration of the Birthday Rule*
7. *Resolution 702 – Providing Reduced Parking for Patients*
8. *Resolution 703 – Tribal Health Program Electronic Health Record Modernization*
9. Resolution 704 – Interrupted Patient Sleep
10. *Resolution 705 – Aging and Dementia Friendly Health Systems*
Resolution 713 – Redesigning the Medicare Hospice Benefit
Resolution 722 – Expanding Protections of End-of-Life Care
11. Resolution 706 – Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
12. Resolution 707 – Expediting Repairs for Power and Manual Wheelchairs
13. Resolution 708 – UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures
14. Resolution 709 – Hospital Bans on Trial of Labor After Cesarean
15. Resolution 710 – Protect Patients with Medical Debt Burden
Resolution 712 – Medical Bankruptcy – A Unique Feature in the USA
16. *Resolution 711 – Doctors’ Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs*

17. *Resolution 714 – Improving Hospice Program Integrity*
18. *Resolution 715 – Published Metrics for Hospitals and Hospital Systems*
19. *Resolution 716 – Transparency and Accountability of Hospitals and Hospital Systems*
20. *Resolution 717 – Improving Patient Access to Supplemental Oxygen Therapies*
21. *Resolution 718 – Insurance Coverage of FDA Approved Medications and Devices*
22. Resolution 719 – Care Partner Access to Medical Records
23. Resolution 720 – Prior Authorization Costs, AMA Update to CMS
24. Resolution 721 – Use of Artificial Intelligence for Prior Authorization
25. Resolution 724– Rural Hospital Payment Models
26. Resolution 725 – Economics of Prior Authorization
27. Resolution 726 – Proper Use of Virtual Assistants
28. *Late 1001 – Outsourcing of Administrative and Clinical Work to Different Time Zones – An Issue of Equity, Diversity, and Inclusion*
29. *Late 1002 – Withdraw and Amend Virtual Credit Card Policy*

Amendments and supplemental materials MUST be sent to RefComG@gmail.com. Please include the Resolution or Report number in the subject line. Do not send testimony to this email address. This address is only operational for the duration of the Reference Committee G hearing.

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A Zoom webinar link is provided here https://zoom.us/webinar/register/WN_y83G44NrQJaQ93W0qvLpvA. This link is view-only. Testimony cannot be accepted via Zoom.

Reference Committee A

CMS Report(s)

- 02 Medicare Coverage of Dental, Vision, and Hearing Services
- 03 Private Insurer Payment Integrity
- 04 Bundled Payments and Medically Necessary Care
- 07 Reporting Multiple Services Performed During a Single Patient Encounter

Resolution(s)

- 101 Updating Physician Job Description for Disability Insurance
- 102 Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use
- 103 Movement Away from Employer-Sponsored Health Insurance
- 104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment
- 105 Studying Population-Based Payment Policy Disparities
- 106 Billing for Traditional Healing Services
- 107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use
- 108 Sustainable Reimbursement for Community Practices
- 109 Improved Access to Care For Patients in Custody of Protective Services
- 110 Long-Term Care Coverage for Dementia Patients
- 111* Potential Negative Consequences of ACOs
- 112* Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs
- 113* Cost of Insulin
- 114* Physician and Trainee Literacy of Healthcare Costs
- 115* Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer
- 116* Medicare Coverage of OTC Nicotine Replacement Therapy
- 117# Payment for Physicians who Practice Street Medicine
- 118# Advancing Acute Care at Home
- 119# Rescinding the Medicare Three-Day Hospital Inpatient Requirement for Nursing Home Admission
- 120# Supporting Permanent Reimbursement of Acute Hospital Care at Home

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 02 New Specialty Organizations Representation in the House of Delegates
- 15 National Cancer Research Patient Identifier
- 21 Specialty Society Representation in the House of Delegates -
Five-Year Review

CC&B Report(s)

- 01 AMA Bylaws and Gender Neutral Language and Miscellaneous Update

CEJA Report(s)

- 01 Utilization Review, Medical Necessity Determination, Prior Authorization Decisions
- 02 Ethical Principles for Physicians In Private Equity Owned Practices
- 03 Short-term Medical Service Trips
- 04 Responsibilities to Promote Equitable Care
- 05 CEJA's Sunset Review of 2013 House Policies

Resolution(s)

- 001 Opposing Mandated Reporting of LGBTQ+ Status
- 002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
- 003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
- 004 Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"
- 005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
- 006 Ensuring Privacy as Large Retail Settings Enter Healthcare
- 007 Independent Medical Evaluation
- 008* Study on the Criminalization of the Practice of Medicine
- 009* Racism - A Threat to Public Health
- 010* Advocating for Increased Support to Physicians in Family Planning and Fertility
- 011* Rights of the Developing Baby
- 012* Viability of the Newborn
- 013* Serial (Repeated) Sperm Donors
- 014* Redressing the Harms of Misusing Race in Medicine
- 015* Report Regarding the Criminalization of Providing Medical Care
- 016# Supporting Efforts to Strengthen Medical Staffs Through Collective Bargaining and/or Unionization
- 017# Establishing a Formal Definition of "Employed Physician"
- 018# Confidentiality of Sexual Orientation and Gender Identity Data

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

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*

#Contained in the Saturday Tote

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
- 245* Biosimilar/Interchangeable Terminology
- 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* Moved to Reference Committee D - Now Resolution 432
- 256* Regulating Misleading AI Generated Advice to Patients
- 257# AMA Efforts on Medicare Payment Reform
- 258# Adjustments to Hospice Dementia Enrollment Criteria
- 259# Strengthening Supplemental Nutrition Assistance Program (SNAP)
- 260# Advocate to the Centers for Medicare and Medicaid Services and The Joint Commission to Redefine the Term "Provider" and Not Delete the Term "Licensed Independent Practitioner"
- 261# Physician Owned Hospitals
- 262# Alignment of Specialty Designations for Advanced Practice Providers With Their Supervising Physicians
- 263# Elimination of Non-Compete Clauses in Employment Contracts

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

Reference Committee C

CME Report(s)

- 01 Council on Medical Education Sunset Review of 2013 House of Delegates' Policies
- 02 Financing Medical Education
- 03 Financial Burdens and Exam Fees for International Medical Graduates
- 04 Decreasing Bias in Assessments of Medical Student Clinical Clerkship Performance
- 05 Support for Institutional Policies for Personal Days for Undergraduate Medical Students
- 06 Modifying Financial Assistance Eligibility Criteria for Medical School Applicants
- 07 Management and Leadership Training in Medical Education
- 08 Challenges to Primary Source Verification of International Medical Graduates Resulting from International Conflict
- 09 The Impact of Midlevel Providers on Medical Education

Resolution(s)

- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
- 302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations
- 303 Medical School Management of Unmatched Medical Students
- 304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement
- 305 Indian Health Service Graduate Medical Education
- 306 Increased Education and Access to Fertility Resources for U.S. Medical Students
- 307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents
- 308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
- 309 Against Legacy Preferences as a Factor in Medical School Admissions
- 310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation
- 311 Residency Application Support for Students of Low-Income Backgrounds
- 312 Indian Health Service Licensing Exemptions
- 313 Filtering International Medical Graduates During Residency or Fellowship Applications
- 314 Support for International Medical Graduates from Turkey
- 315* Prohibit Discriminatory ERAS® Filters In NRMP Match
- 316* Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges
- 317* Supporting Childcare for Medical Residents
- 318* Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions
- 319* Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement
- 320* Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession
- 321* Corporate Compliance Consolidation
- 322* Disclosure of Compliance issues and Creating a National Database of Joint Leadership

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

Reference Committee C

Resolution(s)

323# Amend Policy D-275.948, “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”

**Contained in the Handbook Addendum*
#Contained in the Saturday Tote

Reference Committee D

BOT Report(s)

- 17 AMA Public Health Strategy

CSAPH Report(s)

- 04 School Resource Officer Violence De-Escalation Training and Certification
- 05 Increasing Public Umbilical Cord Blood Donations in Transplant Centers
- 06 Study of Best Practices for Acute Care of Patients in the Custody of Law Enforcement or Corrections
- 07 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders
- 08 Sunset Review of 2013 HOD Policies

Resolution(s)

- 401 Metered Dose Inhalers and Greenhouse Gas Emissions
- 402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance
- 403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers
- 405 Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972” to Include Medical Professionals as a Party Who Can Petition the Court
- 406 Increase Employment Services Funding for People with Disabilities
- 407 Addressing Inequity in Onsite Wastewater Treatment
- 408 School-to-Prison Pipeline
- 409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training
- 410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs
- 411 Protecting Workers During Catastrophes
- 412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal
- 413 Supporting Intimate Partner and Sexual Violence Safe Leave
- 414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population
- 415 Environmental Health Equity in Federally Subsidized Housing
- 416 New Policies to Respond to the Gun Violence Public Health Crisis
- 417 Treating Social Isolation and Loneliness as a Social Driver of Health
- 418 Increasing the Availability of Automated External Defibrillators
- 419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System
- 420 Foster Health Care
- 421 Prescribing Guided Physical Activity for Depression and Anxiety
- 422 National Emergency for Children
- 423 Reducing Sodium Intake to Improve Public Health
- 424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home
- 425* Examining Policing Through a Public Health Lens
- 426* Accurate Abortion Reporting with Demographics by the Center for Disease Control
- 427* Minimizing the Influence of Social Media on Gun Violence
- 428* Mattress Safety in the Hospital Setting

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

Reference Committee D

Resolution(s)

- 429* Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System
- 430* Teens and Social Media
- 431* Qualified Immunity Reform
- 432# Correctional Medicine
- 433# Upholding Scientifically and Medically Valid Practices for Blood Transfusions
- 434# Improving Hazardous Chemical Transport Regulations for Public Health Protections
- 435# Stand Your Ground Laws

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

Reference Committee E

CSAPH Report(s)

- 01 Oppose Scheduling of Gabapentin
- 02 Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices
- 03 Regulation and Control of Self-Service Labs

Resolution(s)

- 501 AMA Study of Chemical Castration in Incarceration
- 502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
- 503 Increasing Diversity in Stem Cell Biobanks and Disease Models
- 504 Moved to Reference Committee B - Now Resolution 256
- 505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations
- 506 Moved to Reference Committee F - Now Resolution 609
- 507 Recognizing the Burden of Rare Disease
- 508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
- 509 Addressing Medical Misinformation Online
- 510 Comparative Effectiveness Research
- 511 Regulation of Phthalates in Adult Personal Sexual Products
- 512 Wheelchairs on Airplanes
- 513 Substance Use History is Medical History
- 514 Adolescent Hallucinogen-Assisted Therapy Policy
- 515 Regulate Kratom and Ban Over-The-Counter Sales
- 516 Fasting is Not Required for Lipid Analysis
- 517* Genetic Predisposition and Healthcare Disparities, Including Cardiovascular Disease in South Asians Residing in the United States
- 518* Defending NIH funding of Animal Model Research From Legal Challenges
- 519* Rescheduling or Descheduling Testosterone
- 520* Supporting Access to At-Home Injectable Contraceptives
- 521* Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs
- 522* Approval Authority of the FDA
- 523* Reducing Youth Abuse of Dextromethorphan
- 524* Ensuring Access to Reproductive Health Services Medications
- 525# Decriminalizing and Destigmatizing Perinatal Substance Use Treatment

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

Reference Committee F

BOT Report(s)

- 01 Annual Report
- 04 AMA 2024 Dues
- 13 Delegate Apportionment and Pending Members
- 18 Making AMA Meetings Accessible
- 20 Surveillance Management System for Organized Medicine Policies and Reports

HOD Comm on Compensation of the Officers

- 01 Report of the HOD Committee on the Compensation of the Officers

Joint Report(s)

- CCB/CLRPD 01 Joint Council Report: Sunset Review of 2013 House Policies

Resolution(s)

- 601 Solicitation using the AMA Brand
- 602 Supporting the Use of Gender-Neutral Language
- 603 Environmental Sustainability of AMA National Meetings
- 604 Speakers Task Force to Review and Modernize the Resolution Process
- 605 Equity and Justice Initiatives for International Medical Graduates
- 606* AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates
- 607* Enabling Sections of the American Medical Association
- 608* Supporting Carbon Offset Programs for Travel for AMA Conferences
- 609* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
- 610# NIH Public Access Plan

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

Reference Committee G

BOT Report(s)

- 14 Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

CMS Report(s)

- 01 Council on Medical Service Sunset Review of 2013 House Policies
- 05 Prescription Drug Dispensing Policies
- 08 Impact of Integration and Consolidation on Patients and Physicians
- 09 Federally Qualified Health Centers and Rural Health Care

Resolution(s)

- 701 Reconsideration of the Birthday Rule
- 702 Providing Reduced Parking for Patients
- 703 Tribal Health Program Electronic Health Record Modernization
- 704 Interrupted Patient Sleep
- 705 Aging and Dementia Friendly Health Systems
- 706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
- 707 Expediting Repairs for Power and Manual Wheelchairs
- 708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures
- 709 Hospital Bans on Trial of Labor After Cesarean
- 710* Protect Patients with Medical Debt Burden
- 711* Doctors' Risk for Termination of Liability Coverage or Medical Privileges Consequent to Dobbs
- 712* Medical Bankruptcy – A Unique Feature in the USA
- 713* Redesigning the Medicare Hospice Benefit
- 714* Improving Hospice Program Integrity
- 715* Published Metrics for Hospitals and Hospital Systems
- 716* Transparency and Accountability of Hospitals and Hospital Systems
- 717* Improving Patient Access to Supplemental Oxygen Therapies
- 718* Insurance Coverage of FDA Approved Medications and Devices
- 719* Care Partner Access to Medical Records
- 720* Prior Authorization Costs, AMA Update to CMS
- 721* Use of Artificial Intelligence for Prior Authorization
- 722* Expanding Protections of End-Of-Life Care
- 723# Vertical Consolidation in Health Care – Markets or Monopolies
- 724# Rural Hospital Payment Models
- 725# The Economics of Prior Authorization
- 726# Proper Use of Overseas Virtual Assistants in Medical Practice
- 727# Health System Consolidation

**Contained in the Handbook Addendum*

#Contained in the Saturday Tote

Informational Reports

BOT Report(s)

- 03 2022 Grants and Donations
- 05 Update on Corporate Relationships
- 06 Redefining AMA's Position on ACA and Healthcare Reform
- 07 AMA Performance, Activities, and Status in 2022
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2022 through February 2023
- 10 American Medical Association Health Equity Annual Report
- 16 Informal Inter-Member Mentoring
- 19 Medical Community Voting in Federal and State Elections

CEJA Opinion(s)

- 01 Amendment to Opinion 4.2.7, "Abortion"
- 02 Amendment to Opinion E-10.8, "Collaborative Care"
- 03 Pandemic Ethics and the Duty of Care

CEJA Report(s)

- 06 Use of De-identified Patient Information D-315.969
- 07 Use of Social Media for Product Promotion and Compensation
- 08 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

CLRPD Report(s)

- 01 Demographic Characteristics of the House of Delegates and AMA Leadership
- 02 A Primer on the Medical Supply Chain

CMS Report(s)

- 06 Health Care Marketplace Plan Selection

Report of the AMPAC Board of Directors

Presented by: Brooke M. Buckley, MD
Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities this election cycle. As the country continues to emerge from the COVID-19 pandemic, many of the stressors that impacted physician practices and their patients continue to pose a significant challenge to our health care system. Issues like time consuming prior authorizations, sky rocketing prescription drug costs and looming cuts to physician Medicare payments remain as major roadblocks to how physicians provide quality care for their patients. The continuing hardships faced by the medical community have only strengthened our commitment to our mission - to provide physicians with opportunities to support candidates for federal office who have demonstrated their support for organized medicine through a willingness to work with physicians to strengthen our ability to care for America's patients. In addition, we continue to help physician advocates grow their abilities through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully take the next step and work on campaigns or run for office themselves.

AMPAC Membership Fundraising

Thank you to the House of Delegate members who have already committed to AMPAC this year and made a contribution, especially those who gave at the Capitol Club levels. Your generosity will enable AMPAC to advance the advocacy initiatives put forth by the AMA as we enter this new election cycle and build a solid foundation for our medicine friendly allies and champions running for federal office in 2024.

This year, AMPAC has moved into a positive transition period of growth for AMPAC membership across all areas. AMPAC has raised a combined total \$500,647.27 compared to receipts of \$442,178.19 for a 13 percent increase over this same time last year for the 2022 election cycle. AMPAC's hard dollar receipts are up by 10 percent over last year and corporate receipts are up 49 percent. Additionally, AMPAC's Capitol Club continues to show solid growth over the last several months with a 2 percent increase in membership with 543 members and this growth is expected to expand during this meeting.

Each year AMPAC strives to hit 100 percent AMPAC participation within AMA's House of Delegates. AMPAC ended 2022 with 69 percent HOD participation, which is trending in the right direction compared to pandemic years prior. Currently, however, participation stands at only 40 percent, which is well below where AMPAC needs to be halfway through the calendar year. As the leaders in the House of Medicine we strongly encourage members in their HOD leadership role to invest in AMPAC by stopping by AMPAC's Booth which is located in the foyer outside the Grand Ballroom during this meeting or by visiting <https://www.ampaonline.org/>

Finally, all current 2023 Capitol Club members are invited to attend a Capitol Club event on Tuesday, June 13 at 12 p.m. with special guest Major Garrett, Chief White House Correspondent for CBS News and Correspondent at Large with National Journal. Mr. Garrett is balanced, well respected and will take questions from the audience live for an exciting discussion and event.

AMPAC is the bi-partisan political action committee of the AMA that was created to advance the advocacy mission set forth by the HOD. We can only be as effective as we are united in our efforts to support this political tool and further the AMA's advocacy initiatives. We hope to count on the support of all HOD members to boost overall AMPAC HOD participation.

Political Action

The AMPAC Board of Directors approved early giving for the 2024 cycle at its previous meeting in February. During this early period, AMPAC prioritizes incumbents who are strong allies of medicine, members of their parties' leadership, on key committees or otherwise in an important position to advance medicine friendly policies on Capitol Hill. Giving to federal candidates who fit these criteria has begun and is expected to intensify into the summer and early fall as activity on Capitol Hill involving key AMA issues begins to gather momentum. Legislation dealing with prior authorization, Pharmacy Benefit Manager (PBM) regulation, prior authorization, and other workforce issues important to medicine, expected end-of-year Medicare physician payment cuts, and others top Congress' health care agenda now that the debt ceiling debate is over. The AMA is now launching its "Fix Medicare Now" campaign, leading the charge for Medicare physician payment reform but also targeting immediate threats including looming end-of-year physician pay cuts. Building momentum for legislation that addresses such threats is a critical component of this effort. As such, it is important during this time for AMPAC to create good opportunities for AMA lobbyists to attend fundraising events with select members of Congress so that they can ensure that the AMA's message is properly communicated on issues like these.

In terms of the political landscape looking ahead to the 2024 elections, a murky picture exists at this still early stage. The House and Senate landscape remain very much in flux with thin majorities in both chambers. Meanwhile, the race for the White House heats up and can only be described as chaotic, particularly on the GOP side with eight declared candidates thus far and potentially more waiting in the wings.

Political Education Programs

After two years of hosting the Candidate Workshop virtually due to COVID-19, the 2023 workshop took place in-person, March 31 – April 2, at the AMA offices in Washington, DC. Registration for the program was strong with 20 participants. This included: 14 member physicians, one non-member physician, one physician spouse, and four member residents and students. Four of these participants had also taken part in the 2022 Campaign School in late September. Over the course of the program participants not only heard from political experts on both sides of the aisle, including an in-person keynote session with Representative Larry Bucshon, MD of Indiana, they were also able to engage with trainers, speakers, and each other even more effectively in the return to the in-person format.

Planning is currently underway for the 2023 Campaign School. AMPAC is excited to announce that the Campaign School is scheduled to be held in-person October 12-15 at the AMA offices in Washington, DC. The Campaign School is renowned for its use of a simulated campaign for the U.S. House of Representatives, complete with demographics, voting statistics and detailed candidate biographies. During the three-day program participants will be placed into campaign teams and with a hands-on approach, our team of political experts will walk them through the simulated campaign and will apply what they learn in real-time exercises on strategy, vote targeting, social media, paid advertising, and public speaking. Insider tactics will be taught by experts on both sides of the political spectrum. As always, the political education programs remain a member benefit with registration fees heavily discounted for AMA members. Registration will open soon on [AMPAConline.org](https://ampaconline.org).

Conclusion

On behalf of the AMPAC Board of Directors, I would like to thank all members of the House of Delegates who support AMPAC and the work we do. Your continued involvement in political and grassroots activities ensures organized medicine a powerful voice in Washington, DC.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Martin Kevin Dineen M.D., FACS

Introduced by American Association of Clinical Urologists, American Urological Association

Whereas, Dr. Marty K. Dineen was not only a gifted Urologic Surgeon and a tireless physician's advocate for organized medicine, he also served our AMA as Delegate of the American Association of Clinical Urologists; and

Whereas, Dr. Dineen earned his Bachelor of Science in Biology from the University of Notre Dame and his medical degree from Louisiana State University (LSU). Following his surgical internship and residency in urology at LSU he then completed a fellowship in the Department of Urologic Oncology at Roswell Park Memorial Institute. Later he joined Atlantic Urological Associates (now Advanced Urology Institute) and began his urologic practice in Ormond Beach, Florida that would span 36 years; and

Whereas, Dr. Dineen served as President of the American Association of Clinical Urologists, President of the Southeastern Section of the American Urological Association (AUA), and President of the Florida Urological Society. He was also a founding member of the Board of Directors of the Urology Care Foundation. Marty was an early proponent and pioneer of Ambulatory Surgical Center development and the movement of inpatient urological services to the outpatient setting, founding one of the first ambulatory surgery centers in the nation; and

Whereas, Marty served on the AUA Public Policy Council and the AUA Coding & Reimbursement Committee in addition to serving on its Board of Directors. The AUA Southeastern Section recognizes Dr. Dineen with the Gee-Dineen Socio-Economic session at each annual meeting; and

Whereas, Dr. Dineen was awarded the AUA Distinguished Service Award for over two decades of outstanding leadership in Health Policy as well as humanitarian service in Haiti to treat urogenital elephantiasis. Since October 2006, Dr. Dineen worked with fellow urologists in Leogane, Haiti, to perform over 2,000 hydrocele surgeries. Dr. Dineen was recognized by his University of Notre Dame with the Dr. Tom Dooley Society Founders Award for his humanitarian efforts. In Haiti there is a medical clinic currently being built in his honor. Recently, Marty was awarded the Lifetime Achievement Award for his contributions to urology by the Florida Urological Society; and

Whereas, Dr. Dineen held appointments as a clinical Assistant Professor of Urology at The University of South Florida School of Medicine and Associate Professor of Urology at The University of Florida Health Sciences Center. He was a mentor to many urology residents and enjoyed teaching them. He served as a peer review editor for the journal UROLOGY and UROLOGY PRACTICE; and

Whereas, Marty was a wonderful husband, father, grandfather, brother, son and friend. He was a talented singer who sang with the Daytona Beach Bel Canto singers for many years; a gifted piano player, pilot, and was also well known for his delicious pies. He coached several local sports teams and sponsored several throughout the community. Like his father, he was an Eagle Scout, a tradition that continued with his son Ryan, for whom he served as a Boy Scout

troop leader. He will long be remembered for his sense of humor, generosity and selflessness; therefore be it

RESOLVED, That our American Medical Association recognize the many contributions made by Dr. Martin Kevin Dineen to the medical profession as well as the Urological community; and be it further

RESOLVED, That our American Medical Association express its sympathy for the passing of Dr. Dineen to his family and present them with a copy of this resolution.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

Kathryn L. Moseley, MD. MPH

Introduced by the Council on Ethical and Judicial Affairs

Whereas, Kathryn L. Moseley, MD, MPH, served with wisdom and grace as a member of the Council on Ethical and Judicial Affairs from 2013 to 2020, ably chairing the council in 2019-2020; and

Whereas, Dr. Moseley similarly served patients and her profession as a member of the Committee on Bioethics of the American Academy of Pediatrics and the Ethics Committee of the American Board of Pediatrics, as Director of Biomedical Ethics for the Henry Ford Health System in Detroit, Michigan, and as a member of the faculty of the Center for Bioethics and Social Sciences in Medicine of the University of Michigan; and

Whereas, Dr. Moseley participated as a member of AMA's Writing Group on the History of African Americans and the Medical Profession, a project instrumental in bringing public attention to racism within the profession; and

Whereas, Dr. Moseley brought her training in not only medicine, ethics, and public health but also theology to bear on issues of trust and health disparities, especially within communities of color, as a researcher and a member of the faculty of the Health Disparities Research Program of the Michigan Institute for Clinical and Health Research at the University of Michigan; and

Whereas, Kathryn L. Moseley, MD, MPH, passed away on June 3, 2023, at the age of 70; therefore be it

RESOLVED, That our American Medical Association express the utmost respect for Kathryn L. Moseley, MD, MPH, and honor her legacy of devotion to the interests of patients and the integrity of the profession she loved and served with dedication.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION

DONALD J. PALMISANO, MD, JD

Introduced by the Louisiana Delegation

Whereas, Donald J. Palmisano, MD, JD, passed away on November 23, 2022; and

Whereas, Dr. Palmisano obtained his medical degree from the Tulane School of Medicine in New Orleans, Louisiana in 1963; and

Whereas, Dr. Palmisano then completed his residency training in general surgery at Charity Hospital, affectionately known to the locals in New Orleans as Big Charity, followed by two years of active duty in the United States Air Force as Chief of Surgery with the 821st Med Group at Ellsworth Air Force Base in South Dakota; and

Whereas, Dr. Palmisano entered the private sector where he practiced general and vascular surgery for 35 years with his brother-in-law and other partners until he was forced to close his practice in 2005 when Hurricane Katrina destroyed the hospitals and homes of his patients; and

Whereas, Dr. Palmisano was a key participant and champion in the development and passage of the Louisiana Medical Malpractice Act of 1975, which placed a total cap on all damages, and was later amended in 1984 to include unlimited future medical payments as incurred; and

Whereas, Dr. Palmisano was once sued for medical malpractice by a patient he had never seen, he decided to attend law school to better understand how such cases were litigated and Dr. Palmisano graduated from the Loyola University College of Law in New Orleans in 1982; and

Whereas, Dr. Palmisano was one of the founding members of the Louisiana Medical Mutual Insurance Company (LAMMICO) and served on the board of directors from 1982 to 1989 as secretary and vice president of claims; and

Whereas, Dr. Palmisano served on the board of directors of The Doctors Company, a physician-owned medical malpractice insurer based in Napa, CA from 2004 to 2019; and

Whereas, in 1989 Dr. Palmisano combined his knowledge of medicine and law to form Intrepid Resources, which provided consulting services for patient safety, risk management, and medical malpractice defense; and

Whereas, Dr. Palmisano was an active member of the Louisiana State Medical Society and served in many capacities over the years including as the 105th President of the Society during 1984-1985; and

Whereas, Dr. Palmisano was also active within the American Medical Association, serving a trustee on the AMA Board of Trustees, and as Secretary/Treasurer prior to serving as President during 2003-2004; and

Whereas, Dr. Palmisano gave thousands of speeches, media interviews, and testimony before the United States Congress on medical liability reform, antitrust issues, health system reform, patient safety and more; and

Whereas, Dr. Palmisano was also an accomplished author having published three books "On Leadership: Essential Principles for Success" (2008); "The Little Red Book of Leadership Lessons" (2012); and "A Leader's Guide to Giving a Memorable Speech" (2020); and

Whereas, Dr. Palmisano received many awards over his career including but not limited to the Air Force Commendation Medal (1970); Loyola University's President Medal (2005); the LSMS Dave Tarver Distinguished Service Award (2020); and

Whereas, Dr. Palmisano, was a renaissance man who enjoyed many talents in areas outside of medicine and law. He will always be remembered as an accomplished author, photographer, lateral thinker, raconteur, sports car enthusiast, instrument rated pilot, gentleman, patriot, and a friend; and

Whereas, Dr. Palmisano was a loving and devoted husband to his wife, Robin, father to daughter Mary Ellen, father to Donna and her husband Jerry, father to son Donald Jr. and wife Ana, and grandfather to seven wonderful grandchildren, Brittany, Ryan, Marco, Alexis, Diego, Pablo and Nico, and great grandfather to Meryl and Lainey; and

Whereas, Dr. Palmisano lived his life based on advice from his father that he passed onto his family, which simply stated that in order to achieve success "Do your homework, have courage, and don't give up"; therefore be it

RESOLVED, That our American Medical Association acknowledge with deep gratitude and sincere appreciation the lifelong work performed by Donald J. Palmisano, MD, JD, in service to the practice of medicine; and be it further

RESOLVED, That our AMA extend its heartfelt condolences to the family of Donald J. Palmisano, MD, JD, and adopt this resolution as an expression of deepest respect for our colleague and dear friend; and be it further

RESOLVED, That a copy of this memorial resolution be forwarded to Dr. Palmisano's family.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

MEMORIAL RESOLUTION

VENKAT K. RAO, MD

Introduced by the Michigan Delegation to the AMA

Whereas, Venkat K. Rao, MD, a physician trained in Internal Medicine with specialties in Pulmonary, Critical Care, and Sleep Medicine, was born August 5, 1951, and passed away on June 3, 2023; and

Whereas, Doctor Rao grew up in Chintagumpala, India, came to the United States in 1976, and resided in mid-Michigan for more than 30 years; and

Whereas, Doctor Rao was a family man, friend, and servant leader; and

Whereas, Doctor Rao utilized his knowledge, compassion, and leadership attributes to improve the profession of medicine, provide opportunities to physicians in training, and strengthen his community; and

Whereas, Doctor Rao, in addition to holding the position of Chair of Internal Medicine at McLaren Flint, volunteered much of his time to serving on medical boards and committees at the local, state, and national level; and

Whereas, So many people's lives were impacted for the better through Doctor Rao's care as a physician and generous contributions of his time and expertise to organizations, including but not limited to, the Michigan State Medical Society, Genesee County Medical Society, and Foundation for Mott Community College where he served or was serving on their respective Boards; and

Whereas, Doctor Rao was appointed to the Michigan Board of Medicine in 2017, reappointed in 2021, and elected as Chair earlier this year; and

Whereas, Doctor Rao was a current member of the Michigan Delegation to the American Medical Association, serving with distinction for 11 years. He dedicated many years to the AMA International Medical Graduate Section, volunteering on many of their committees; and

Whereas, Doctor Rao was a tireless physician who gave generously of his time; and

Whereas, Doctor Rao was a leader, mentor, and motivator to many; therefore be it

RESOLVED, That our American Medical Association House of Delegates recognize and honor Venkat K. Rao, MD, for his outstanding service to the profession of medicine and the countless patients whose lives were touched by his hard work and dedication.

RESOLVED, That our American Medical Association House of Delegates extend its deepest sympathy to the family members of Venkat K. Rao, MD.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-A-23

Subject: Specialty Society Representation in the House of Delegates -
Five-Year Review

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the
2 House of Delegates (HOD) required to submit information and materials for the 2023 American
3 Medical Association (AMA) Annual Meeting in compliance with the five-year review process
4 established by the House of Delegates in Policy G-600.020, “Summary of Guidelines for
5 Admission to the House of Delegates for Specialty Societies,” and AMA Bylaw 8.5, “Periodic
6 Review Process.”

7
8 Organizations are required to demonstrate continuing compliance with the guidelines established
9 for representation in the HOD. Compliance with the five responsibilities of professional interest
10 medical associations and national medical specialty organizations is also required as set out in
11 AMA Bylaw 8.2, “Responsibilities of National Medical Specialty Societies and Professional
12 Interest Medical Associations.”

13
14 The following organizations were reviewed for the 2023 Annual Meeting:

15
16 Aerospace Medical Association
17 American Academy of Dermatology
18 American Academy of Facial Plastic and Reconstructive Surgery, Inc.
19 American Academy of Family Physicians
20 American Academy of Hospice and Palliative Medicine
21 American Academy of Neurology
22 American Academy of Psychiatry and the Law
23 American Association for Hand Surgery
24 American Association of Clinical Urologists, Inc.
25 American Clinical Neurophysiology Society
26 American College of Medical Quality
27 American Rhinologic Society
28 American Society for Reconstructive Microsurgery
29 American Society of Addiction Medicine
30 American Society of Echocardiography
31 American Society of Neuroimaging
32 American Society of Ophthalmic Plastic and Reconstructive Surgery
33 Endocrine Society
34 GLMA—Health Professionals Advancing LGBTQ+ Equality
35 North American Neuromodulation Society
36 North American Neuro-Ophthalmology Society
37 Spine Intervention Society

The American Society of General Surgeons, American Society of Hematology, American Society of Transplant Surgeons, International Society for Hair Restoration Surgery, and United States and Canadian Academy of Pathology were also reviewed at this time because they failed to meet the requirements in June 2022.

Each organization was required to submit materials demonstrating compliance with the guidelines and requirements along with appropriate membership information. A summary of each group's membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical specialty organizations and professional medical interest associations represented in the HOD (Exhibit C), and the AMA Bylaws pertaining to the five-year review process (Exhibit D) are also attached.

The materials submitted indicate that: Aerospace Medical Association, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgeons, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American Rhinologic Society, American Society of Addiction Medicine, American Society of Echocardiography, American Society of Hematology, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society of Transplant Surgeons, Endocrine Society, International Society for Hair Restoration Surgery, North American Neuromodulation Society, North American Neuro-Ophthalmology Society, and Spine Intervention Society meet all guidelines and are in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

The materials submitted also indicate that the American College of Medical Quality, American Society for Reconstructive Microsurgery, American Society of General Surgeons, American Society of Neuroimaging, GLMA—Health Professionals Advancing LGBTQ+ Equality, and United States and Canadian Academy of Pathology did not meet all guidelines and are not in compliance with the five-year review requirements of specialty organizations represented in the AMA HOD.

RECOMMENDATIONS

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

1. The Aerospace Medical Association, American Academy of Dermatology, American Academy of Facial Plastic and Reconstructive Surgeons, American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Psychiatry and the Law, American Association for Hand Surgery, American Association of Clinical Urologists, Inc., American Clinical Neurophysiology Society, American Rhinologic Society, American Society of Addiction Medicine, American Society of Echocardiography, American Society of Hematology, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society of Transplant Surgeons, Endocrine Society, International Society for Hair Restoration Surgery, North American Neuromodulation Society, North American Neuro-Ophthalmology Society, and Spine Intervention Society retain representation in the AMA HOD. (Directive to Take Action)

- 1 2. Having failed to meet the requirements for continued representation in the AMA House of
2 Delegates as set forth in AMA Bylaw B-8.5, the American College of Medical Quality,
3 American Society for Reconstructive Microsurgery, American Society of Neuroimaging,
4 GLMA—Health Professionals Advancing LGBTQ+ Equality be placed on probation and
5 be given one year to work with AMA membership staff to increase their AMA
6 membership. (Directive to Take Action)
7
- 8 3. Having failed to meet the requirements for continued representation in the AMA House of
9 Delegates as set forth in the AMA Bylaw B-8.5 at the end of the one-year grace period, the
10 American Society of General Surgeons and United States and Canadian Academy of
11 Pathology lose representation in the AMA HOD but retain it for the AMA Specialty and
12 Service Society (SSS) and may apply for reinstatement in the HOD, through the SSS, when
13 they believe they can comply with all of the current guidelines for representation in the
14 HOD, in accordance with AMA Bylaw B-8.5.3.2.2. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX***Exhibit A - Summary Membership Information***

Organization	AMA Membership of Organization's Total Eligible Membership
Aerospace Medical Association	150 of 672 (22%)
American Academy of Dermatology	3748 of 14,539 (26%)
American Academy of Facial Plastic and Reconstructive Surgery, Inc.	162 of 616 (26%)
American Academy of Family Physicians	24,706 of 95,939 (26%)
American Academy of Hospice and Palliative Medicine	951 of 3922 (24%)
American Academy of Neurology	2460 of 16,007 (15%)
American Academy of Psychiatry and the Law	321 of 1149 (28%)
American Association for Hand Surgery	184 of 705 (26%)
American Association of Clinical Urologists, Inc.	1092 of 3439 (32%)
American Clinical Neurophysiology Society	101 of 322 (31%)
American College of Medical Quality	54 of 148 (36%)
American Dermatological Association, Inc.	171 of 440 (38%)
American Rhinologic Society	105 of 138 (76%)
American Society for Reconstructive Microsurgery	110 of 690 (16%)
American Society of Addiction Medicine	818 of 3763 (22%)
American Society of General Surgeons	No data submitted
American Society of Echocardiography	1140 of 5232 (22%)
American Society of Hematology	1025 of 6806 (15%)
American Society of Neuroimaging	38 of 116 (33%)
American Society of Ophthalmic Plastic and Reconstructive Surgery	154 of 684 (23%)
American Society of Transplant Surgeons	195 of 828 (24%)
Endocrine Society	1367 of 6879 (20%)
GLMA—Health Professionals Advancing LGBTQ+ Equality	46 of 143 (48%)
International Society for Hair Restoration Surgery	100 of 240 (42%)
North American Neuromodulation Society	247 of 1032 (26%)
North American Neuro-Ophthalmology Society	108 of 469 (23%)
Spine Intervention Society	625 of 2432 (26%)
United States and Canadian Academy of Pathology	900 of 4656 (19%)

Exhibit B - Summary of Guidelines for Admission to the House of Delegates for Specialty Societies (Policy G-600.020)

Policy G-600.020

1. The organization must not be in conflict with the Constitution and Bylaws of the American Medical Association with regard to discrimination in membership.
2. The organization must:
 - (a) represent a field of medicine that has recognized scientific validity;
 - (b) not have board certification as its primary focus; and
 - (c) not require membership in the specialty organization as a requisite for board certification.
3. The organization must meet one of the following criteria:
 - (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or
 - (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or
 - (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA.
4. The organization must be established and stable; therefore, it must have been in existence for at least five years prior to submitting its application.
5. Physicians should comprise the majority of the voting membership of the organization.
6. The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, and eligible to serve on committees or the governing body.
7. The organization must be active within its field of medicine and hold at least one meeting of its members per year.
8. The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states.
9. The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization.
10. If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

Exhibit C

8.2 Responsibilities of National Medical Specialty Societies and Professional Interest Medical Associations. Each national medical specialty society and professional interest medical association represented in the House of Delegates shall have the following responsibilities:

- 8.2.1** To cooperate with the AMA in increasing its AMA membership.
- 8.2.2** To keep its delegate(s) to the House of Delegates fully informed on the policy positions of the society or association so that the delegates can properly represent the society or association in the House of Delegates.
- 8.2.3** To require its delegate(s) to report to the society on the actions taken by the House of Delegates at each meeting.
- 8.2.4** To disseminate to its membership information as to the actions taken by the House of Delegates at each meeting.
- 8.2.5** To provide information and data to the AMA when requested.

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

8 - Representation of National Medical Specialty Societies and Professional Interest Medical Associations in the House of Delegates

8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society, or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society's or the professional interest medical association's compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may take one of the following actions:

8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(A-23)

Introduced by: Organized Medical Staff Section

Subject: Supporting Efforts to Strengthen Medical Staffs Through Collective Bargaining and/or Unionization

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Medical staffs everywhere are facing increasingly hostility in their work environments
2 from many different sources, including hospital administration, government regulation and
3 legislation, scope creep of all kinds, and burnout at an ever-increasing rate; and
4

5 Whereas, Physicians continue to see a decline in medical staff self-governance and morale,
6 along with a decrease in job satisfaction and increasing concerns for patient care; and
7

8 Whereas, The percentage of employed physicians reportedly reaches 70 percent and continues
9 to rise; and
10

11 Whereas, The solutions to many of these problems can be achieved through the various tools of
12 collective bargaining and unionization; therefore be it
13

14 RESOLVED, That our American Medical Association reevaluate the various efforts to achieve
15 collective bargaining and/or unionization for physicians nationally (Directive to Take Action); and
16 be it further
17

18 RESOLVED, That our AMA develop a specific program of assistance, including education in the
19 process of collective actions and potentially financial assistance, to be available through a
20 process of application, review, and approval for organizers of such collective action (Directive to
21 Take Action); and be it further
22

23 RESOLVED, That our AMA request CEJA to review the advisory restricting collective action in
24 section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians
25 who have exhausted other non-disruptive methods for reform (Directive to Take Action).
26

Fiscal Note: \$50K – Develop a specific program of assistance, including education.

Received: 6/9/23

RELEVANT AMA POLICY

Collective Bargaining for Physicians H-385.946

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.

Citation: Res. 239, A-97; Reaffirmed: I-98; Reaffirmed: A-01; Reaffirmed: A-05; Reaffirmed: A-06; Reaffirmed: A-08; Reaffirmed: I-10; Reaffirmed: Res. 206, A-19

Physician Collective Bargaining H-385.976

Our AMA's present view on the issue of physician collective negotiation is as follows:

- (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.
- (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.
- (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.
- (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.
- (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Citation: BOT Rep P, I-88; Modified: Sunset Report I-98; Reaffirmed: A-00; Reaffirmed: I-00; Reaffirmed: I-03; Reaffirmed: A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmed: A-05; Reaffirmed: A-06; Reaffirmed: A-08; Reaffirmed; BOT Rep. 17, A-09; Reaffirmed: I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT Action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19

Employee Associations and Collective Bargaining for Physicians D-383.981

Our AMA will study and report back on physician unionization in the United States.

Citation: Res. 601, I-14; Reaffirmed: Res. 206, A-19

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

Citation: Res. 229, A-12; Reaffirmed: Res. 206, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017
(A-23)

Introduced by: Organized Medical Staff Section

Subject: Establishing a Formal Definition of "Employed Physician"

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Our American Medical Association's own research has found that as of 2021, the
2 majority of patient care physicians in the country work outside of physician-owned medical
3 practices with the majority share of private physicians dropping below 50 percent for the first
4 time since the AMA analysis began in 2012¹; and

5
6 Whereas, Other research suggests that the share of physicians employed by hospitals, health
7 systems or corporate entities may be even higher and that the Covid-19 pandemic may have
8 accelerated the trend of physicians leaving private practice in favor of employment²; and

9
10 Whereas, Our AMA currently has no standing definition of what it means to be an employed
11 physician despite the myriad ways that a physician can practice on an employed, contractual, or
12 hybrid basis, creating potential confusion in determining the exact needs and best practices for
13 support of physicians who are employed; and

14
15 Whereas, The AMA Organized Medical Staff Section has been tasked with addressing the
16 needs and perspectives of employed physicians but lacks the specific parameters for
17 understanding this critical population; therefore be it

18
19 RESOLVED, That our American Medical Association adopt the following as its definition of
20 "employed physician":

21
22 An employed physician is any physician, not in training, who derives compensation,
23 financial or otherwise, from a contractual relationship with a practice, hospital, or other
24 funding entity and has no direct controlling interest in the entity" (New HOD Policy).
25

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

Received: 6/9/23

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2. Avalere Health. (2022). *COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2021*. Physicians Advocacy Institute. http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkqjKXB_yZflmFdXlvGg%3d%3d

RELEVANT AMA POLICY

Definition of a Physician H-405.969

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine.
2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign.
Citation: CME Rep. 4, A-94; Reaffirmed: Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08; Reaffirmed in lieu of Res. 235, A-09

Definition and Use of the Term Physician H-405.951

Our AMA:

1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency.
2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above:
 - a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician;
 - b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and
 - c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician.
3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care.
4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider.
5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree.
6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (*JAMA*) Editorial Governance Plan, which protects the editorial independence of *JAMA*.
7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign
Citation: Res. 214, A-19; Reaffirmed: I-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(A-23)

Introduced by: Resident and Fellow Section

Subject: Confidentiality of Sexual Orientation and Gender Identity Data

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Adolescents have identified lack of confidentiality as a barrier to seeking health care;
2 they are more willing to seek care from and communicate with physicians who assure
3 confidentiality¹⁻³; and
4

5 Whereas, Each state in the United States legally entitles adolescents to consent to treatment for
6 medically emancipated conditions that may include contraception, pregnancy, diagnosis and
7 treatment of sexually transmitted diseases (STDs), human immunodeficiency virus or other
8 reportable diseases, treatment of substance abuse problems, and mental health⁴⁻⁶; and
9

10 Whereas, It is well-documented that some adolescents will only seek health care or openly
11 communicate with a health professional if their parents are not involved, and ethical and
12 professional frameworks support the provision of confidential adolescent health care when
13 needed^{1,7-8}; and
14

15 Whereas, Pervasive stigma and discrimination in school, family, and healthcare settings have
16 been linked to a range of health disparities among sexual and gender minority (SGM) youth,
17 including mood disorders, disordered eating, cigarette smoking, substance use disorders,
18 suicidality, violence victimization, HIV, and sexually transmitted infections⁹⁻¹⁰; and
19

20 Whereas, To promote more positive health outcomes, it is beneficial for clinicians to know their
21 patients' sexual orientation and gender identity (SOGI) information so they can provide space
22 for discussing concerns, make appropriate referrals, and encourage family acceptance of SGM
23 identities, which is critical for positive psychosocial outcomes¹¹; and
24

25 Whereas, Some but not all families are aware and supportive of their child's SGM identity¹²⁻¹³;
26 and
27

28 Whereas, The intentional or accidental disclosure of a child's SOGI to a legal guardian or other
29 governmental or non-governmental entities can pose a grave risk to that child's safety and
30 wellbeing, particularly in contexts where SGM people are highly stigmatized or criminalized; and
31

32 Whereas, AMA Policy H-315.983, Patient Privacy and Confidentiality, states that "there exists a
33 basic right of patients to privacy of their medical information and records;" therefore be it
34

35 RESOLVED, That our American Medical Association amend Policy H-65.959, "Opposing
36 Mandated Reporting of People Who Question Their Gender Identity" by addition and deletion to
37 read as follows:
38

39 RESOLVED, Our AMA opposes mandated reporting or disclosure of patient information related
40 to sexual orientation, of individuals who question or express interest in exploring their gender

- 1 identity, gender dysphoria, intersex identity, and any information related to gender transition for
 2 all individuals, including minors.

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

Received: 6/9/23

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RELEVANT AMA POLICY

Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation H-315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians. Citation: [Res. 212, I-16; Reaffirmed in lieu of: Res. 008, A-17; Modified: Res. 16, A-19; Appended: Res. 242, A-19; Modified: Res. 04, I-19]

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: [BOT Rep. 17, A-04; Reaffirmed: CCB/CLRPD Rep. 1, A-14]

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain

constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation. Citation: [CMS Rep. 6, I-06; Reaffirmed: CMS Rep. 01, A-16]

3.3.2 Confidentiality & Electronic Medical Records

Information gathered and recorded in association with the care of a patient is confidential, regardless of the form in which it is collected or stored.

Physicians who collect or store patient information electronically, whether on stand-alone systems in their own practice or through contracts with service providers, must:

- (a) Choose a system that conforms to acceptable industry practices and standards with respect to:
 - (i) restriction of data entry and access to authorized personnel;
 - (ii) capacity to routinely monitor/audit access to records;
 - (iii) measures to ensure data security and integrity; and
 - (iv) policies and practices to address record retrieval, data sharing, third-party access and release of information, and disposition of records (when outdated or on termination of the service relationship) in keeping with ethics guidance.
- (b) Describe how the confidentiality and integrity of information is protected if the patient requests.
- (c) Release patient information only in keeping with ethics guidance for confidentiality.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(A-23)

Introduced by: Integrated Physician Practice Section

Subject: Advancing Acute Care at Home

Referred to: Reference Committee A

1 Whereas, During the COVID-19 pandemic, federal and state governments issued waiver
2 flexibilities that allowed hospitals to provide advanced level services to patients at home under
3 certain circumstances¹; and
4

5 Whereas, The waiver flexibilities built on the success of previous acute care at home models
6 that have been tested over decades, showing that advanced care at home can be a safe,
7 effective way to provide care to patients that is associated with lower costs and better patient
8 outcomes and satisfaction compared with inpatient hospitalization²; and
9

10 Whereas, As part of the omnibus spending bill that became law December 29, 2022, the
11 Centers for Medicare & Medicaid Services (CMS) extended, through December 31, 2024, the
12 Acute Hospital Care at Home initiative whereby individual hospitals may seek waivers to
13 operate acute care at home programs; and
14

15 Whereas, The State Departments of Health serve as regulators for CMS and in many cases
16 state and federal laws/regulations conflict making implementation of acute care at home
17 impossible or much more difficult than CMS likely anticipated. For example, in Wisconsin, fire
18 safety regulations for hospitals cannot be met in a home setting resulting in barriers to acute
19 care at home; and
20

21 Whereas, Currently, advocacy groups such as Advanced Care at Home and AmediSys are
22 actively lobbying CMS and the legislature to extend the Hospital at Home Waiver to a
23 permanent CMS program. The AMA could work in partnership with these and other key
24 stakeholders on addressing state regulatory barriers; and
25

26 Whereas, There has been opposition by nursing unions engendered by perceived or real
27 changes in work requirements, patient safety and job security concern; and
28

29 Whereas, The AMA's Council on Medical Services issued a report I-21, Financing of Home and
30 Community-Based Services, that noted "The hospital at home model is an important component
31 of the shift away from institutionalized care and has been successful in allowing patients with
32 particular conditions to remain in their homes and avoid risks associated with inpatient
33 admission and care." The Council recommended that CMS and private insurers offer flexibility to
34 implement hospital at home programs for the subset of patients who meet the criteria; therefore
35 be it
36

37 **RESOLVED**, That our American Medical Association advocate for passage of federal legislation
38 that provides permanence to the Centers for Medicare and Medicaid Services acute care at
39 home model (Directive to Take Action); and be it further

1 RESOLVED, That our AMA work with interested state medical associations to identify state-
 2 level barriers to implementing acute care at home, to include but not be limited to: health and
 3 safety regulation applicability to services in the home, union opposition to acute care at home,
 4 and Mobile Integrated Health/Community Paramedicine limitations in states (Directive to Take
 5 Action); and be it further

6
 7 RESOLVED, That our AMA, in coordination with other acute care at home advocacy groups,
 8 advocate that the federal government work with states to address the concerns of current state
 9 regulators (Directive to Take Action); and be it further

10
 11 RESOLVED, That our AMA engage with nursing organizations to share perspectives and
 12 address concerns about the benefits and challenges of acute care at home (Directive to Take
 13 Action).

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

Received: 6/9/23

REFERENCES

1. A variety of terminology has been traditionally used to refer to this health care delivery model, such as Acute Care at Home, Hospital at Home, Advanced Care at Home, etc. For the sake of simplicity, here it is referred to as Acute Care at Home and, where necessary, Hospital at Home.
2. Federman, A.D. et al. (2018) Association of a bundled hospital-at-home and 30-day postacute transitional care program with clinical outcomes and patient experiences; *JAMA Internal Medicine*; 178(8); p. 1033-1040. Accessed 3/27/23:
<https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2685092>

RELEVANT AMA POLICY

N-21-CMS Report 4: Financing of Home and Community-Based Services

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

1. That our American Medical Association (AMA) support federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS). (New HOD Policy)
2. That our AMA support policies that help train, retain, and develop an adequate HCBS workforce (New HOD Policy)
3. That our AMA support efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS. (New HOD Policy)
4. That our AMA support that Medicaid's Money Follows the Person demonstration program be extended or made permanent. (New HOD Policy)
5. That our AMA support cross-agency and federal-state strategies that can help improve coordination among HCBS programs and streamline funding and the provision of services. (New HOD Policy)
6. That our AMA support HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices. (New HOD Policy)
7. That our AMA support that the Centers for Medicare & Medicaid Services and private insurers extend flexibility to implement innovative programs including but not limited to hospital at home programs. (New HOD Policy)
8. That our AMA reaffirm Policy H-280.945, which provides a comprehensive set of principles to improve the financing of long-term services and supports and supports incentivizing states to expand the availability of and access to HCBS and permitting Medigap and Medicare Advantage plans to offer a respite care benefit. (Reaffirm HOD Policy)
9. That our AMA reaffirm Policy H-290.958 which supports increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (Reaffirm HOD Policy)

Financing of Long-Term Services and Supports H-280.945

Our AMA supports:

- (1) policies that standardize and simplify private LTCI to achieve increased coverage and improved affordability;
- (2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees;
- (3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI;
- (4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities;
- (5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy;
- (6) Medicare Advantage plans offering LTSS in their benefit packages;
- (7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit;
- (8) a back-end public catastrophic long-term care insurance program;
- (9) incentivizing states to expand the availability of and access to home and community-based services; and
- (10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.

Citation: CMS Rep. 05, A-18; Reaffirmed: I-18; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMD Rep. 4, I-21.

Policy Directions for the Financing of Long-Term Care H-280.991

The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.

Citation: BOT Rep. O, A-88; BOT Rep. X, I-88; Reaffirmed: CMS Rep 3, A-94; BOT Rep. S, I-87; Reaffirmed: CMS Rep. 3, A-94; CMS Rep. 11, I-95; Reaffirmation A-04; Modified: CMS Rep. 6, I-05; Reaffirmed: BOT Rep. 32, A-32, A-09; Reaffirmation: A-11; Reaffirmed: CMS Rep. 05, A-18

Medicaid Reform H-290.958

Our AMA supports increases in states' Federal Medical Assistance Percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

Citation: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 4, 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: CMS Rep. 2, A-98; Reaffirmed: A-99 and Res. 104, A-99;

Reaffirmed: A-00; Appended: CMS Rep. 6, A-01; Reaffirmed: A-02; Modified: CMS Rep. 8, A-03;

Reaffirmed: CMS Rep. 1, A-05; Reaffirmed: A-05; Reaffirmed: A-07; Modified: CMS Rep. 8, A-08;

Reaffirmed: A-11; Modified: CMS Rep. 1, I-11; Reaffirmed; CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: A-22; Reaffirmed; CMS Rep. 3, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(A-23)

Introduced by: Organized Medical Staff Section

Subject: Rescinding the Medicare Three-Day Hospital Inpatient Requirement for
Nursing Home Admission

Referred to: Reference Committee A

1 Whereas, The Medicare three-day hospital inpatient requirement for nursing home admission,
2 waived at the beginning of the COVID Pandemic for all Medicare recipients, was reinstituted on
3 May 15th 2023 for Medicare fee-for-service but not Medicare Advantage or Medicare
4 accountable care organization (ACO) patients; and
5

6 Whereas, The three-day rule was instituted in 1965 when hospital stays were much longer and
7 routine for procedures and conditions that are now less than three nights or even outpatient;
8 and
9

10 Whereas, Many hospital stays are now classified as observation status for the first two days and
11 those days cannot count towards fulfilling the three-day rule; and
12

13 Whereas, Research has shown that the poorest Medicare beneficiaries nationwide are more
14 likely both to have their repeated hospital stays classified as observation and not to receive
15 nursing home care as a result, and if these beneficiaries receive care in a nursing home
16 following hospitalization, they are less likely to return to an acute care hospital; and
17

18 Whereas, The three-day rule discriminates against the 40 percent of the Medicare recipients not
19 in Medicare Advantage or ACO plans whose care needs for extended care facility stays are
20 exactly the same as patients in Medicare Advantage and ACO plans no longer subject to the
21 limitations of care imposed by the three-day rule; and
22

23 Whereas, The three-day rule creates an artificial and dangerous restriction of care that
24 jeopardizes patient health and physicians' ability to act in the best interests of their patients;
25 therefore be it
26

27 RESOLVED, That our American Medical Association request a stakeholders meeting with the
28 Centers for Medicare and Medicaid Services to advocate that the Medicare three-day hospital
29 inpatient requirement for skilled nursing facility admissions be immediately rescinded for
30 uniformity and safety for all Medicare recipients (Directive to Take Action).

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

Received: 6/9/23

RELEVANT AMA POLICY

Three Day Stay Rule H-280.947

1. Our American Medical Association will continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients.
2. Our AMA will continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services.
3. Our AMA will actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement.

Citation: Sub. Res. 103, A-15; Res. 110, A-15; Reaffirmation: A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(A-23)

Introduced by: Young Physicians Section

Subject: Supporting Permanent Reimbursement of Acute Hospital Care at Home

Referred to: Reference Committee A

1 Whereas, Home Hospital is an innovative healthcare delivery model that allows for inpatient-
2 level care to be delivered to patients at home, with the first program dating back to 1991,
3 however its growth has been historically limited by lack of sufficient reimbursement; and
4

5 Whereas, During the COVID-19 pandemic, the Centers for Medicare & Medicaid Services
6 (CMS) expanded on the Hospitals Without Walls effort^{1,2} by introducing a waiver that
7 reimbursed hospitals the same for acute care in the home compared to the traditional inpatient
8 setting; and
9

10 Whereas, Since the CMS Acute Hospital Care at Home (AHCaH) waiver program, over 124
11 systems, including 278 hospitals in 37 States are now listed as approved for AHCaH⁶; and
12

13 Whereas, A number of studies and high quality reviews found non-inferiority with respect to
14 several measures including mortality, transfers to hospital and superiority with respect to patient
15 satisfaction, lower costs (38% lower than usual care patients in one study), and fewer low-value
16 services, such as laboratory orders, imaging studies and consultations^{4,5}; and
17

18 Whereas, In other countries like Australia, where reimbursement mechanisms have been long
19 established, hospitalization at home programs have been credited with decreasing new hospital
20 construction in Australia and has seen extensive international adoption; In Victoria, Australia, for
21 example, every metropolitan and regional hospital has a hospital at home program, and roughly
22 6 percent of all hospital bed-days are provided that way⁷; and
23

24 Whereas, The savings to hospitals from lower cost of care could result in greater incentive to
25 expand programs in underserved and indigent communities largely supported by Medicaid; and
26

27 Whereas, The AHCaH waiver was originally set to expire with the end of the public health
28 emergency, but was extended until December 31, 2024 with the passage of the Consolidated
29 Appropriations Act, 2023 (CAA 2023); and
30

31 Whereas, Extension of the AHCaH initiative will enable hospitals to continue to establish and
32 implement AHCaH programs, as well as allowing for the collection of quality, patient experience
33 and reimbursement data around AHCaH programs to assess of the effectiveness of such
34 programs; and
35

36 Whereas, Existing AMA Policy supports the CMS and private insurers extending flexibility to
37 implement innovative programs including, but not limited to, hospital at home programs; and
38 Whereas, Without permanent legislation around the AHCaH initiative, Home Hospital programs
39 will no longer receive Medicare (and likely Medicaid) reimbursement after the extension expires,

1 which could have significant negative impact on existing and aspiring Home Hospital programs;
2 therefore be it

3
4 RESOLVED, That our American Medical Association advocate for policy making the
5 reimbursement of Home Hospital permanent as currently enabled through the temporary
6 Centers for Medicare & Medicaid Services Acute Hospital Care at Home waiver (Directive to
7 Take Action); and be it further

8
9 RESOLVED, That our AMA support legislation that promotes parity between the reimbursement
10 for Home Hospital care and traditional inpatient care amongst all payors (New HOD Policy); and
11 be it further

12
13 RESOLVED, That our AMA support efforts to promote the sustainability and growth of Home
14 Hospital, including those encouraging research and innovation in the home-based acute care
15 space. (New HOD Policy)

16
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 6/9/23

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7. Commonwealth fund website. <<https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance#2>> Accessed on 04/29/23.

RELEVANT AMA POLICY

Financing of Home and Community-Based Services H-280.944

Our AMA supports: (1) federal funding for payment rates that promote access and greater utilization of home and community-based services (HCBS); (2) policies that help train, retain, and develop an adequate HCBS workforce; (3) efforts to simplify state plan amendments and Medicaid waivers to allow additional state flexibility to offer HCBS; (4) that Medicaid's Money Follows the Person demonstration program be extended or made permanent; (5) cross-agency and federal-state strategies that can help improve coordination among HCBS programs and streamline funding and the provision of services; (6) HCBS programs tracking protocols and outcomes to make meaningful comparisons across states and identify best practices; and (7) that the Centers for Medicare and Medicaid Services and private insurers extend flexibility to implement innovative programs including but not limited to hospital at home programs.

Citation: CMS Rep. 4, I-21;

The Education of Physicians in Home Care H-210.991

It is the policy of the AMA that: (1) faculties of the schools of medicine be encouraged to teach the science and art of home care as part of the regular undergraduate curriculum;

(2) graduate programs in the fields of family practice, general internal medicine, pediatrics, obstetrics, general surgery, orthopedics, physiatry, and psychiatry be encouraged to incorporate training in home care practice; (3) the concept of home care as part of the continuity of patient care, rather than as an alternative care mode, be promoted to physicians and other health care professionals; (4) assessment for home care be incorporated in all hospital discharge planning; (5) our AMA develop programs to increase physician awareness of and skill in the practice of home care; (6) our AMA foster physician participation (and itself be represented) at all present and future home care organizational planning initiatives (e.g., The Joint Commission, ASTM International, Food and Drug Administration, etc.); (7) our AMA encourage a leadership role for physicians as active team participants in home care issues such as quality standards, public policy, utilization, and reimbursement issues, etc.; and (8) our AMA recognize the responsibility of the physician who is involved in home care and recommend appropriate reimbursement for those health care services. Citation: Joint CSA/CME Rep., A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-02; Modified: CSAPH Rep. 1, A-12; Modified: CME Rep. 1, A-22;

Principles of the Patient-Centered Medical Home H-160.919

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the Patient-Centered Medical Home" as follows:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.

4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.

5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

Citation: Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 03, I-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 259
(A-23)

Introduced by: Medical Student Section

Subject: Strengthening Supplemental Nutrition Assistance Program (SNAP)

Referred to: Reference Committee B

1 Whereas, Temporary COVID-era expansions of the Supplemental Nutrition Assistance Program
2 (SNAP) expired in May 2023 with the end of the Public Health Emergency, resulting in
3 widespread benefit disruption in the face of persistent inflation¹⁻⁷; and
4

5 Whereas, SNAP benefits, which averaged \$230 per household per month in 2020, have
6 historically been insufficient, with average households exhausting over 75% of their benefits in
7 two weeks⁸⁻¹¹; and
8

9 Whereas, In 2021 the US Department of Agriculture (USDA) updated SNAP's benefit formula
10 for the first time in 15 years to better reflect accurate costs of healthy diets, increasing benefits
11 by 21%, keeping 2.3 million out of poverty, and reducing child poverty by 8.6%^{3,12-13}; and
12

13 Whereas, Many states' SNAP incentive programs double participants' purchasing power by
14 matching benefits used at farmer's markets, community-supported agriculture networks, and
15 other farm direct outlets dollar-for-dollar¹⁴; and
16

17 Whereas, Increased SNAP purchasing power at farm direct outlets is associated with increased
18 spending on fruits and vegetables and 26% higher fruit and vegetable consumption¹⁵⁻¹⁶; and
19

20 Whereas, A bipartisan Congressional bill would permanently codify COVID-era expansions that
21 expanded SNAP for purchase of hot, heated, and prepared items at SNAP-eligible vendors,
22 thereby increasing healthy options for participants with limited time or capacity to prepare
23 meals, including seniors, those with larger households, and those with disabilities^{9,17-20}; and
24

25 Whereas, The US Farm Bill, which authorizes SNAP, is set to expire on September 30, 2023,
26 presenting a critical advocacy opportunity as lawmakers debate overturning crucial benefit
27 increases, reversing the updated benefit formula, and cutting SNAP funds²¹⁻²⁵; and
28

29 Whereas, Nutrition assistance in Puerto Rico, American Samoa, and the Northern Mariana
30 Islands is annually funded by capped block grants instead of SNAP²⁶; and
31

32 Whereas, Despite territories experiencing 20% higher rates of food insecurity compared to
33 mainland states, block grants reduce overall nutrition assistance and limit flexibility to meet
34 increased need during crisis²⁷⁻²⁹; and
35

36 Whereas, Documented adult immigrants are subject to a five-year SNAP eligibility waiting
37 period, contributing to a 24% lower SNAP participation rate among households with mixed
38 immigration status compared to households with all citizens³⁰⁻³²; and
39

Whereas, SNAP benefits adjust based on the number of eligible household members, so households with mixed immigration status receive reduced per-capita benefits³¹⁻³²; and

Whereas, The 900,000 Deferred Action for Childhood Arrivals (DACA) recipients in the US legally reside and work in the US and must pay taxes (\$6 billion in federal taxes, \$4 billion to Medicare and Social Security, and \$3 billion in state and local taxes annually), but are ineligible for public benefits³³⁻³⁵; and

Whereas, Over 200,000 DACA recipients served as frontline workers during COVID in healthcare, education, food service, and other sectors³⁶; and

Whereas, Increased immigration enforcement may be associated with increased food insecurity³⁷; therefore be it

RESOLVED, That our American Medical Association support increases and oppose decreases in funding, eligibility, benefit generosity, and purchasing power incentives in the Supplemental Nutrition Assistance Program (SNAP) (New HOD Polic); and be it further

RESOLVED, That our AMA support allowing the use of SNAP benefits to purchase hot, heated, and prepared foods at SNAP-eligible vendors (New HOD Policy); and be it further

RESOLVED, That our AMA support expanding SNAP to U.S. territories that currently receive capped block grants for nutrition assistance (New HOD Policy); and be it further

RESOLVED, That our AMA actively support elimination of the five-year SNAP waiting period for otherwise qualifying immigrants and expansion of SNAP to otherwise qualifying Deferred Action Childhood Arrivals (DACA) recipients. (New HOD Policy)

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

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RELEVANT AMA POLICY

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthy foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Res. 414, A-10; Reaffirmation, A-12; Reaffirmation, A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation, A-14; Reaffirmation, I-14; Reaffirmation, A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food; and (4) will advocate for CMS and other relevant agencies to develop, test, and then implement evidence-based innovative models to address food insecurity, such as food delivery and transportation services to supermarkets, food banks and pantries, and local farmers markets for healthy food options.

Res. 921, I-18; Modified: Res. 417, A-21; Appended: Res. 117, A-22

Support of Health Care to Legal Immigrants H-290.983

Our AMA opposes federal and state legislation denying or restricting legal immigrants Medicaid and immunizations.

Res. 211, A-97; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12; Reaffirmed: CMS Rep. 3, I-21

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927

Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition. Res. 254, A-18

Exemptions to Work Requirements and Eligibility Expansions in Public Assistance Programs D-440.919

Our AMA: (1) supports reduction and elimination of work requirements applied to the used as eligibility criteria in public assistance programs, including the Supplemental Nutrition Assistance Program (SNAP) and the Temporary Assistance for Needy Families Program (TANF); (2) supports states' ability to expand eligibility for public assistance programs beyond federal standards, including automatically qualifying individuals for a public assistance program based on their eligibility for another program; and (3) will work with state medical societies to encourage states to establish express lane eligibility (ELE) programs that use eligibility data from the maximum number of Express Lane Agencies (ELAs) feasible, which include SNAP, TANF, and other programs as described by the Centers for Medicare & Medicaid Services, to facilitate enrollment in Medicaid and the Children's Health Insurance Program (CHIP). Res. 215, A-21

Food Stamp Incentive Program D-150.983

Our AMA supports legislation to provide a meaningful increase in the value of food stamps when used to purchase fruits and vegetables. Res. 405, A-07

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 260
(A-23)

Introduced by: Organized Medical Staff Section

Subject: Advocate to the Centers for Medicare and Medicaid Services and The Joint Commission to Redefine the Term “Provider” and Not Delete the Term “Licensed Independent Practitioner”

Referred to: Reference Committee B

1 Whereas, Communication is the key to a strong patient-doctor relationship; it is critical to use
2 correct terms and particularly important to use the word “physician” instead of “provider”; and
3

4 Whereas, Patient care experience is of the utmost importance to our profession and using the
5 word “provider” to describe physicians is detrimental to that interaction; and
6

7 Whereas, The premise of the “provider” based environment is that health care delivery is
8 essentially a commercial transaction, a market-based enterprise with a market ethic; and
9

10 Whereas, The word “provider” is confusing to patients and they deserve to know who does what
11 on the team of medical professional who take care of them; and
12

13 Whereas, The word “provider” levels distinctions and implies a uniformity of expertise and
14 knowledge among health care professionals as well as erroneously implies that “providers” are
15 interchangeable and patients can expect to receive the same level of care from any “provider”;
16 and
17

18 Whereas, By lumping the care team together with the word “provider”, patients do not know
19 whether they are seeing a nurse, physician, therapist, physician assistant, or nurse practitioner;
20 and
21

22 Whereas, Our American Medical Association considers the generic terms “health care
23 providers” and “providers” to be inadequate to describe the extensive education and
24 qualifications of physicians licensed to practice medicine in all its branches and has instituted an
25 editorial policy prohibiting the use of the term “provider” in lieu of “physician” in all AMA
26 publications outside of JAMA (AMA Policy H-405.968); and
27

28 Whereas, In December 2022, The Joint Commission (TJC) stated they will no longer use the
29 term “licensed independent practitioner” in its hospital and critical access hospital standards,
30 replacing it with the term “licensed practitioner” as of February 2023¹; and
31

32 Whereas, According to the TJC, “the revisions are consistent with current terminology used by
33 the Centers for Medicare & Medicaid Conditions of Participation,” and “better reflects the full
34 scope of practice of licensed practitioners allowed by their license and permitted by state and
35 federal law and regulation while keeping the intent of the requirement”²; and
36

37 Whereas, In addition to eliminating the term “licensed independent practitioner,” TJC is also
38 updating, revising and/or deleting the following terms from its glossary: Staff (revised); Clinical

1 staff (revised); Practitioner (replaced with Licensed practitioner); Licensed independent
2 practitioner (deleted); and Provider (new)³; and
3

4 Whereas, TJC pre-publication standards effective February 19, 2023, revised glossary
5 definitions defines "provider" as "a licensed individual or organization that provides health care
6 services outside the accredited organization"³; and
7

8 Whereas, The TJC definition of "provider" refers to both individuals and organizations, which is
9 inherently confusing and does not allow the distinction of expertise and knowledge of
10 physicians; therefore be it
11

12 RESOLVED, That our American Medical Association request a meeting with the Center for
13 Medicare and Medicaid services (CMS), and The Joint Commission to discuss the definition of
14 terms used in CMS Conditions of Participation, and in TJC Standards (Directive to Take Action);
15 and be it further
16

17 RESOLVED, That our American Medical Association advocate that in state and federal rules
18 and regulations and legislation that the use the term "providers" not be used to refer to
19 "physicians" as consistent with AMA policy H-405.968 (Directive to Take Action); and be it
20 further,
21

22 RESOLVED, that our American Medical Association encourage the Centers for Medicare and
23 Medicaid Services (CMS) and The Joint Commission not to delete the term and definition of
24 "licensed independent practitioner". (Directive to Take Action)
25

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

Received: 6/9/23

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RELEVANT AMA POLICY

Clarification of the Term "Provider" in Advertising, Contracts and Other Communications H-405.968

1. Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform.
2. Our AMA: (a) considers the generic terms "health care providers" or "providers" as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches; (b) will institute an editorial policy prohibiting the use of the term "provider" in lieu of "physician" or other health professionals for all AMA publications not otherwise covered by the existing JAMA Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA and The JAMA Network journals; and (c) will forward to the editorial board of JAMA the recommendation that the term "physician" be used in lieu of "provider" when referring to MDs and DOs.

Citation: Sub. Res. 712, I-94 Reaffirmed: Res. 226, I-98 Reaffirmation I-99 Res. 605, A-09 Reaffirmed: CLRPD Rep. 1, A-09 Modified: Speakers Rep., A-15 Reaffirmed: BOT Rep. 09, A-19

Education of the General Public on the Role of Physician and Non-Physician Health Care Providers H-450.955

The AMA will educate the general public and legislators to the differences between physician and non-physician providers of clinical services regarding their unique training, experience, broad based knowledge, ability and expertise, which impacts on their ability to provide high quality clinical care.

Citation: res. 308, A-98; Reaffirmed: A-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: BOT Rep. 9, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 261
(A-23)

Introduced by: Private Practice Physicians Section

Subject: Physician Owned Hospitals

Referred to: Reference Committee B

1 Whereas, Section 6001 of the Affordable Care Act (ACA) generally prohibits physician-owned
2 hospitals from expanding capacity without an exception specifically granted from the Secretary
3 of Health and Human Services; and
4

5 Whereas, That ACA provision limits physician ownership in most hospitals in percentage that
6 are not high Medicaid facilities; and
7

8 Whereas, Other health care entities and health care professionals do not have similar
9 ownership restrictions; and
10

11 Whereas, Data outlining the impact of these ownership limitations are lacking, both for patient
12 outcomes as well as for physician wellbeing and effectiveness; and
13

14 Whereas, Anecdotal experiences of physicians support the concept that this has marginalized
15 physicians from leadership within their own profession and area of expertise; and
16

17 Whereas, While the corporations that have been empowered by the ownership limitation have
18 doubtless benefited from it, it is not clear that any such benefit has redounded to physicians;
19 and
20

21 Whereas, A recent Senate Finance Committee report¹ proposed changes to the Physician Self-
22 Referral Law, commonly called the Stark law, and literature supports² that the ban on physician
23 owned hospitals has harmed competition and data demonstrates declining physician
24 independence; therefore be it
25

26 RESOLVED, That our American Medical Association study the patient selection practices of
27 both physician-owned and non-physician-owned hospitals to better understand the impact of
28 hospital ownership status on access to care through:

- 29 1. A thorough review of the existing literature;
- 30 2. Analyzing patient characteristics across both physician-owned and non-physician-
31 owned hospitals to elucidate whether there are any meaningful differences between
32 these 2 populations. This study should take into account that half of physician-owned
33 hospitals are community hospitals and half are specialty hospitals focused on cardiac,
34 orthopedic, or surgical care;
- 35 3. Proposing solutions if there are meaningful differences in these patient populations to
36 ensure equitable access to care (Directive to Take Action); and be it further
37

38 RESOLVED, That our AMA conduct a comprehensive study into the impact of Section 1877 of
39 the Social Security Act, the Physician Self-Referral Law (also called the Stark Law), on
40 physician-owned hospitals and market-wide consolidation, including the following:

1. Analyzing the impact that restrictions on physician-owned hospitals enacted by the Stark Law have had on patient access to care, in terms of both cost and quality;
2. Examining the impact of the Stark Law on physician practices, especially those that are integrated or affiliated with physician-owned hospitals;
3. Understanding the extent to which the Stark Law has driven market consolidation and, in doing so, impacted healthcare costs, quality, and patient access to care;
4. Proposing alternative approaches to the Stark Law, including consideration of repeal of relevant provisions, that would promote competition and improve patient access to high-quality care (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impact of Section 6001 of the Patient Protection and Affordable Care Act on physician hospital ownership metrics, physician fiscal health and retirement, physician burnout, patient continuity of care, physician turnover within hospitals, and most importantly physicians' empowerment to advocate for the health and wellbeing of their patients (Directive to Take Action); and be it further

RESOLVED, That our AMA report the initial findings of studies into Section 1877 of the Social Security Act and/or Section 6001 of the Patient Protection and Affordable Care Act to the House of Delegates by Annual 2024 (Directive to Take Action); and be it further

RESOLVED, That our AMA work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of the repeal of the ban on physician-owned hospitals on patients, physicians, and hospital prices. (Directive to Take Action)

Fiscal Note: \$100k - external research expertise and data, plus internal staffing costs.

Received: 6/9/23

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RELEVANT AMA POLICY

Physicians' Involvement in Commercial Ventures H-140.984

Our AMA opposes an across-the-board ban on self-referrals because of benefits to patients including increased access and competition, but proposes a list of standards to ensure ethical and acceptable financial arrangements:

- (1) Opportunity to Invest - The opportunity to invest in the medical or health care facility established by a health care service(s) (HCS) financial arrangement should be open to all individuals who are financially able and interested in the investment. This would include non-physicians. The only exception allowed would be for a sole community health care provider where ownership could be limited to potential referring physicians or their immediate family due to a lack of other individuals who have sufficient capital and interest to establish the facility.
- (2) Real Investment at Risk - Each investor should be undertaking a real financial risk similar to that which might occur in any other similar commercial investment. A referring physician should not be allowed to become involved in the HCS investment without incurring a real financial risk. The ability of a physician to refer patients must not be considered "capital" to become an investor in the facility. Each investor in the medical facility must be at risk by virtue of a binding commitment to capitalize the venture, such as a commitment to contribute money, property or services.
- (3) Patient Referral Requirement - No investor in the medical facility can be required or coerced in any manner to refer patients to the facility. No investor can be required to divest his or her investment for

failure to refer patients. No investor can be required to divest because he or she moves from the area or ceases practicing medicine.

(4) Distribution of Profit or Equity - Distribution should be based generally on the amount contributed to capital. Remuneration or profit distribution may not be related to patient referrals.

(5) Disclosure of Ownership Interest - A physician or other health care professional or provider with an ownership interest in a medical or other health care facility or service to which the physician refers patients must disclose to the patients this ownership interest. A general disclosure can be made in a manner which is appropriate to his or her practice situation.

(6) Request for Care - Each patient of a physician with an ownership interest (or whose immediate family member has an interest) must be provided with a physician's request for ancillary care to enable the patient to select a facility for such care. However, in accordance with the physician's ethical responsibility to provide the best care for the patient, the physician must be free to recommend what in the physician's judgment is the most appropriate facility, including his or her own facility.

(7) Notification of Ownership Interest to Payer - If the physician (or immediate family member) has an ownership interest in a medical or health care facility or service to which he or she refers patients who are Medicare beneficiaries, this physician should identify the ownership interest on the Medicare claim form. If the Medicare carrier detects a pattern suggesting inappropriate utilization, the matter could be referred to the PRO for follow-up pursuant to the existing PRO review process. Such PRO review would have to be conducted in a uniformly fair, open-minded manner.

(8) Internal Utilization Review Program - Each medical facility with referring physician owners (or immediate family members) must have an internal utilization review program to monitor referrals by such physicians. Regular reports from this internal program should be made available to the Medicare carrier on request.

(9) Compliance with Standards - Failure to comply with any one individual standard or compliance with all the standards, in and of itself, would not be sufficient to find that the arrangement is illegal. The entire arrangement needs to be examined to determine whether it is merely a sham arrangement to conceal a kickback scheme or whether it is "legal." Failure to comply with standards would subject the HCS investment arrangement to further scrutiny.

Citation: BOT Rep. ZZ, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 201, I-00; Reaffirmed: A-02; Reaffirmed: I-04; Reaffirmed: A-09; Reaffirmed: Res. 239, A-12; Reaffirmed: A-15; Reaffirmed: CMS Rep. 5, A-17

Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices D-140.951

Our AMA will study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership or management of physician practices and report back on the status of any ethical dimensions inherent in these arrangements, including consideration of the need for ethical guidelines as appropriate. Such a study should evaluate the impact of private equity ownership, including but not limited to the effect on the professional responsibilities and ethical priorities for physician practices.

Citation: Res. 026, A-22

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

Code of Medical Ethics: 9.6.9 Physician Self-Referral

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

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first.

When physicians enter into arrangements that provide opportunities for self-referral they must:

- (a) Ensure that referrals are based on objective, medically relevant criteria.
- (b) Ensure that the arrangement:
 - (i) is structured to enhance access to appropriate, high quality health care services or products; and
 - (ii) within the constraints of applicable law:
 - a. does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
 - b. does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
 - c. adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
- (c) Take steps to mitigate conflicts of interest, including:
 - (i) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
 - (ii) establishing mechanisms for utilization review to monitor referral practices; and
 - (iii) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
- (d) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

AMA Principles of Medical Ethics: II,III,VIII

Citation: Issued: 2016

Physicians' Self-Referral H-140.861

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

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 - (b) within the constraints of applicable law:
 - (i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
 - (ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
 - (iii) adheres to fair business practices vis-a-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
- (3) Take steps to mitigate conflicts of interest, including:
 - (a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
 - (b) establishing mechanisms for utilization review to monitor referral practices; and
 - (c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
- (4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of

available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.

Accountable Care Organization Principles H-160.915

Our AMA adopts the following Accountable Care Organization (ACO) principles:

1. Guiding Principle - The goal of an ACO is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.

2. ACO Governance - ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first.

A. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.

B. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.

C. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.

D. Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.

3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.

4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.

5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group

practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the 'shared savings' model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

A. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.

B. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.

C. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.

D. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

E. In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.

8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.

9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.

10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects. ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.

11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.

12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.

13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

Citation: CEJA Rep. 1, I-08; Reaffirmed: A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 262
(A-23)

Introduced by: Private Practice Physicians Section

Subject: Alignment of Specialty Designations for Advanced Practice Providers With
Their Supervising Physicians

Referred to: Reference Committee B

Whereas, Advanced Practice Providers (APP) such as nurse practitioners and physicians assistants, have established scope of practice directly determined by the specialty of their supervisory physician and their practice site; and

Whereas, APPs, in collaboration with their supervisory physicians, provide care commensurate with the specialty training and board certification of the physician; and

Whereas, Currently APPs 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 APPs creates the following harms to the practice of medicine and the quality of care for our patients:

1. APPs can completely change their profession specialty focus overnight, creating major training requirements and costs for the practice team that hires them;
2. Lower income physician specialties like primary care are disproportionately impacted by the frequent departure of APPs for higher income specialties;
3. Costly training periods for APPs 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 whereby specialties with higher physician salaries unfairly lure away APPs from the practices of lower salaried physicians, making those practices unable to compete with salaries offered by disparately higher income specialties;
5. Primary care practices, for example, are left with untenable training cost losses and exponentially high turnover in an already volatile and predatory market; and

Whereas, If residency and specialty training makes sense for physicians, some type of established apprenticeship training program within established specialties must also make sense for APPs; 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 create a national task force that will make recommendations for the best process for advanced practice providers (APPs) to develop specialty designations or an associated apprenticeship process that is parallel to the specialties of the physicians that supervise them (Directive to Take Action); and be it further

1 RESOLVED, That our AMA study and report back at Interim 2023 on the economic impact to
2 medical practices of specialty switching by advanced practice providers (Directive to Take
3 Action); and be it further
4

5 RESOLVED, That our AMA study and report back at the 2023 Interim Meeting about possible
6 options on how advanced practice providers can best be obligated to stay in a specialty tract
7 (Directive to Take Action).

Fiscal Note: \$200k - cost of establishing a task force, travel costs, and staff expenses. It also includes funds for external research expertise.

Received: 6/9/23

RELEVANT AMA POLICY

Scopes of Practice of Physician Extenders H-35.973

Our AMA supports the formulation of clearer definitions of the scope of practice of physician extenders to include direct appropriate physician supervision and recommended guidelines for physician supervision to ensure quality patient care.

Citation: Res. 213, A-02; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: BOT Rep. 7, A-21

Physician Extenders H-310.913

1. In academic environments, our AMA will only support payment models for non-physician practitioners that do not interfere with graduate medical training.

2. Our AMA supports the concept that procedural training is a critical portion of resident education and the augmentation of patient care by non-physician practitioners should not interfere with a resident's ability to achieve competence in the performance of required procedures.

Citation: Res. 208, I-10; Appended: CME Rep. 8, A-13

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.

(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.

(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.

(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.

(5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities.

(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

Citation: BOT Rep. 23, A-96; Reaffirmed: A-99; Reaffirmed: Res. 240 and Reaffirmation: A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: A-12, Reaffirmed: BOT Rep. 16, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 263
(A-23)

Introduced by: Resident and Fellow Section

Subject: Elimination of Non-Compete Clauses in Employment Contracts

Referred to: Reference Committee B

1 Whereas, About one in five American workers—approximately 30 million people—are bound by
2 a non-compete clause, which are a type of restrictive covenant that limit employees from
3 pursuing better employment opportunities¹; and
4

5 Whereas, It was estimated in 2018 that 45% of practicing primary care physicians in group
6 practices were bound by non-compete clause agreements²; and
7

8 Whereas, A non-compete clause is a contractual term between an employer and a worker that
9 blocks the worker from working for a competing employer, or starting a competing business,
10 typically within a certain geographic area and period of time after the worker's employment
11 ends¹; and
12

13 Whereas, Non-compete clauses decrease competition and promote lower wages for workers¹;
14 and
15

16 Whereas, Women and racial minorities appear to be disproportionately affected by non-compete
17 clauses with some studies finding a reduction in earnings twice that of white male workers³; and
18

19 Whereas, Non-compete clauses contribute to physician burnout and can limit physician ability to
20 provide quality care in underserved communities²; and
21

22 Whereas, The Federal Trade Commission is proposing preventing further non-compete clauses
23 and requiring employers to rescind existing non-compete clauses, and the Commission
24 estimates that the proposed rule would increase American workers' earnings between \$250
25 billion and \$296 billion per year¹; therefore be it
26

27 RESOLVED, That our American Medical Association support the elimination of restrictive not-to-
28 compete clauses within contracts for all physicians in clinical practice, regardless of the for-profit
29 or not-for-profit status of the employer (New HOD Policy); and be it further
30

31 RESOLVED, That our AMA strongly advocate for policies that enable all physicians, including
32 residents and fellows currently in training, to have greater professional mobility and the ability to
33 serve multiple hospitals, thereby increasing specialist coverage in communities and improving
34 overall patient care (Directive to Take Action); and be it further
35

36 RESOLVED, That our AMA ask the Council on Ethical and Judicial Affairs to evaluate amending
37 the AMA Code of Medical Ethics in order to oppose non-compete clauses. (Directive to Take
38 Action)

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

Received: 6/9/23

REFERENCES

1. Non-Compete Clause Rulemaking. Federal Trade Commission. Published January 5, 2022. <https://www.ftc.gov/legal-library/browse/federal-register-notice/non-compete-clause-rulemaking>
2. Garcia L. Lose-lose: noncompete agreements hurt doctors and patients. Accessed July 29, 2021. <https://www.aafp.org/news/blogs/freshperspectives/entry/20210303fp-noncompete.html>
3. Johnson M, Lavetti K, Lipsitz M. The Labor Market Effects of Legal Restrictions on Worker Mobility. *SSRN Electronic Journal*. Published online 2019. doi:<https://doi.org/10.2139/ssrn.3455381>

RELEVANT AMA POLICY

Code of Medical Ethics 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.

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]

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]

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.

There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program.

Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) **EDUCATION IN THE BROAD FIELD OF MEDICINE.** GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) **SCHOLARLY ACTIVITIES FOR RESIDENTS.** Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) **FACULTY SCHOLARSHIP.** All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that

may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

Citation: [CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18; Reaffirmed: CME Rep. 01, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 323
(A-23)

Introduced by: Resident and Fellow Section

Subject: Amend Policy D-275.948, "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training"

Referred to: Reference Committee C

1 Whereas, Physicians strive for the highest degree of patient care and professionalism¹; and

2
3 Whereas, Professionalism in medicine has been achieved through self-governance and self-regulation¹; and

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6 Whereas, Non-physicians serving in leadership roles in physician organizations compromises the objective of self-regulation and self-governance; and

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8
9 Whereas, The President and CEO of the National Resident Matching Program (NRMP) is currently a non-physician who has never participated in the MATCH, never completed a residency or fellowship, and yet also held prior leadership positions, including executive director at the Accreditation Council for Graduate Medical Education (ACGME) overseeing accreditation of physician residency and fellowship programs and held the position of designated institution official (DIO) for a graduate medical education (GME) program²; and

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16 Whereas, The newly elected Vice Chair of the National Board of Medical Examiners (NBME) is a non-physician who has never taken an NBME examination for board certification, yet now holds the position of Vice Chair of the organization³; and

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20 Whereas, The current chair of the Accreditation Council for Graduate Medical Education (ACGME) is a non-physician with a primarily human resources background⁴; and

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23 Whereas, Non-physicians, who do not go through physician education, accreditation, certification, licensing, and credentialing, may have difficulty appreciating the needs and challenges of physician trainees and therefore should not be making major decisions for physicians and representing physicians in the highest roles of these organizations; and

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28 Whereas, The purpose of having non-physicians on the physician boards was to have a public voice on these boards, not to lead the organization itself in the highest roles of the organizations; and

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32 Whereas, Non-physicians can participate on physician boards as a public member without leading the organization in the highest roles; and

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35 Whereas, Our AMA leads the "Stop the Scope Creep campaign," educating legislators about the differences in training between physicians and non-physicians; and

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Whereas, Having non-physicians leading physician boards is contradictory to the AMA message about scope creep and the importance of education; and

Whereas, Our advocacy to legislators about the importance of physician education is compromised if we have non-physicians in the highest roles determining physician standards; and

Whereas, There is no shortage of highly qualified physicians that would be able to excel in these leadership roles now held by non-physicians which would be consistent with our AMA Stop the Scope Creep campaign to have physicians in these roles; and

Whereas, Having these non-physician individuals lead national standard-setting organizations in our physician profession undermines physician confidence in these organizations; therefore be it

RESOLVED, That our American Medical Association amend policy D-275.948 by addition to read as follows:

1.) Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision; and

2.) Our AMA will work with and advocate to key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (1) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected; and (2) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision; and

3.) Our AMA opposes any non-physician having a voting position on a regulatory body or physician board responsible for physician education, accreditation, certification, licensing, or credentialing. (Modify Current HOD Policy)

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

Received: 6/9/23

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RELEVANT AMA POLICY

Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training D-275.948

Our AMA will work with key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (1) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected; and (2) review their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision. Citation: [CME Rep. 5, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 434
(A-23)

Introduced by: Medical Student Section

Subject: Improving Hazardous Chemical Transport Regulations for Public Health Protections

Referred to: Reference Committee D

Whereas, Hazardous materials are defined as a substance or material that the Secretary of Transportation has determined is capable of posing an unreasonable risk to health, safety, and property¹; and

Whereas, According to the American Association of Railroads, railroads transport more than 2 million carloads of hazardous materials annually²; and

Whereas, Within the last 30 years, there have been multiple catastrophic train derailments involving hazardous chemicals (2023, East Palestine, Ohio³; 2020, Seattle, WA⁴; 2015, Maryville, TN⁵; 2012, Paulsboro, NH⁶; 2005, Graniteville, SC⁷; 2002, Minot, ND⁸; 1992, MN and WI Border⁹; 1991, Dunsmuir, CA¹⁰) that resulted in casualties, evacuation of surrounding towns, displacement of residents, significant environmental pollution, and chemical exposures resulting in long-term health complications for affected individuals³⁻¹⁰; and

Whereas, The chemicals spilled by railway derailments in states including Tennessee, New Jersey, South Carolina, and California exposed surrounding communities to hazardous chemicals including acrylonitrile, vinyl chloride, chlorine, and herbicides, leading to chronic medical issues such as increased blood pressure, lung damage, increased rates of post-traumatic stress disorder, and increased risk for liver angiosarcoma^{5-7,10}; and

Whereas, Long-term exposure to benzene, ethylhexyl acrylate, and vinyl chloride have been associated with multiple malignancies including acute myeloid leukemia and hepatocellular carcinoma¹¹⁻¹³; and

Whereas, Exposure to hazardous chemicals commonly results in hospitalizations for symptoms including but not limited to respiratory issues, skin irritation, burning of the eyes, nausea, vomiting, diarrhea, headache, drowsiness, and dizziness^{5-7,10}; and

Whereas, Railroads and hazardous material transport across all modalities are regulated federally¹⁴⁻¹⁷; and

Whereas, About one-fifth of all inspections by the DOT of commercial vehicles (railroad, highway, and waterway) resulted in a vehicle being placed out-of-service (OOS) for a serious violation such as operating under hazardous conditions or lacking required operating authority¹⁸; and

Whereas, Current regulations require tank cars to have thermal protection barriers for rail transportation of Class 3 flammable liquids, but as of 2021, only 56.8 percent of the 103,312 tank cars used to carry these liquids met these safety requirements¹⁸; and

Whereas, As of March 1, 2023, the FRA announced a safety initiative for the transportation of hazardous waste, inspecting routes of hazardous waste transport and evaluating electronically controlled pneumatic (ECP) break regulations¹⁹; and

Whereas, Recently, in February 2023, a railway derailment in East Palestine, Ohio, led to combustion of hazardous material containers, including chemicals such as isobutylene, butyl acrylate, benzene, ethylhexyl acrylate, ethylene glycol monobutyl ether, and 115,580 gallons of vinyl chloride²⁰; and

Whereas, After hazardous chemical spillage, despite the Environmental Protection Agency sampling the area's water, air, and soil for contamination, detectable levels of hazardous material remain, causing concern for long-term health consequences from exposure to said chemicals²¹; and

Whereas, Public Health Registries have served as a quick and effective tool to help communities learn about exposures where consequences are unclear²²⁻²³; and

Whereas, The World Trade Center (WTC) Health Registry involved a collaborative effort between various local and government health agencies to voluntarily enroll people most directly exposed to environmental effects, identify and track the long-term physical and mental health effects of the WTC attack, disseminate findings and recommendations, and develop disaster preparedness and public policy for use in the event of future disasters²⁴⁻²⁶; and

Whereas, The WTC Health Registry helped develop our understanding of the medical consequences of exposure to toxic smoke, dust, and debris, and contributed to the creation of the James Zadroga 9/11 Health and Compensation Act of 2010, which offers screenings, medical monitoring and treatment of WTC-related conditions for emergency responders and survivors within the disaster area²⁴⁻²⁶; and

Whereas, Other public health registries, including the Texas Flood Registry, have utilized the successful model of the WTC Health Registry to collect exposure data through collaboration between local health departments, academia, and community stakeholders to identify key areas for environmental health research²⁴⁻²⁷; and

Whereas, Norfolk Southern and other rail companies have successfully lobbied to limit safety regulations and the scope of railroad transportation safety legislation²⁸⁻²⁹; and

Whereas, AMA policy advocates for chemical manufacturers to provide safety information and gives federal agencies regulatory authority over hazardous chemicals (D-135.976); and

Whereas, The AMA monitors repercussions of health emergencies, for instance the Gulf oil spill, but other health emergencies lack registry or documentation (D-135.980); and

Whereas, AMA policy calls for the development of adequate transportation systems and monitoring of the transportation and storage of hazardous materials (H-135.993) but does not address root complications of transportation and storage of hazardous materials; therefore be it

RESOLVED, That our American Medical Association amend H-135.993 by addition and deletion to read as follows:

H-135.993 Transportation and Storage of ~~Regulating~~ Hazardous Materials to Protect Public Health

Our AMA (1) requests governmental agencies to develop adequate systems, which include instruction for detoxification or neutralization in event of emergencies, for continuous monitoring of transportation and storage of hazardous materials-, (2) advocates for regulations that govern the transportation of hazardous materials to prioritize public health and safety over cost or other considerations, (3) supports efforts to hold companies that are responsible for chemical spills liable for the cost of healthcare incurred by people exposed to hazardous chemicals, and (4) supports the creation of a registry for people affected by hazardous chemical exposures in order to monitor the health effects of these exposures, with cohort reports released as appropriate.

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

Received: 06/09/2023

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RELEVANT AMA POLICY

Modern Chemicals Policies H-135.942

Our AMA supports: (1) the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern; and (2) the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment.

Sub. Res. 404, A-08; Reaffirmation A-10; Reaffirmed: CSAPH Rep. 5, A-11; Reaffirmation I-16; Reaffirmed in lieu of: Res. 505, A-19

Expansion of Hazardous Waste Landfills Over Aquifers H-135.943

Our AMA:

1. recognizes that the expansion of hazardous waste landfills or the construction of new hazardous waste landfills over principal aquifers represents a potential health risk for the public water supply and is inconsistent with sound principles of public health policy, and therefore should be opposed;
2. will advocate for the continued monitoring of groundwater sources, including principal aquifers, that may be contaminated by hazardous waste landfill or other landfill leachate; and
3. supports efforts to improve hazardous waste treatment, recycling, and disposal methods in order to reduce the public health burden.

CSAPH Rep. 4, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976 D-135.976

Our AMA will: (1) collaborate with relevant stakeholders to advocate for modernizing the Toxic Substances Control Act (TSCA) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies reasonable authority to regulate hazardous chemicals in order to protect the health of all individuals, especially vulnerable populations; (2) support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; and (3) work with members of the Federation to promote a reformed TSCA that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH).

Res. 515, A-12; Modified: Res. 907, I-13; Reaffirmation I-13; Reaffirmation I-16

Gulf Oil Spill Health Risks and Effects D-135.980

Our AMA will encourage the National Institute of Environmental Health Sciences and the Natural Resource Damage Assessment program to: (1) continue to monitor health effects (including mental health effects) and public health surveillance activities related to the Gulf oil spill, and provide relevant information and resources as they become available; and (2) monitor the results of studies examining the health effects of the Gulf oil spill and report back as appropriate.

CSAPH Rep. 3, I-10; Modified: CSAPH Rep. 5, A-13

Modern Chemicals Policies D-135.987

Our AMA: (1) will call upon the United States government to implement a national modern, comprehensive chemicals policy that is in line with current scientific knowledge on human and environmental health, and that requires a full evaluation of the health impacts of both newly developed and industrial chemicals now in use; and (2) encourages the training of medical students, physicians, and other health professionals about the human health effects of toxic chemical exposures.

Sub. Res. 404, A-08; Reaffirmation A-10; Reaffirmation I-16

Transportation and Storage of Hazardous Materials H-135.993

Our AMA requests governmental agencies to develop adequate systems, which include instruction for detoxification or neutralization in event of emergencies, for continuous monitoring of transportation and storage of hazardous materials.

Sub. Res. 42, I-74; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Adverse Impacts of Delaying the Implementation of Public Health Regulations D-440.925

Our AMA will monitor and evaluate regulation delays that impact public health, and advocate as appropriate to decrease regulatory delays.

Res. 529, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 435
(A-23)

Introduced by: Resident and Fellow Section

Subject: Stand Your Ground Laws

Referred to: Reference Committee D

1 Whereas, On April 13th, 2023, Ralph Yarl, a 16-year-old black child was shot in the head in
2 Kansas City after accidentally going to the wrong address to pick up his younger siblings;¹ and
3

4 Whereas, On April 15th, 2023, Kaylin Gillis, a 20-year-old white woman was shot and killed in
5 Hebron, NY after her friends accidentally pulled their car up to the wrong house;² and
6

7 Whereas, Self-defense is defined by Cornell Law School's free legal dictionary, Wex, as "The
8 use of force to protect oneself from an attempted injury by another. If justified, self-defense is a
9 defense to a number of crimes and torts involving force, including murder, assault and battery.";³
10 and
11

12 Whereas, The doctrine of self-defense typically includes the rule to retreat, where "a party is not
13 entitled to a defense of self-defense unless they first tried to mitigate the necessity of force by
14 fleeing the situation, so long as retreating could be done safely";⁴ and
15

16 Whereas, The Castle Doctrine is an exception to a self-defense claim, specifically in regards to
17 "the duty to retreat before using deadly self-defense if a party is in their own home";⁴ and
18

19 Whereas, Stand-your-ground laws further expand The Castle Doctrine to allow for use of deadly
20 force without duty to retreat in self-defense situations in public places;⁵ and
21

22 Whereas, Missouri, the state in which Ralph Yarl was shot, has an expanded stand-your-ground
23 law that "removes the duty to retreat before using deadly force in defense of self or others in any
24 place a person has a right to be";⁶ and
25

26 Whereas, As of April 2021, stand-your-ground laws or expanded castle doctrine existed in 35
27 states;⁵ and
28

29 Whereas, A 2020 study of Stand-your-ground laws showed that evidence that they may
30 increase violent crime, and there is inconclusive evidence as to how they affect defensive gun
31 use;⁵ and
32

33 Whereas, As of April 28, 2023, there have been 493 unintentional shootings, 232
34 murder/suicide incidents, and 356 incidents of defensive use of a firearm in the year 2023;⁷ and
35

36 Whereas, As of April 28, 2023, there have been 13,843 total deaths due to gun violence, and
37 10,922 injuries in the year 2023;⁷ and
38

39 Whereas, In 2016 following the Pulse Nightclub shooting, our AMA declared gun violence a
40 public health crisis;⁸ and

Whereas, Since 2016, our AMA has been at the forefront of advocating for legislation focused on public health and firearm safety; and

Whereas, At Interim 2022, our AMA voted to continue our efforts and build on existing House policy with Board of Trustee Report 2, establishing a “task force to focus on gun violence prevention including gun-involved suicide”; therefore be it

RESOLVED, That our American Medical Association study the public health implications of “Stand Your Ground” laws and castle doctrine. (Directive to Take Action)

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

Received: 6/9/23

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RELEVANT AMA POLICY

Prevention of Firearm Accidents in Children H-145.990

1) Our AMA (a) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (i) inquire as to the presence of household firearms as a part of childproofing the home; (ii) educate patients to the dangers of firearms to children; (iii) encourage patients to educate their children and neighbors as to the dangers of firearms; and (iv) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (b) encourages state medical societies to work with other organizations to increase public education about firearm safety; (c) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (d) supports enactment of Child Access Prevention laws that are consistent with AMA policy. 2) Our AMA and all interested medical societies will (a) educate the public about: (b) best practices for firearm storage safety; (c) misconceptions families have regarding child response to encountering a firearm in the home; and (c) the need to ask other families with whom the child interacts regarding the presence and storage of firearms in other homes the child may enter. Citation: [Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18; Appended: Res. 923, I-22]

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

- (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
- (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
- (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
- (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
- (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
- (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
- (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

3. Our AMA will support research examining the major sources of illegally possessed firearms, as well as possible methods of decreasing their proliferation in the United States.

4. Our AMA will work with key stakeholders including, but not limited to, firearm manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm injury victims advocacy groups, healthcare providers, and state and federal government agencies to develop evidence-informed public health recommendations to mitigate the effects of violence committed with firearms.

5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis.

Citation: [CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19; Appended: Res. 907, I-22; Reaffirmed: Res. 921, I-22]

AMA Campaign to Reduce Firearm Deaths H-145.988

The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home. Citation: [Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13]

Further Action to Respond to the Gun Violence Public Health Crisis D-145.992

Our AMA will (a) make readily accessible on the AMA website the comprehensive summary of AMA policies, plans, current activities, and progress regarding the public health crisis of firearm violence; (b) establish a task force to focus on gun violence prevention including gun-involved suicide; (c) support and consider providing grants to evidence-based firearm violence interruption programs in communities, schools, hospitals, and clinics; (d) collaborate with interested state and specialty societies to increase engagement in litigation related to firearm safety; and (e) report annually to the House of Delegates on our AMA's efforts relating to legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence. Citation: [BOT Rep. 2, I-22]

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress

to lift the gun violence research ban. Citation: [Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 921, I-22]

Gun Regulation H-145.999

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm. Citation: [Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 525
(A-23)

Introduced by: Resident and Fellow Section

Subject: Decriminalizing and Destigmatizing Perinatal Substance Use Treatment

Referred to: Reference Committee E

1 Whereas, People of Color are disproportionately undertreated and over criminalized for
2 substance use during pregnancy, as they are more likely to receive toxicology testing and be
3 reported to Child Protective Services (CPS) despite being no more likely to test positive, being
4 tested more often for clinically inappropriate reasons, and having lower rates of linkage to
5 evidence-based substance use treatment¹⁻⁵; and
6

7 Whereas, The American College of Obstetricians & Gynecologists and American Academy of
8 Pediatrics currently recommend universal verbal substance use screening, so that pregnant
9 people can be referred to appropriate treatment, and currently do not recommend routine
10 toxicology testing during prenatal, perinatal, or postpartum care^{6,7}; and
11

12 Whereas, The Supreme Court ruling in *Ferguson v. City of Charleston* determined that
13 toxicology testing of pregnant patients without informed consent is a violation of 4th Amendment
14 rights, yet even data published as recently as 2022 have demonstrated that involuntary
15 toxicology testing remains all too common^{8,9}; and
16

17 Whereas, Since 2003, the federal Child Abuse Prevention and Treatment Act (CAPTA) has
18 required health care providers to notify CPS about babies impacted by illegal substance use,
19 and in 2016, CAPTA was expanded to remove specificity for “illegal” drugs, resulting in the
20 criminalization of legal marijuana use as well as evidence-based treatments like methadone and
21 buprenorphine¹⁰; and
22

23 Whereas, CAPTA is interpreted at the state level, and a 2019 review article summarized that 24
24 states automatically consider substance use during pregnancy to be child abuse, 3 states
25 automatically consider it grounds for incarceration, 25 states mandate CPS reporting of any
26 suspected substance use during pregnancy, 8 states require toxicology testing, and 11 mandate
27 CPS reporting of positive toxicology tests¹¹; and
28

29 Whereas, Rigorous quasi-experimental studies have proven that punitive policies to mandate
30 reporting of pregnant people who use drugs cause increased rates of child abuse reporting,
31 child welfare system involvement, and family separation with no improvement in neonatal opioid
32 withdrawal syndrome (NOWS) incidence and lower likelihood of prenatal and postpartum
33 substance use treatment¹²⁻¹⁶; and
34

35 Whereas, Our American Medical Association has strong policy opposing the criminalization of
36 maternal substance use and advocating for improved access to evidence-based substance use
37 disorder treatment for pregnant people (H-420.950, H-420.962, H-420.953), but has not
38 adequately engaged in advocacy to reshape the intersections of perinatal substance use and
39 involvement with CPS or the criminal-legal system^{17,18}; therefore be it

- 1 RESOLVED, That our American Medical Association advocate that prenatal and peripartum
2 toxicology tests should not be obtained without the informed consent of the birthing parent if
3 they have capacity to provide consent. (Directive to Take Action)

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

Received: 6/9/23

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RELEVANT AMA POLICY

Substance Use Disorders During Pregnancy H-420.950

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected.

Citation: (Res. 209, A-18; Modified: Res. 520, A-19)

Infant Victims of Substance Abuse H-420.971

It is the policy of the AMA: (1) to develop educational programs for physicians to enable them to recognize, evaluate and counsel women of childbearing age about the impact of substance use disorders on their children; and (2) to call for more funding for treatment and research of the long-term effects of maternal substance use disorders on children.

Citation: (Res. 101, A-90; Reaffirmation A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19)

Perinatal Addiction - Issues in Care and Prevention H-420.962

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care.

Citation: (CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17; Reaffirmed: Res. 514, A-19)

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)

Drug Testing H-95.985

Our AMA believes that physicians should be familiar with the strengths and limitations of drug testing techniques and programs:

1. Due to the limited specificity of the inexpensive and widely available non-instrumented devices such as point-of-care drug testing devices, acceptable clinical drug testing programs should include the ability to access highly specific, analytically acceptable confirmation techniques, which definitively establish the identities and quantities of drugs, in order to further analyze results from presumptive testing methodologies. Physicians should consider the value of data from non-confirmed preliminary test results, and should not make major clinical decisions without using confirmatory methods to provide assurance about the accuracy of the clinical data.
2. Results from drug testing programs can yield accurate evidence of prior exposure to drugs. Drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use, nor does it provide valid or reliable information about harm or potential risk of harm to children or, by itself, provide indication or proof of child abuse, or neglect or proof of inadequate parenting.
3. Before implementing a drug testing program, physicians should: (a) understand the objectives and questions they want to answer with testing; (b) understand the advantages and limitations of the testing technology; (c) be aware of and educated about the drugs chosen for inclusion in the drug test; and (d) ensure that the cost of testing aligns with the expected benefits for their patients. Physicians also should be satisfied that the selection of drugs (analytes) and subjects to be tested as well as the screening and confirmatory techniques that are used meet the stated objectives.

4. Since physicians often are called upon to interpret results, they should be familiar with the disposition characteristics of the drugs to be tested before interpreting any results. If interpretation of any given result is outside of the expertise of the physician, assistance from appropriate experts such as a certified medical review officer should be pursued.

Citation: (CSA Rep. J, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: CSAPH Rep. 01, I-16; Reaffirmed: Res. 520, A-19)

Identifying and Reporting Suspected Child Abuse H-515.960

1. Our American Medical Association recognizes that suspected child abuse is being underreported by physicians.
 2. Our AMA supports development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention.
 3. Our AMA supports the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse.
 4. Our AMA recognizes the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse.
 5. Our AMA acknowledges that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the joint development of didactic programs designed to foster increased interaction and to minimize conflicts or distrust.
 6. Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims.
 7. Our AMA encourages all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers.
 8. Our AMA will support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense.
- Citation: (CSAPH Rep. 2, I-09; Appended: Res. 411, A-18)

Child Protection Legislation H-60.948

The AMA opposes legislation that would: (1) hinder, obstruct or weaken investigations of suspected child and adolescent abuse, and (2) hamper or interfere with child protection statutes.

Citation: (Sub. Res. 219, I-97; Reaffirmed: BOT Rep. 33, A-07; Reaffirmed: BOT Rep. 22, A-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 724
(A-23)

Introduced by: Organized Medical Staff Section

Subject: Rural Hospital Payment Models

Referred to: Reference Committee G

1 Whereas, Our American Medical Association's mission is to promote the betterment of public
2 health; and
3

4 Whereas, Prior to the COVID-19 pandemic, the death rate was 20 percent higher in rural
5 America than in urban areas due to lower rates of insurance coverage, higher rates of poverty,
6 and less access to health care¹; and
7

8 Whereas, Rural hospitals generally operate on a smaller margin, thereby limiting their ability to
9 pay the higher wages of nurses and staff; and
10

11 Whereas, Prior to the COVID-19 pandemic, rural communities nationwide saw an average
12 mortality rate increase of six percent following a rural hospital closure²; and
13

14 Whereas, Across the United States, a total of 631 rural hospitals—about 30 percent of all rural
15 hospitals—are at risk of closing in the immediate or near future due to persistent financial losses
16 on patient services, inadequate revenues to cover expenses, and low financial resources,
17 according to a report from the Center for Healthcare Quality and Payment Reform³; and
18

19 Whereas, More than 200 rural hospitals are identified as being at immediate risk of closure,
20 losing money on patient services before the COVID-19 pandemic and lacking sufficient
21 resources to cover those losses, according to the same report³; and
22

23 Whereas, Rural hospital closures affect everyone, not just residents of rural communities, as
24 most of the nation's food supply, coal mining, oil production, and solar and wind energy facilities
25 all rely on rural hospitals for healthcare services⁴; and
26

27 Whereas, The primary cause of rural hospital closures is when payments from commercial
28 health insurance plans don't sustain essential services in rural communities⁴; and
29

30 Whereas, Unlike large urban hospitals, small rural hospitals don't make large profits on patients
31 with private insurance that can be used to offset losses on uninsured patients and patients with
32 Medicaid⁴; and
33

34 Whereas, Rural hospitals need both adequate payments and a better payment system in order
35 to provide essential healthcare services for their communities as current fee-for-service and
36 cost-based payment systems don't provide the support rural hospitals need, nor will the global
37 payments Medicare and others have proposed⁴; and

Whereas, Further closure of rural hospitals will be devastating to the rural health care delivery system, with an untold number of patients harmed from reduced access to care; therefore be it

RESOLVED, That our American Medical Association urgently collaborate with appropriate stakeholders to protect health care delivery in underserved, rural communities and work to preserve the economic viability of rural sole community hospitals which are the primary lines of healthcare defense in rural America (Directive to Take Action); and be it further

RESOLVED, That our AMA study alternative rural hospital payment models for feasibility, including a patient-centered payment model and standby capacity payments for essential services, in helping preserve rural community hospitals financially and preserving access to care for patients (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm policies H-465.979, H-200.972, H-465.990, and H-465.994. (Reaffirm HOD Policy)

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

Received: 6/9/23

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RELEVANT AMA POLICY

Economic Viability of Rural Sole Community Hospitals H-465.979

Our AMA: (1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.

Citation: CMS Rep. 3, A-15

Primary Care Physicians in Underserved Areas H-200.972

1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:

- (a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
- (b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.
- (c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
- (d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.
- (e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.
- (f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who

help meet the needs of underserved patient populations.

(g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.

2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.

Citation: CMS Rep. I-93-2 Reaffirmation A-01; Reaffirmation I-03; Modified: CME Rep. 13, A-06;

Reaffirmed: CMS Rep. 01, A-16; Modified: CME Rep. 04, I-18; Appended: Res. 206, I-19,

Reaffirmation: I-22

Closing of Small Rural Hospitals H-465.990

Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care.

Citation: Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 807, I-13; Reaffirmed: CMS Rep. 3, A-15

Improving Rural Health H-465.994

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public health to:

- Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Advocate for adequate and sustained funding for public health staffing and programs.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08;

Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19

Modified: CSAPH Rep. 2, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 725
(A-23)

Introduced by: Organized Medical Staff Section

Subject: The Economics of Prior Authorization

Referred to: Reference Committee G

1 Whereas, A primary concern of our American Medical Association is to optimize individual
2 medical care and the betterment of public health; and
3

4 Whereas, The original justification for prior authorization of medications was to restrain the
5 escalation of the cost of medical care¹; and
6

7 Whereas, The list price of a drug greatly differs from the net price, which incorporates discounts
8 and rebates, and that the use of list price leads to misleading implications for health care policy
9 as reported in studies²; and
10

11 Whereas, The factor of net cost of a medication to the insurer is likely a strong factor in
12 determination to cover, or not cover, a given prescription; and
13

14 Whereas, There is a trend, in the opinion of many, for prescribed medications to be denied prior
15 authorization even when the cost of a medication is low; and
16

17 Whereas, The prescribing physicians is in the best position to choose the appropriate
18 medication for an individual patient given the multiple factors to consider³; and
19

20 Whereas, Information as to the actual cost basis involved in prior authorization would be useful
21 in contesting adverse prior authorization determinations as well as in advocacy for more
22 medically appropriate determinations in general; and
23

24 Whereas, There are numerous sources of information on aggregate pharmaceutical prices
25 (including net) and spending, but none that report on the influence of the various factors on the
26 process of prior authorization for an individual prescription; and
27

28 Whereas, The federal government has processes for gathering information already in place,
29 such as the Prescription Drug Pricing Dashboard as well as the Congressional Budget Office,
30 but not at the granular level of individual prescriptions⁴; and
31

32 Whereas, There have been bipartisan attempts in the last several years to increase the
33 transparency of drug pricing and costs which have not passed Congress⁵; therefore be it
34

35 RESOLVED, That our American Medical Association advocate to the federal government that
36 third party payors and surrogates include economic information on the net costs of medications
37 denied prior authorization and, where applicable, comparative net costs of alternative approved
38 or suggested medications for each rejected prior authorization. (Directive to Take Action)

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

Received: 6/9/23

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RELEVANT AMA POLICY

Prior Authorization Relief in Medicare Advantage Plans H-320.938

Our AMA supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- a. List services and prescription medications that require a PA on a website and ensure that patient informational materials include full disclosure of any PA requirements.
- b. Notify providers of any changes to PA requirements at least 45 days prior to change.
- c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.
- d. Standardize a PA request form.
- e. Minimize PA requirements as much as possible within each plan and eliminate the application of PA to services and prescription medications that are routinely approved.
- f. Pay for services and prescription medications for which PA has been approved unless fraudulently obtained.
- g. Allow continuation of medications already being administered or prescribed when a patient changes health plans, and only change such medications with the approval of the ordering physician.
- h. Make an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.
- i. Define a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans.

Citation: Res. 814, I-18; Reaffirmed: A-22

Private Health Insurance Formulary Transparency H-125.979

1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.

5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.

6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.

7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.

8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.

Citation: Sub. Res. 724, A-14; Appended: Res. 701: A-16; Appended: Alt. Res. 806, I-17; Reaffirmed: CMS Rep. 7, A-18; Reaffirmed: BOT Rep. 20, A-19; Reaffirmed: CMS Rep. 5, A-19; Reaffirmed: CMS Rep. 2, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 726
(A-23)

Introduced by: Private Practice Physicians Section

Subject: Proper Use of Overseas Virtual Assistants in Medical Practice

Referred to: Reference Committee G

1 Whereas, Due to inflation and rising wages, many medical practices are turning to overseas
2 virtual assistants to help with administrative tasks; and
3

4 Whereas, Overseas virtual assistants are widely used in many industries; and
5

6 Whereas, To date, the American Medical Association has yet to comment publicly or devise
7 policy regarding the best practices for utilizing overseas virtual assistants in such a way that will
8 be beneficial to physicians practices while still maintaining the AMA's commitment to fostering
9 safe, equitable workforces; therefore be it
10

11 RESOLVED, That our American Medical Association support the concept that properly trained
12 overseas virtual assistants are an acceptable way to staff administrative roles in medical
13 practices (New HOD Policy); and be it further
14

15 RESOLVED, That our AMA study and offer formal guidance for physicians on how best to utilize
16 overseas virtual assistants in such a way as to ensure protections for physicians, practices, and
17 patient outcomes (Directive to Take Action).

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

Received: 6/29/23

RELEVANT AMA POLICY

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.

2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).

3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate

reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Citation: CME Rep. 04, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 727
(A-23)

Introduced by: Private Practice Physicians Section

Subject: Health System Consolidation

Referred to: Reference Committee G

1 Whereas, The COVID-19 pandemic resulted in unprecedented human suffering on a scale
2 unbeknownst to modern society since the 1918 Flu Pandemic with over 700,000 Americans
3 dead nationwide while physicians suffered moral injury, burnout, exhaustion, and depression
4 due to a lack of preparedness; and

5
6 Whereas, The healthcare delivery system faced massive operational challenges¹, stimulating
7 policymakers to re-examine care delivery markets, including the harms of health system
8 consolidation and mergers²; and

9
10 Whereas, In a large part because of mergers, the majority of Americans now live in highly
11 concentrated health care delivery markets³, including both hospital systems and health systems,
12 the latter comprised of both outpatient practice chains, hospitals, and other healthcare service
13 markets; and

14
15 Whereas, The harms of healthcare delivery consolidation and mergers are significant and
16 directly negatively affect patients. Specific harms are numerous and well-documented⁴,
17 including a lack of quality benefits and decrements in patient experience⁵, higher hospital
18 prices⁶, decreasing patient access and driving rising health insurance premiums, both of which
19 harm patients; and

20
21 Whereas, Increasing consolidation of physicians into health systems^{7,8} decreases physician
22 control over medical practice, hampers independent practice and choices over how and where
23 physicians practice medicine⁹, and places corporations at the center of the patient-physician
24 relationship, thus driving burnout due to a loss of control over the public environment¹⁰; and

25
26 Whereas, Systemic harms of health system and hospital consolidation are more insidious and
27 long-term, including a loss of innovation in care delivery and productivity as manifested by over
28 twenty years of absent labor productivity growth, a finding unparalleled by other industries¹¹;
29 and

30
31 Whereas, Health care delivery consolidation is a bipartisan problem, acknowledged by both
32 Democrats¹² and Republicans¹³; and

33
34 Whereas, Our AMA is a national leader in addressing consolidation in healthcare and bringing
35 the patient voice to these conversations with its "Competition in health insurance: A
36 comprehensive study of U.S. Markets" now in its twentieth year¹⁴. The AMA successfully used
37 this study in 2016 to conduct further analyses to assist the U.S. Department of Justice and
38 National Association of Attorneys General to successfully challenge the Anthem-Cigna and
39 Aetna-Humana mergers¹⁵; and

40

Whereas, Our AMA previously committed to studying health system consolidation (Health System Consolidation D-215.984), but we now face an acceleration of hospital and health system consolidation since the beginning of the COVID19 pandemic¹⁶ with impending mega deals and mergers on the horizon¹⁷; therefore be it

RESOLVED, That our American Medical Association commit to undertaking an annual report assessing nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing rapidly evolving and accelerating healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation (Directive to Take Action); and be it further

RESOLVED, That our AMA annual report on nationwide hospital consolidation will be modeled after the "Competition in health insurance: A comprehensive study of U.S. Markets" in its comprehensiveness to include for example such data and analyses as:

1. A review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets;
2. A list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation;
3. Analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets;
4. Analyses of healthcare costs and prices have changed in affected markets after a large consolidation transaction has taken place (Directive to Take Action); and be it further

RESOLVED, That our AMA report the initial findings of this study to the House of Delegates by Annual 2024 (Directive to Take Action); and be it further

RESOLVED, That our AMA report the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future healthcare policy. (Directive to Take Action)

Fiscal Note: \$200k - cover the significant costs of starting the called for analysis. This includes staff time, data purchase, and potential external expertise.

Received: 6/9/23

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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. 7, A-19; Reaffirmed: I-22

Health Care Entity Consolidation D-383.980

Our AMA will (1) study the potential effects of monopolistic activity by health care entities that may have a majority of market share in a region on the patient-doctor relationship; and (2) develop an action plan for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to protect physician practices which are confronted with potentially monopolistic activity by health care entities.

Citation: BOT Rep. 8, I-15

Hospital Merger Study H-215.969

1 It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues:

- (A) medical staff representation on the board of directors;
- (B) clinical services to be offered by the institutions;
- (C) process for approving and amending medical staff bylaws;
- (D) selection of the medical staff officers, medical executive committee, and clinical department chairs;
- (E) credentialing and recredentialing of physicians and limited licensed providers;
- (F) quality improvement;
- (G) utilization and peer review activities;
- (H) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
- (I) conflict resolution mechanisms;

(J) the role, if any, of medical directors and physicians in joint ventures;

(K) control of medical staff funds;

(L) successor-in-interest rights;

(M) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and

2. Our AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.

Citation: CMS Rep. 5, I-01; Reaffirmed: CMS Rep. 7, A-11; Appended: Res. 3, I-13; Reaffirmed: CMS Rep. 07, A-19

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

Citation: Res. 299, A-12; Reaffirmed: Res. 206, A-19

Health System Consolidation D-215.984

Our AMA will: (1) study nationwide health system and hospital consolidation in order to assist policymakers and the federal government in assessing healthcare consolidation for the benefit of patients and physicians who face an existential threat from healthcare consolidation; and (2) regularly review and report back on these issues to keep the House of Delegates apprised on relevant changes that may impact the practice of medicine, with the first report no later than the 2023 Annual Meeting.

Citation: Res. 702, A-22

RESOLUTIONS - BY SPONSOR (A-23)

Albert L. Hsu, MD, Delegate

- 247* Assessing the Potentially Dangerous Intersection Between AI and Misinformation
 - 430* Teens and Social Media
-

American Academy of Child and Adolescent Psychiatry

- 006 Ensuring Privacy as Large Retail Settings Enter Healthcare
 - 217 Increase Access to Naloxone in Schools Including by Allowing Students to Carry Naloxone in Schools
 - 421 Prescribing Guided Physical Activity for Depression and Anxiety
 - 422 National Emergency for Children
 - 513 Substance Use History is Medical History
 - 514 Adolescent Hallucinogen-Assisted Therapy Policy
-

American Academy of Dermatology

- 111* Potential Negative Consequences of ACOs
 - 234* Medicare Physician Fee Schedule Updates and Grassroots Campaign
-

American Academy of Hospice and Palliative Medicine

- 713* Redesigning the Medicare Hospice Benefit
 - 714* Improving Hospice Program Integrity
-

American Academy of Pediatrics

- 109 Improved Access to Care For Patients in Custody of Protective Services
 - 216 Improved Foster Care Services for Children
 - 419 Increased Suicide Risk for Children, Youths, and Young Adults in the Welfare System
 - 420 Foster Health Care
 - 424 Job Security Related to Leave for Caregiver When a Child in Foster Care is Placed in Their Home
-

American Academy of Physical Medicine and Rehabilitation

- 512 Wheelchairs on Airplanes
 - 604 Speakers Task Force to Review and Modernize the Resolution Process
 - 707 Expediting Repairs for Power and Manual Wheelchairs
-

American Association of Clinical Urologists

- 201 Pharmacists Prescribing for Urinary Tract Infections
-

American Association of Neurological Surgeons

- 715* Published Metrics for Hospitals and Hospital Systems
 - 716* Transparency and Accountability of Hospitals and Hospital Systems
-

American Association of Public Health Physicians

- 244* Recidivism
- 429* Promoting the Highest Quality of Healthcare and Oversight for Those Involved in the Criminal Justice System

American College of Cardiology

236* AMA Support for Nutrition Research

American College of Chest Physicians

112* Removal of Barriers to Care for Lung Cancer Screening in Medicaid Programs

717* Improving Patient Access to Supplemental Oxygen Therapies

American College of Emergency Physicians

235* EMS as an Essential Service

American College of Gastroenterology

708 UnitedHealthcare Comprehensive Prior Authorization for Gastrointestinal Endoscopy Procedures

American College of Rheumatology

610# NIH Public Access Plan

American College of Surgeons

254* Eliminating the Party Statement Exception in Quality Assurance Proceedings

American Society for Gastrointestinal Endoscopy

721* Use of Artificial Intelligence for Prior Authorization

American Society for Metabolic and Bariatric Surgery

224 Advocacy Against Obesity-Related Bias by Insurance Providers

American Society for Surgery of the Hand

256* Regulating Misleading AI Generated Advice to Patients

504 Moved to Reference Committee B - Now Resolution 256

American Society of Addiction Medicine

008* Study on the Criminalization of the Practice of Medicine

American Thoracic Society

225* Regulation of “Cool/Non-Menthol” Tobacco Products

518* Defending NIH funding of Animal Model Research From Legal Challenges

Arizona

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

Association for Clinical Oncology

- 245* Biosimilar/Interchangeable Terminology
 - 246* Modification of CMS Interpretation of Stark Law
 - 522* Approval Authority of the FDA
 - 720* Prior Authorization Costs, AMA Update to CMS
-

California

- 237* Prohibiting Covenants Not-To-Compete in Physician Contracts
-

Delaware

- 427* Minimizing the Influence of Social Media on Gun Violence
-

District of Columbia

- 108 Sustainable Reimbursement for Community Practices
-

Endocrine Society

- 223 Protecting Access to Gender Affirming Care
-

Georgia

- 113* Cost of Insulin
 - 255* Moved to Reference Committee D - Now Resolution 432
 - 432# Correctional Medicine
 - 606* AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternate Delegates
 - 718* Insurance Coverage of FDA Approved Medications and Devices
-

GLMA: Health Professionals Advancing LGBTQ+ Equality

- 519* Rescheduling or Descheduling Testosterone

Illinois

- 013* Serial (Repeated) Sperm Donors
 - 114* Physician and Trainee Literacy of Healthcare Costs
 - 115* Advocating for All Payer Coverage of Wigs for Patients Undergoing Treatment for Cancer
 - 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
 - 316* Physician Medical Conditions and Questions on Applications for Medical Licensure, Specialty Boards, and Institutional Privileges
 - 317* Supporting Childcare for Medical Residents
 - 318* Fostering Pathways for Resident Physicians to Pursue MBA Programs in Order to Increase the Number of Qualified Physicians for Healthcare Leadership Positions
 - 520* Supporting Access to At-Home Injectable Contraceptives
 - 521* Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs
 - 608* Supporting Carbon Offset Programs for Travel for AMA Conferences
 - 719* Care Partner Access to Medical Records
-

Indiana

- 248* Supervised Consumption Sites
 - 249* Restrictions on Social Media Promotion of Drugs
 - 250* Medicare Budget Neutrality
 - 523* Reducing Youth Abuse of Dextromethorphan
-

Integrated Physician Practice Section

- 118# Advancing Acute Care at Home
-

International Medical Graduates Section

- 313 Filtering International Medical Graduates During Residency or Fellowship Applications
 - 314 Support for International Medical Graduates from Turkey
 - 605 Equity and Justice Initiatives for International Medical Graduates
-

Maryland

- 251* Federal Government Oversight of Augmented Intelligence
 - 252* Strengthening Patient Privacy
-

Matthew D. Gold, M.D., Delegate

- 607* Enabling Sections of the American Medical Association

Medical Student Section

- 001 Opposing Mandated Reporting of LGBTQ+ Status
- 002 Exclusion of Race and Ethnicity in the First Sentence of Case Reports
- 003 Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
- 004 Amending Policy H-525.988, “Sex and Gender Differences in Medical Research”
- 005 Providing Culturally and Religiously Sensitive Attire Options at Hospitals for Patients and Employees
- 102 Reforming the Medicare Part B “Buy and Bill” Process to Encourage Biosimilar Use
- 103 Movement Away from Employer-Sponsored Health Insurance
- 104 Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment
- 105 Studying Population-Based Payment Policy Disparities
- 106 Billing for Traditional Healing Services
- 107 Reducing the Cost of Centers for Medicare and Medicaid Services Limited Data Sets for Academic Use
- 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
- 215 Supporting Legislative and Regulatory Efforts Against Fertility Fraud
- 259# Strengthening Supplemental Nutrition Assistance Program (SNAP)
- 304 Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement
- 305 Indian Health Service Graduate Medical Education
- 306 Increased Education and Access to Fertility Resources for U.S. Medical Students
- 307 Amending Access to Confidential Health Services for Medical Students and Physicians H-295.858 to Include Annual Opt-Out Mental Health Screening for Suicide Prevention for Residents
- 308 Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants
- 309 Against Legacy Preferences as a Factor in Medical School Admissions
- 310 Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System of Accreditation
- 311 Residency Application Support for Students of Low-Income Backgrounds
- 312 Indian Health Service Licensing Exemptions
- 403 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 404 Additional Interventions to Prevent Human Papillomavirus (HPV) infection and HPV-Associated Cancers
- 405 Amendment to AMA Policy “Firearms and High-Risk Individuals H-145.972” to Include Medical Professionals as a Party Who Can Petition the Court
- 406 Increase Employment Services Funding for People with Disabilities
- 407 Addressing Inequity in Onsite Wastewater Treatment
- 408 School-to-Prison Pipeline

- 409 Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training
 - 410 Formal Transitional Care Program for Children and Youth with Special Health Care Needs
 - 411 Protecting Workers During Catastrophes
 - 412 Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal
 - 413 Supporting Intimate Partner and Sexual Violence Safe Leave
 - 414 Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population
 - 415 Environmental Health Equity in Federally Subsidized Housing
 - 416 New Policies to Respond to the Gun Violence Public Health Crisis
 - 418 Increasing the Availability of Automated External Defibrillators
 - 434# Improving Hazardous Chemical Transport Regulations for Public Health Protections
 - 501 AMA Study of Chemical Castration in Incarceration
 - 502 Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures
 - 503 Increasing Diversity in Stem Cell Biobanks and Disease Models
 - 505 Improving Access to Opioid Antagonists for Vulnerable and Underserved Populations
 - 506 Moved to Reference Committee F - Now Resolution 609
 - 507 Recognizing the Burden of Rare Disease
 - 508 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
 - 509 Addressing Medical Misinformation Online
 - 510 Comparative Effectiveness Research
 - 511 Regulation of Phthalates in Adult Personal Sexual Products
 - 602 Supporting the Use of Gender-Neutral Language
 - 603 Environmental Sustainability of AMA National Meetings
 - 609* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
 - 701 Reconsideration of the Birthday Rule
 - 702 Providing Reduced Parking for Patients
 - 703 Tribal Health Program Electronic Health Record Modernization
 - 704 Interrupted Patient Sleep
 - 706 Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis
 - 709 Hospital Bans on Trial of Labor After Cesarean
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 - 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
 - 315* Prohibit Discriminatory ERAS® Filters In NRMP Match
 - 710* Protect Patients with Medical Debt Burden
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- 009* Racism - A Threat to Public Health
- 232* Supervised Injection Facilities (SIFs) Allowed by Federal Law
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 - 319* Supporting Diversity, Equity, & Inclusion Offices and Initiatives at United States Medical Schools to Enhance Longitudinal Community Engagement
 - 320* Banning Affirmative Action is a Critical Threat to Health Equity and to the Medical Profession
 - 431* Qualified Immunity Reform
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- 007 Independent Medical Evaluation
 - 220 Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations
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- 724# Rural Hospital Payment Models

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 - 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
 - 302 Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations
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 - 323# Amend Policy D-275.948, “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”
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 - 417 Treating Social Isolation and Loneliness as a Social Driver of Health
 - 516 Fasting is Not Required for Lipid Analysis
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- 117# Payment for Physicians who Practice Street Medicine
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- 011* Rights of the Developing Baby
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- 101 Updating Physician Job Description for Disability Insurance
- 120# Supporting Permanent Reimbursement of Acute Hospital Care at Home
- 402 Encouraging Discussion of Family Planning Counseling as Part of Recommended Routine Health Maintenance

**Contained in the Handbook Addendum*

#Contained in the Saturday Handbook