

# REFERRAL CHANGES AND OTHER REVISIONS

## 2024 Annual Meeting

### WITHDRAWN RESOLUTIONS

- Res. 010 – Supporting the Health of Our Democracy
- Res. 011 – Voter Protections During and After Incarceration

### REVISED REPORTS

- BOT 31 – The Morrill Act and its Impact on the Diversity of the Physician Workforce

### RESOLUTIONS WITH ADDITIONAL SPONSORS

(Additional sponsors underlined)

- Res. 226 – Protecting Access to IVF Treatment  
(Missouri, Endocrine Society)
- Res. 230 – Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion  
(American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Contact Dermatitis Society and American College of Mohs Surgery, American Society of Plastic Surgeons, American Academy of Facial Plastics and Reconstructive Surgery, The Aesthetic Society)
- Res. 428 – Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals  
(New England, Endocrine Society)
- Res. 430 – Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages  
(New England, The American Society for Radiation Oncology, Association for Clinical Oncology, The American College of Surgeons)

**ORDER OF BUSINESS  
SECOND SESSION**

**Saturday, June 8, 2024  
12:30 PM**

- 1. Call to Order by the Speaker – Lisa Bohman Egbert, MD**
- 2. Report of the Rules and Credentials Committee – Carlos Zapata, MD**
- 3. Presentation Correction and Adoption of Minutes from the November 2023 Interim Meeting**
- 4. Referral Changes and Other Revisions**
- 5. Acceptance of Business**

**--REPORTS--**

**Report(s) of the Board of Trustees - Willie Underwood, III, MD, MSc, MPH, Chair**

- 01 Annual Report
- 02 New Specialty Organizations Representation in the House of Delegates
- 04 AMA 2025 Dues
- 09 Council on Legislation Sunset Review of 2014 House P
- 11 Safe and Effective Overdose Reversal Medications in Educational Settings
- 13 Prohibiting Covenants Not-to-Compete
- 14 Physician Assistant and Nurse Practitioner Movement Between Specialties
- 15 Augmented Intelligence Development, Deployment, and Use in Health Care
- 16 Support for Mental Health Courts
- 17 Drug Policy Reform
- 18 Supporting Harm Reduction
- 19 Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication
- 21 American Medical Association Meeting Venues and Accessibility
- 23 United States Professional Association for Transgender Health Observer Status in the House of Delegates
- 25 Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences
- 26 Equity and Justice Initiatives for International Medical Graduates
- 28 Encouraging Collaboration Between Physicians and Industry in AI Development
- 29 Transparency and Accountability of Hospitals and Hospital Systems
- 30 Proper Use of Overseas Virtual Assistants in Medical Practice
- 31 The Morrill Act and Its Impact on the Diversity of the Physician Workforce
- 33 Employed Physicians
- 35 Mitigating the Cost of Medical Student Participation in AMA Meetings
- 36 Specialty Society Representation in the House of Delegates - Five-Year Review

**Report(s) of the Council on Ethical and Judicial Affairs - David A. Fleming, MD, Chair**

- 01 Short-Term Global Health Clinical Encounters
- 02 Research Handling of De-Identified Patient Data (D-315.969)
- 03 Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
- 04 Physicians' Use of Social Media for Product Promotion and Compensation
- 05 CEJA's Sunset Review of 2014 House Policies

**Report(s) of the Council on Long Range Planning and Development - Gary Thal, MD, Chair**

- 01 Establishment of a LGBTQ+ Section

**Report(s) of the Council on Medical Education - Cynthia Jumper, MD, MPH, Chair**

- 01 Council on Medical Education Sunset Review of 2014 House of Delegates' Policies
- 02 The Current Match Process and Alternatives

**Report(s) of the Council on Medical Service - Sheila Rege, MD, Chair**

- 01 Council on Medical Service Sunset Review of 2014 House Policies
- 02 Improving Affordability of Employment-Based Health Coverage
- 03 Review of Payment Options for Traditional Healing Services
- 05 Patient Medical Debt
- 06 Economics of Prescription Medication Prior Authorization
- 07 Ensuring Privacy in Retail Health Care Settings
- 08 Sustainable Payment for Community Practices

**Report(s) of the Council on Science and Public Health - David J. Welsh, MD, MBA, Chair**

- 01 Council on Science and Public Health Sunset Review of 2014 House Policies
- 02 Comparative Effectiveness Research
- 03 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders
- 04 Sex and Gender Differences in Medical Research
- 05 Biosimilar/Interchangeable Terminology
- 06 Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases
- 07 Androgen Deprivation in Incarceration
- 08 Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing
- 09 Prescribing Guided Physical Activity for Depression and Anxiety
- 10 Teens and Social Media
- 11 Stand Your Ground Laws
- 12 Universal Screening for Substance Use and Substance Use Disorders during Pregnancy
- 13 Decreasing Youth Access to E-Cigarettes

**Report(s) of the HOD Committee on Compensation of the Officers-Claudette Dalton, MD, Chair**

- 01 Compensation Committee Report

**Joint Report(s)**

- 01 Joint Council Sunset Review of 2014 House Policies

**Report(s) of the Speakers - Lisa Bohman Egbert, MD, Speaker; John H. Armstrong, MD, Vice Speaker**

- 01 Report of the Resolution Modernization Task Force Update

**--EXTRACTION OF INFORMATIONAL REPORTS--**

**BOT Report(s)**

- 03 2023 Grants and Donations
- 05 Update on Corporate Relationships
- 06 Redefining AMA's Position on ACA and Health Care Reform
- 07 AMA Performance, Activities, and Status in 2023
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2023 through February 2024
- 10 American Medical Association Health Equity Annual Report
- 12 AMA Efforts on Medicare Payment Reform
- 20 Criminalization of Providing Medical Care
- 22 AMA Public Health Strategy: Update
- 24 Report on the Preservation of Independent Medical Practice
- 27 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates
- 32 Independent Medical Evaluation
- 34 Demographic Report of the House of Delegates and AMA Membership

**CEJA Opinion(s)**

- 06 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

**CLRPD Report(s)**

- 02 Scenarios on Collective Action and Physician Unions

**CMS Report(s)**

- 04 Health System Consolidation

**Report(s) of the Speakers**

- 02 Report of the Election Task Force 2
- 03 Updated Parliamentary Authority

**--INTRODUCTION OF RESOLUTIONS--**

- 001 Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
- 002 Removal of the Interim Meeting Resolution Committee
- 003 Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity
- 004 The Rights of Newborns that Survive Abortion
- 005 AMA Executive Vice President
- 006 Treatment of Family Members
- 007 AMA Supports a Strategy for Eliminating Nuclear Weapons
- 008 Consolidated Health Care Market
- 009 Updating Language Regarding Families and Pregnant Persons
- 010 Withdrawn

- 011 Withdrawn
- 012 Ethical Pricing Procedures that Protect Insured Patients
- 013 Ethical Impetus for Research in Pregnant and Lactating Individuals
- 014 The Preservation of the Primary Care Relationship
- 015 Health and Racial Equity in Medical Education to Combat Workforce Disparities
- 016 Guiding Principles for the Healthcare of Migrants
- 017 Addressing the Historical Injustices of Anatomical Specimen Use
- 018 Opposing Violence, Terrorism, Discrimination, and Hate Speech
- 019 Supporting the Health of Our Democracy
- 020 Voter Protections During and After Incarceration
- 021 Opposition to Capital Punishment
- 022 Health and Racial Equity in Medical Education to Combat Workforce Disparities
- 023\* Change Healthcare Security Lapse—The FBI Must Investigate
- 024\* Augmented Intelligence and Organized Medical Staff
- 101 Infertility Coverage
- 102 Medicaid & CHIP Benefit Improvements
- 103 Medicare Advantage Plans
- 104 Medicaid Estate Recovery Reform
- 105 Medigap Patient Protections
- 106 Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum
- 107 Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies
- 108 Requiring Payments for Physician Signatures
- 109 Coverage for Dental Services Medically Necessary for Cancer Care
- 110 Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses
- 111 Protections for “Guarantee Issue” of Medigap Insurance and Traditional Medicare
- 112 Private and Public Insurance Coverage for Adaptive Sports Equipment including Prostheses and Orthoses
- 113 Support Prescription Medication Price Negotiation
- 114 Breast Cancer Screening/Clinical Breast Exam Coverage
- 115 Payments by Medicare Secondary or Supplemental plans
- 116\* Increase Insurance Coverage for Follow-Up Testing After Abnormal Screening Mammography
- 117\* Insurance Coverage for Gynecologic Oncology Care
- 118\* Public and Private Payer Coverage of Diagnostic Interventions Associated With Colorectal Cancer Screening and Diagnosis
- 201 Research Correcting Political Misinformation and Disinformation on Scope of Practice
- 202 Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims
- 203 Medicaid Patient Accountability
- 204 Staffing Ratios in the Emergency Department
- 205 Medical-Legal Partnerships & Legal Aid Services
- 206 Indian Health Service Youth Regional Treatment Centers
- 207 Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse

208 Improving Supplemental Nutrition Programs  
209 Native American Voting Rights  
210 Support for Physicians Pursuing Collective Bargaining and Unionization  
211 Deceptive Hospital Badging 2.0  
212 Advocacy Education Towards a Sustainable Medical Care System  
213 Access to Covered Benefits with an Out of Network Ordering Physician  
214 Support for Paid Sick Leave  
215 American Indian and Alaska Native Language Revitalization and Elder Care  
216 The AMA Supports H.R. 7225, the Bipartisan “Administrative Law Judges Competitive Service Restoration Act”  
217 Protecting Access to IVF Treatment  
218 Designation of Descendants of Enslaved Africans in America  
219 Bundling for Maternity Care Services  
220 Restorative Justice for the Treatment of Substance Use Disorders  
221 Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability  
222 Studying Avenues for Parity in Mental Health & Substance Use Coverage  
223 Increase in Children’s Hospital Graduate Medical Education Funding  
224 Antidiscrimination Protections for LGBTQ+ Youth in Foster Care  
225 Humanitarian Efforts to Resettle Refugees  
226 Protecting Access to IVF Treatment  
227 Medicare Reimbursement for Telemedicine  
228 Waiver of Due Process Clauses  
229 Opposition to Legalization of Psilocybin  
230 Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion  
231 Supporting the Establishment of Rare Disease Advisory Councils  
232 Medicare Advantage Part B Drug Coverage  
233 Prohibiting Mandatory White Bagging  
234 State Prescription Drug Affordability Boards - Study  
235 Establish a Cyber-Security Relief Fund  
236 Support of Physicians Pursuing Collective Bargaining and Unionization  
237 Encouraging the Passage of the Preventive Health Savings Act (S.114)  
238 AMA Supports Efforts to Fund Overdose Prevention Sites  
239 Requiring stores that sell tobacco products to display NYS Quitline information  
240 Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas  
241 Healthcare Cybersecurity Breaches  
242 Cancer Care in Indian Health Services Facilities  
243 Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes  
244 Graduate Medical Education Opportunities for American Indian and Alaska Native Communities  
245\* Patient Access to Covered Benefits Ordered by Out-of-Network Physicians  
246\* Augmented Intelligence in Health Care  
247\* Prohibit Health Benefit Plans From Charging Cost Sharing for Covered Prostate Cancer Screening  
248\* Sustain Funding for HRSA (Health Resources Services and Administration) 340B Grant-Funded Programs

- 249\* Pediatric Specialty Medicaid Reimbursement
- 250\* Endorsement of the Uniform Health-Care Decisions Act
- 251\* Streamline Payer Quality Metrics
- 252\* Model Legislation to Protect the Future of Medicine
- 253\* Addressing the Failed Implementation of the No Surprises Act IDR Process
- 301 Fairness for International Medical Students
- 302 The Role of Maintenance of Certification
- 303 Amend Policy D-275.948 Title “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”. Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards.
- 304 Spirituality in Medical Education and Practice
- 305 Public Service Loan Forgiveness Reform
- 306 Unmatched Graduating Physicians
- 307 Access to Reproductive Health Services When Completing Physician Certification Exams
- 308 Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being
- 309 Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine
- 310 Accountability & Transparency in GME funding with Annual Report
- 311 Physician Participation in Healthcare Organizations
- 312 AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians
- 313 CME for Rural Preceptorship
- 314 Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule
- 315 Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations
- 316 Reassessment of Continuing Board Certification Process
- 317 Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians
- 318 Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care
- 319 AMA Support of U.S. Pathway Programs
- 320\* Anti-Racism Training for Medical Students and Medical Residents
- 401 Addressing Social Determinants of Health Through Closed Loop Referral Systems
- 402 Guardianship and Conservatorship Reform
- 403 Occupational Screenings for Lung Disease
- 404 Protections Against Surgical Smoke Exposure
- 405 Default Proceed Firearm Sales and Safe Storage Laws
- 406 Opposition to Pay-to-Stay Incarceration Fees
- 407 Racial Misclassification
- 408 Indian Water Rights
- 409 Toxic Heavy Metals
- 410 Access to Public Restrooms
- 411 Missing and Murdered Indigenous Persons

412 Lithium Battery Safety  
413 Sexuality and Reproductive Health Education  
414 Addressing the Health Sector's Contributions to the Climate Crisis  
415 Building Environmental Resiliency in Health Systems and Physician Practices  
416 Furthering Environmental Justice and Equity  
417 Reducing Job-Related Climate Risk Factors  
418 Early and Periodic Eye Exams for Adults  
419 Addressing the Health Risks of Extreme Heat  
420 Equity in Dialysis Care  
421 Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)  
422 Immunization Registry  
423 HPV Vaccination to Protect Healthcare Workers over Age 45  
424 LGBTQ+ Senior Health  
425 Perinatal Mental Health Disorders among Medical Students and Physicians  
426 Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action  
427 Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals  
428 Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals  
429 Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants  
430 Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages  
431 Combatting the Public Health Crisis of Gun Violence  
432 Resolution to Decrease Lead Exposure in Urban Areas  
433 Improving Healthcare of Rural Minority Populations  
434\* Universal Newborn Eye Screening  
435\* Radiation Exposure Compensation  
501 Fragrance Regulation  
502 Tribally-Directed Precision Medicine Research  
503 Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)  
504 FDA Regulation of Biosimilars  
505 Mitigating the Harms of Colorism and Skin Bleaching Agents  
506 Screening for Image Manipulation in Research Publications  
507 Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies  
508 AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis  
509 Addressing Sarcopenia and its Impact on Quality of Life  
510 Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and "Natural Cures"  
511 National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling  
512 Opioid Overdose Reversal Agents Where AED's Are Located  
513 Biotin Supplement Packaging Disclaimer  
514\* Safety With Devices Producing Carbon Monoxide



- 515\* Advocacy for More Stringent Regulations/Restrictions on the Distribution of Marijuana
- 601 Annual Holocaust Remembrance Event
- 602 Ranked Choice Voting
- 603 End Attacks on Health and Human Rights in Israel and Palestine
- 604 Confronting Ageism in Medicine
- 605 Walking the Walk of Climate Change
- 606 Creation of an AMA Council with a Focus on Digital Health Technologies and AI
- 607 Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health
- 608 The American Medical Association Diversity Mentorship Program
- 609\* Standardization of the Endorsement Process
- 610\* Opposition to Collective Punishment
- 701 Opposition to the Hospital Readmissions Reduction Program
- 702 The Corporate Practice of Medicine, Revisited
- 703 Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation
- 704 Pediatric Readiness in Emergency Departments
- 705 20 Minute Primary Care Visits
- 706 Automatic Pharmacy-Generated Prescription Requests
- 707 Alternative Funding Programs
- 708 Medicolegal Death Investigations
- 709 Improvements to Patient Flow in the U.S. Healthcare System
- 710 The Regulation of Private Equity in the Healthcare Sector
- 711 Insurer Accountability When Prior Authorization Harms Patients
- 712 Full transparency - Explanation of Benefits
- 713 Transparency – non-payment for services to patients with ACA exchange plans with unpaid premiums
- 714\* Automatic Downcoding of Claims
- 715\* Electronic Medical Records Submission
- 716\* Impact of Patient Non-adherence on Quality Scores
- 717\* Mentorship to Combat Prior Authorization
- 718\* Transparency at the Pharmacy Counter
- 719\* Support Before, During, and After Hospital Closure or Reduction in Services
- 720\* The Hazards of Prior Authorization
- 721\* Developing Physician Resources to Optimize Practice Sustainability

\* Contained in the Meeting Tote

## **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. In 2024 the country faces several challenges in health care, including many that directly impact physician practices and their patients. Issues like the yearly threat of cuts to physician Medicare payments, lack of an annual inflationary update under the Medicare Economic Index (MEI), time consuming prior authorizations and sky rocketing prescription drug costs remain as major roadblocks to how physicians provide quality care for their patients. In the face of these ongoing challenges to the medical community we remain steadfast in our commitment to our core 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**

Many thanks to the House of Delegate members who have already demonstrated their support to AMPAC during this election year. We especially appreciate those who generously contributed at the Capitol Club levels. Your generosity will empower AMPAC to advance the advocacy initiatives proposed by the AMA and establish a strong groundwork for our allies and champions in the medical field who are running for federal office in 2024.

This year, AMPAC continues showing growth across all areas. AMPAC's cycle receipts through May 31 are \$1,385,195.58 in total which represents an 8 percent increase compared to the previous election cycle. Specifically, AMPAC's hard dollars have risen by 9 percent. Participation in AMPAC's Capitol Club remains pivotal in ensuring a consistent revenue stream during this election year. In recent weeks there has been solid growth, particularly following the announcement and promotion of the Capitol Club luncheon speaker. Currently, there are 553 members, which is a 2 percent increase compared to the 543 members at this same time last year. We anticipate further growth during this meeting.

Every year, AMPAC aims to achieve 100% participation within the American Medical Association's (AMA) House of Delegates (HOD). In 2023, AMPAC achieved 75% HOD participation, but currently, participation stands at only 44%, which falls well below the target for halfway through an election year. As leaders in the House of Medicine, we strongly encourage HOD members to invest in AMPAC by visiting AMPAC's Booth, conveniently located in the foyer outside the Grand Ballroom during this meeting or by visiting <https://www.ampaonline.org/>

Finally, all current 2024 Capitol Club members are invited to attend a Capitol Club event on Tuesday, June 11 at 12 p.m. with special guest speaker Jon Meacham, Presidential Historian and Pulitzer-Prize winning author. The luncheon is invitation-only for all 2024 Capitol Club members and will take place on Tuesday, June 11 at 12:00 p.m. There will be an additional VIP book signing event at 11:30 a.m. prior to the luncheon for all 2024 Capitol Club Platinum members.

AMPAC serves as the bipartisan political action committee of the AMA, established to advance the advocacy mission outlined by the HOD. Our effectiveness relies on our collective commitment to supporting this

essential political tool and advancing the AMA's advocacy initiatives. We encourage all HOD members to join forces, boost overall AMPAC HOD participation, and help us achieve our \$150,000 goal during this meeting.

### **Political Action**

2024 is shaping up to be an extremely competitive election cycle as control of both the House and Senate hang in the balance. In the closely divided House, the focus will be on the roughly 40-50 House districts considered to be among the most competitive in the country which will determine majority control in the next Congress. These districts stretch across the country from Alaska to Florida, Maine to California. While in the Senate, though thirty-four seats are on the ballot, control of the upper chamber is likely to come down to just seven or eight competitive contests.

AMPAC is taking advantage of this highly contentious landscape by looking at open-seat opportunity races, some of which involve physician candidates, as well as medicine-friendly incumbents to support and further strengthen the relationship with organized medicine. With issues such as prior authorization and Medicare reform showing movement, even in Congress' current, stagnant state, AMPAC contributions are creating critical strategic interactions with those in the best positions to move these key priorities forward.

As AMPAC completed its early giving phase in 2023 and held its Congressional Review Committee process at the beginning of this year, robust contribution activity is now underway. AMPAC has invested well over half a million dollars in the 2024 cycle and expects activities will intensify headed into the summer and the elections in the fall.

### **Political Education Programs**

The 2024 Candidate Workshop took place in-person, March 22-24, at the AMA offices in Washington, DC. Registration for the program was strong with 23 registrants. This included: 19 member physicians and four member residents and students. Of note, three participants were currently running for Congress, including Herb Conaway, MD, a current state legislator who is running in New Jersey's third Congressional district as a democrat and if he emerges from his primary, has a strong chance to win in November.

During the program participants heard from political experts on both sides of the aisle about what it takes to run a winning campaign. This included sessions on the importance of a disciplined campaign plan and message; the secrets of effective fundraising; what kinds of advertising may be right for your campaign; how to work with the media; as well as how to build your campaign team and a successful grassroots organization. The program also included a keynote session with Representative Mariannette Miller-Meeks, MD of Iowa, who shared her stories and insights from the campaign trail as a physician candidate for office.

Promotion is currently underway for the 2024 Campaign School. The program will take place July 25-28 at the AMA offices in Washington, DC. As always, the political education programs remain a member benefit with registration fees heavily discounted for AMA members. Program dates will be announced soon on AMPACOnline.org.

### **Conclusion**

On behalf of the AMPAC Board of Directors, I express gratitude to all House of Delegates members who support AMPAC and our work. Your ongoing engagement in political and grassroots activities strengthens organized medicine's influential voice in Washington, DC.

# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

### **Edward H. Dench, MD**

Introduced by Jill Owens, MD, Pennsylvania Chair; James D. Grant MD MBA FASA,  
American Society of Anesthesiologists

Whereas, Edward H. Dench, MD, of State College, Pennsylvania, born on August 18, 1945, in Philadelphia, Pennsylvania and departed this life on May 9, 2024, at the age of 78, leaving behind a legacy of great dedication and service; and

Whereas, Dr. Dench, lived a life marked by passion and commitment to medicine, aviation, and his community, embodying the virtues of perseverance and thoughtfulness in every aspect of his personal and professional life; and

Whereas, Dr. Dench's academic journey began with his graduation from Penn State University with a B.S. in Aerospace Engineering was followed by an M.D. from the University of Pennsylvania, and continued with a residency at the University of Pennsylvania Hospital; and

Whereas, Dr. Dench's love of Aerospace Medicine led him to the Navy, where he served as a Naval Flight Surgeon and earned the Navy & Marine Corps Medal for daring rescue of a Marine in Kauai; and

Whereas, Dr. Dench served the surrounding State College area as Anesthesiologist and Aviation Medical Examiner for 40 years; and

Whereas, Dr. Dench championed a peer review system for doctors analogous to aviation reporting, prioritizing learning and transparency; and

Whereas, nationally recognized for his leadership, Dr. Dench held influential positions at the Pennsylvania Medical Society, PA Society of Anesthesiologists, and as a recurrent delegate for both the AMA and American Society of Anesthesiologists; and

Whereas, Dr. Dench is survived by his wife Valerie Dench of State College, PA, 5 children and 1 stepchild (Darla, Lana, Edward III, Erin, Robert, and Vanessa), 8 grandchildren, and 3 siblings; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Edward H. Dench's passing with a moment of silence; and be it further

RESOLVED, that our American Medical Association record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Edward H. Dench.

## **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

### **Memorial Resolution**

#### **George R. Green, MD**

Introduced by Jill Owens, MD, Pennsylvania Chair; Steve Tolber, MD,  
American Academy of Allergy, Asthma and Immunology Delegate

Whereas, George R. Green, MD, of Lafayette Hill, Pennsylvania, born on October 14, 1934, in Philadelphia, Pennsylvania and departed this life on January 28, 2024, at the age of 89, leaving behind a legacy of profound dedication, service, and compassion; and

Whereas, Dr. Green, lived a life marked by exceptional contributions to medicine, education, and the community, embodying the virtues of humility, perseverance, and kindness in every aspect of his personal and professional life; and

Whereas, Dr. Green's academic journey, marked by his graduation from the University of Pennsylvania School of Medicine with Alpha Omega Alpha honors, and furthered by his internship and residency at the Hospital of the University of Pennsylvania and the Mayo Clinic respectively, and a fellowship in Allergy and Immunology at the University of Pennsylvania, set a foundation for a career that would impact countless lives; and

Whereas, Dr. Green dedicated over 50 years of service at Abington Memorial Hospital, where he specialized in Internal Medicine and Allergy and Immunology, founding Abington Medical Specialists and serving in numerous leadership roles, including as the Chief of the Division of Allergy and Immunology, Chairman of the Medical Education Committee, and Medical Staff President, thereby significantly advancing the field of healthcare; and

Whereas, nationally recognized for his leadership, Dr. Green held influential positions in the American Academy of Allergy, Asthma and Immunology, the American Medical Association, the Pennsylvania Medical Society, and the Montgomery County Medical Society, recognized as a steadfast patient advocate and a consistent champion of small specialties and independent private practice, as well as quality healthcare; and

Whereas, Dr. Green's scholarly contributions, including seminal research on penicillin hypersensitivity and authorship of pivotal texts, have left an indelible mark on the field of Allergy and Immunology, contributing to the betterment of patient care and medical knowledge; and

Whereas, his commitment to graduate medical education as a volunteer clinical faculty member and Professor of Medicine at the Hospital of the University of Pennsylvania, mentoring countless medical students, residents, and fellows, reflects his unwavering dedication to nurturing the next generation of physicians; and

Whereas, Dr. Green combined medicine with aviation by serving as a FAA medical examiner, volunteering for Angel Flights providing air transportation to those in need, and serving as president of the northeast chapter of Flying Physician Association; and

Whereas, Dr. Green is survived by his wife Trudy Green of Lafayette Hill PA, 4 children (George Jr, Trudy, Matthew, and David) and 8 grandchildren; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Green's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. George R Green.

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

## Memorial Resolution

### Jeffrey Kaufman, MD, FACS

Introduced by American Association of Clinical Urologists,  
American Urological Association

Whereas, Dr. Jeffrey Kaufman 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 from 2008-2014; and

Whereas, Jeffrey received his undergraduate degree with honors from UCLA before obtaining his M.D. from the University of Southern California. After two years of training in general surgery, he completed his urology residency at the University of California, San Diego. Following a pediatric urology fellowship at Children's Hospital of Michigan, he returned to Orange County, California where he began his private practice in general urology with a teaching affiliation at the University of California, Irvine. Over the past 34 years, he developed a deep interest in the socioeconomic and health policy aspects of urology and participated in several leadership roles; and

Whereas, Dr. Kaufman served as president of the American Association of Clinical Urologists, president of the Western Section AUA, Chief of Staff at Western Medical Center-Santa Ana, president of the Orange County Urological Society, president of the California Urologic Association, and as a member of the UROPAC Board of Directors; and

Whereas, Dr. Kaufman was awarded the AUA's Distinguished Service Award for *decades of outstanding leadership and service to the AUA's Western Section, the AUA Board of Directors and health policy advocacy*; and

Whereas; Jeffrey leaves behind his wife Linda of 47 years, daughters Jennifer & Lindsay, and grandchildren Ezra, Aaron, Isla, Kaia, and Bodhi. His family writes: "*This dear man, with such a passion for life, who did everything to the fullest extent, and had an impact on so many, will be deeply missed*"; therefore be it

RESOLVED, that our American Medical Association House of Delegates recognize the many contributions made by Dr. Jeffrey Kaufman to the medical profession as well as the Urological community; and be it further

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

# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

**Craig Kliger, MD**

Introduced by the California Medical Association

Whereas, Craig Kliger, MD, was a respected colleague who served patients and his profession as a Delegate to the American Medical Association since 1985, serving on the Council on Ethical and Judicial Affairs during his residency, and was recently appointed to the AMA CPT Editorial Board for his expertise in coverage, payment, and coding issues; and

Whereas, Dr. Kliger served as a dedicated Trustee and Delegate to the California Medical Association and is known for his decade-long leadership on CMA's Council on Medical Services where he guided the association through many difficult medical practice issues; and

Whereas, Dr. Kliger was a fellowship trained cornea specialist who devoted his career to advocacy, becoming one of the rare physicians to lead a professional society as the Executive Vice President of the California Academy of Eye Physicians and Surgeons (CAEPS) for eighteen years where he championed the profession and patient safety; and

Whereas, Dr. Kliger was honored by the American Academy of Ophthalmology many times including receiving the highest level of recognition in 2022 - the Outstanding Advocate Award – for his gifts as a writer, strategist, and leader who grew the state society and its PAC, developed an effective overall advocacy and key contact program, and built coalitions that culminated in the defeat of a major scope of practice expansion against surgical privileges for optometrists in the California Legislature; and

Whereas, Dr. Kliger was instrumental in establishing the Shulman Fellowship program in 2006 where every ophthalmology residency program in California would send young ophthalmologists to participate in the American Academy of Ophthalmology Congressional Advocacy Day which built a strong legacy of advocacy among ophthalmologists to protect patients and the profession; He also expanded public education in California and continuing medical education for ophthalmologists; and

Whereas, Dr. Kliger was widely recognized for his ability to work through complex issues in a fair manner, such as using his extensive knowledge and expertise in coding and reimbursement issues to actively engage with third-party payers and Noridian, the Medicare Contractor, to protect physician practices and patient access to medical care; and

Whereas, Dr. Craig Kliger, MD passed away on April 16, 2024, at the young age of 62 and will be missed for his dry sense of humor, attention to detail and organization, tenacity, and tireless leadership to protect patients and improve the profession for all physicians; therefore be it

RESOLVED, That our American Medical Association express the utmost respect for Craig Kliger, MD, and honor his legacy of advocacy and devotion to patients, and the profession he loved and served with dedication.



# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

### **Robert E. McAfee, MD**

Introduced by Richard A. Evans, MD, Delegate, and Maroulla Gleaton, MD,  
Delegate on behalf of the Maine Delegation

Whereas, Robert E. McAfee MD, passed away on December 16, 2023, in Portland, Maine;

Whereas, Dr. McAfee was a general and vascular surgeon who practiced in Portland, Maine, his hometown. He received his B.S. degree from Bates College and his M.D. degree from Tufts University School of Medicine in 1960. Dr. McAfee completed his internship and surgical residency at the Maine Medical Center (MMC) in 1965, and was attending surgeon at MMC for 31 years as well as Chief of Surgery and Vascular Surgery at Mercy Hospital; and

Whereas, Dr. McAfee was elected President-Elect of the American Medical Association (AMA) in June 1993 and served as the 149<sup>th</sup> President of the AMA from June 1994 to June 1995. Long active in organized medicine, Dr. McAfee was past president of the Maine Medical Association and the Cumberland County Medical Society, and held many leadership roles; and

Whereas, Dr. McAfee served as Vice Chair of the AMA's Board of Trustees from 1990 to 1992 and was a member of the Executive Committee of the Board from 1988 to 1992. He served as an AMA Commissioner to the Joint Commission on Accreditation of Healthcare Organizations from 1986 to 1992 and was President of the AMA Education and Research Foundation from 1986 to 1988; and

Whereas, Dr. McAfee took an active role in community, state and national health care issues, focusing his attention on family violence. He was appointed to the American Bar Association's Commission on Domestic Violence; served on the Advisory Committee to the Attorney General and the Secretary of the Department of Health and Human Services in the Clinton administration; was a member of the Center for Disease Control and Prevention Advisory Committee for Injury Prevention and Control and its Subcommittee on Violence; served on the National Advisory Committee of the Family Violence Defense Fund and was the founding chair of the Physician's Coalition Against Family Violence representing twenty three physician specialty organizations; and

Whereas, Dr. McAfee received several honorary degrees and many awards including the Maine Medical Association's 2022 President's Award for Distinguished Service, and in 2012 was recognized by the Daniel Hanley Center for Health Leadership for his "lifetime of extraordinary leadership in Maine and the nation"; and therefore be it

RESOLVED, that the House of Delegates recognize Dr. McAfee's passing with a moment of silence; and be it further

RESOLVED, that this resolution be recorded and presented to Dr. McAfee's family.

# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

### **Edith P. Mitchell, MD**

Introduced by Jill Owens, MD, Pennsylvania Chair; AMA Minority Affairs Section,  
National Medical Association; Steve Young Lee, MD, FACP,  
Association for Clinical Oncology (ASCO) Delegation Chair

Whereas, Edith P. Mitchell, MD, FCPP, FRCP, MACP, born on November 20, 1947, in Brownsville, Tennessee and departed this life unexpectedly on January 21, 2024, at the age of 76, leaving behind a legacy of profound compassion, trailblazing, and impact; and

Whereas, Dr. Mitchell, lived a life marked by exceptional contributions to innovation, equity, and the community, embodying the virtues of determination, excellence, and compassion in every aspect of her personal and professional life; and

Whereas, Dr. Mitchell's academic journey, marked by her graduation from the Medical College of Virginia (now Virginia Commonwealth University) as the only black female in attendance, furthered by her service to the United States Air Force, and followed by an internship and residency in internal medicine at Meharry Medical College, simultaneously a member of Alpha Kappa Alpha, set a foundation for a career that would impact the practice of medicine and countless lives; and

Whereas, Dr. Mitchell's early career at the University of Missouri led her to be awarded the 1991 Distinguished Service Award, and was followed by her work to provide safe drinking water and hepatitis vaccine administration which led to her appointment in 1993 as the Missouri Surgeon General and later the first black female to be promoted to Brigadier general in the Missouri Air National Guard; and

Whereas, Dr. Mitchell joined the faculty of medicine and medical oncology as associate director of Diversity Programs for the Sidney Kimmel Comprehensive Cancer Center at Thomas Jefferson University in Philadelphia, PA, after retiring from the United States Air Force, where she conducted research into pancreatic cancer that led to innovative care including new drug evaluation, chemotherapy, and therapeutic regimens; and

Whereas, Dr. Mitchell's work at Thomas Jefferson University was commemorated with numerous awards including the American Cancer Society Cancer Control Award, National Medical Association Council on Concerns of Women Physicians Pfizer Research Award, Physician of the Year by CancerCare, Practitioner of the Year from Philadelphia County Medical Society, and the Distinguished Service Award from the Pennsylvania Medical Society; and

Whereas, Dr. Mitchell's relentless pursuit to eliminate health disparities, expand minority participation in clinical trials, and improve care for her patients led her to establish the Center to Eliminate Cancer Disparities within Jefferson, present advice and opinions to the Congressional Black Caucus, and later serve on President Biden's Cancer Moonshot Initiative panel; and

Whereas, Dr. Mitchell served the American Medical Association proudly as a National Medical Association Delegate; and

Whereas, Dr. Mitchell dutifully served as the National Medical Association Representative on the AMA Minority Affairs Section Governing Council from June 2016 to June 2019; and

Whereas, Dr. Mitchell is predeceased by her husband, Delmar, and survived by her two daughters; therefore be it

RESOLVED, that our American Medical Association recognize Dr. Mitchell's passing with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and a copy of this resolution be sent to the family of Dr. Edith P. Mitchell.

# **AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES**

## **Memorial Resolution**

**John Neeld, MD**

Introduced by American Society of Anesthesiologists, Medical Association of Georgia

Whereas, Dr. Neeld was a revered and dedicated member of the medical community, known for his unwavering commitment to excellence, compassionate care, and leadership; and

Whereas, Dr. Neeld as a distinguished anesthesiologist in private practice, whose skilled hands and compassionate demeanor brought comfort and healing to countless patients over the years; and

Whereas, Dr. Neeld served with unparalleled devotion as President of the American Society of Anesthesiologists and the Chair of the Anesthesiology section council at the American Medical Association (AMA), where his leadership was instrumental in shaping policies and initiatives that advanced the field of anesthesiology and improved patient care nationwide; and

Whereas, Dr. Neeld also served as the Chair of AMPAC, demonstrating exceptional leadership in advocating for the interests of physicians and patients; and

Whereas, Dr. Neeld leaves behind a legacy of professionalism, integrity, and dedication that will continue to inspire and guide us all; therefore be it

RESOLVED, that our American Medical Association honor the memory of Dr. Neeld and express our deepest gratitude for his invaluable contributions to the field of medicine; and be it further

RESOLVED, that his legacy live on in the hearts and minds of all who had the privilege of knowing him, and may his spirit of excellence and compassion continue to inspire future generations of physicians.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

**Memorial Resolution**

**Donald E. Parlee, MD**

Introduced by Jill Owens, MD, Pennsylvania Chair; Virginia Hall, MD;  
AMA Delegate and Chair of the Foundation of the Pennsylvania Medical Society

Whereas, physicians lost a beloved mentor and dedicated leader of our profession in the passing of Donald E. Parlee, MD, on March 21, 2024; and

Whereas, Dr. Parlee earned his medical degree from the Lewis Katz School of Medicine at Temple University in 1959 and completed his residency in diagnostic radiology at the University of Pennsylvania Health System in 1963; and

Whereas, Dr. Parlee enjoyed a 43-year career as a board-certified radiologist at Doylestown Hospital where he helped to grow the hospital's radiology department from one to 20 radiologists, serving as its chief for 25 years, and established its School of Radiologic Technology where he was fondly known for his gentle teaching style; and

Whereas, Dr. Parlee was a recognized physician leader and held prominent positions including President and then Secretary of the Bucks County Medical Society, Vice Chair of the Foundation of the Pennsylvania Medical Society, decades as Delegate to the Pennsylvania Medical Society, and, for 10 years, PAMED Delegate to the American Medical Association; and

Whereas, Dr. Parlee served as volunteer trustee for The Foundation of the Pennsylvania Medical Society for 13 years and generously supported its mission through his relationship with the Eden Charitable Foundation; and

Whereas, for his steadfast advocacy for physicians and patients, Dr. Parlee received the R. William Alexander MD Award for grassroots and political advocacy from the Pennsylvania Medical Political Action Committee; and

Whereas, from 1966-1968, Dr. Parlee served his country in Vietnam as a radiologist for the U.S. Army, earning him a Bronze Star; and

Whereas, Dr. Parlee's legacy will endure through his renowned generous philanthropy to charities for healthcare, education, and nature, as well as his esteemed leadership; therefore be it

RESOLVED, that our American Medical Association recognizes the outstanding contributions of Donald E. Parlee, MD, to the profession of medicine with a moment of silence; and be it further

RESOLVED, that our AMA record this resolution in the minutes and that the AMA extend condolences to his wife Joan and their family.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

### Supplementary Report of Committee on Rules and Credentials (A-24)

Presented by: L. Carlos Zapata, MD, Chair

Saturday, June 8, 2024

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Madam Speaker, Members of the House of Delegates:

#### (1) LATE RESOLUTIONS

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

#### Recommended for acceptance:

- Late 1003 - The HRSA – Organ Procurement and Transplantation Network (OPTN) Modernization Initiative
- Late 1004 - Regulation of Nicotine Analogue Products

#### Recommended against acceptance:

- Late 1001 - National Shortages of Stimulant Medication
- Late 1002 - Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS

#### (2) REAFFIRMATION RESOLUTIONS

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

- Resolution 203 – Medicaid Patient Accountability
- Resolution 207 – Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse
- Resolution 211 – Deceptive Hospital Badging 2.0
- Resolution 213 – Access to Covered Benefits with an Out of Network Ordering Physician
- Resolution 221 – Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability
- Resolution 228 – Waiver of Due Process Clauses
- Resolution 237 – Encouraging the Passage of the Preventive Health Savings Act (S.114)

- Resolution 240 – Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas
- Resolution 241 – Healthcare Cybersecurity Breaches
- Resolution 244 – Graduate Medical Education Opportunities for American Indian and Alaska Native Communities
- Resolution 311 – Physician Participation in Healthcare Organizations
- Resolution 413 – Sexuality and Reproductive Health Education
- Resolution 431 – Combatting the Public Health Crisis of Gun Violence
- Resolution 508 – AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis
- Resolution 510 – Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”
- Resolution 512 – Opioid Overdose Reversal Agents Where AED’s Are Located
- Resolution 712 – Full Transparency – Explanation of Benefits
- Resolution 713 – Transparency – Non-Payment for Services to Patients with ACA Exchange Plans with Unpaid Premiums
- Resolution 715 – Electronic Medical Records Submission

Madam Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Mark Bair, MD; Mary Ann Contogiannis, MD; Kyle Edmonds, MD; James W. Thomas, MD, MBA; David Savage, MD, PhD; Jason Schneider, MD; and on behalf of the committee those who appeared before the committee.

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Mark Bair, MD  
Utah

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Mary Ann Contogiannis, MD  
North Carolina

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Kyle Edmonds, MD  
California

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James W. Thomas, MD, MBA\*  
Pennsylvania

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David Savage, MD, PhD\*  
American Society of Clinical Oncology

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Jason Schneider, MD  
GLMA

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L. Carlos Zapata, MD  
New York

\*Alternate Delegate

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

Resolution 203 – Medicaid Patient Accountability

- Physician Payment Reform H-390.849
- Work of the Task Force on the Release of Physician Data H-406.991

Resolution 207 – Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse

- Abbreviated Pathway for Biosimilar Approval H-125.980
- Substitution of Biosimilar Medicines and Related Medical Products D-125.989
- Pharmacy Benefit Manager (PBM) Control of Treating Disease States D-120.924
- Price of Medicine H-110.991
- Third-Party Pharmacy Benefit Administrators H-110.963

Resolution 211 – Deceptive Hospital Badging 2.0

- Clarification of the Title “Doctor” in the Hospital Environment D-405.991
- Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation D-35.992
- Professional Nurse Staffing in Hospitals H-360.986
- Clarification of Healthcare Physician Identification: Consumer Truth & Transparency D-405.974
- Proper Visual Identification of Nonphysicians Who See Patients H-35.984
- Truth in Advertising H-405.964
- Definition of a Physician H-405.969

Resolution 213 – Access to Covered Benefits with an Out of Network Ordering Physician

- Direct Primary Care H-385.912

Resolution 221 – Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability

- Medicare Prescription Drug and Vaccine Coverage and Payment D-330.898

Resolution 228 – Waiver of Due Process Clauses

- Waiver of Due Process Clauses H-230.950

Resolution 237 – Encouraging the Passage of the Preventive Health Savings Act (S.114)

- Value-Based Decision-Making in the Health Care System D-155.994
- The US Preventive Services Task Force Guide to Clinical Preventive Services H-425.988
- Value of Preventive Services H-460.894
- Preventive Medicine Services H-425.987

Resolution 240 – Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas

- Conrad 30 J-1 Visa Waivers D-255.985
- Diversity in the Physician Workforce and Access to Care D-200.982
- J-1 Visas and Waivers D-255.993

Resolution 241 – Healthcare Cybersecurity Breaches

- Ransomware and Electronic Health Records D-478.960



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

Resolution 244 – Graduate Medical Education Opportunities for American Indian and Alaska Native Communities

- Indian Health Service H-350.977

Resolution 311 – Physician Participation in Healthcare Organizations

- Participation of Physicians on Healthcare Organization Boards H-405.953

Resolution 413 – Sexuality and Reproductive Health Education

- Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

Resolution 431 – Combatting the Public Health Crisis of Gun Violence

- Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
- Gun Violence as a Public Health Crisis D-145.995
- Further Action to Respond to the Gun Violence Public Health Crisis D-145.992
- Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975

Resolution 508 – AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis

- Marketing Guardrails for the “Over-Medicalization” of Cannabis Use D-95.958
- Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
- Cannabis Product Safety D-95.956

Resolution 510 – Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”

- Dietary Supplements and Herbal Remedies H-150.954

Resolution 512 – Opioid Overdose Reversal Agents Where AED’s Are Located

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

Resolution 712 – Full Transparency – Explanation of Benefits

- Universal Explanation of Benefits Forms H-390.865
- Misleading Explanation of Benefits Language by Insurance Carriers H-190.994

Resolution 713 – Transparency – Non-Payment for Services to Patients with ACA Exchange Plans with Unpaid Premiums

- Health Insurance Exchange and 90-Day Grace Period H-185.938

Resolution 715 – Electronic Medical Records Submission

- Standardized Preauthorization Forms H-320.944
- National Health Information Technology D-478.995
- Electronic Data Interchange Status Report H-315.979

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: LATE 1001  
(A-24)

Introduced by: American Academy of Child and Adolescent Psychiatry

Subject: National Shortages of Stimulant Medication

Referred to: Reference Committee E

Whereas, our American Medical Association recognizes that children's mental health and barriers to mental health care access for children represent a national emergency that requires urgent attention from all interested parties; and

Whereas, nearly 6 million youth ages 3-17 suffer with Attention-Deficit/Hyperactivity Disorder (ADHD)<sup>1</sup>; and

Whereas, ADHD is usually diagnosed in childhood and often lasts into adulthood<sup>2</sup>; and

Whereas, untreated ADHD can lead to mental and behavioral disorders, including mood and substance use disorders, unintended injuries resulting from ADHD-related impulsivity, and long-term impacts on relationship-building, educational achievement, and professional success<sup>3</sup>; and

Whereas, the U.S. Food and Drug Administration first acknowledged a stimulant shortage in October 2022<sup>4</sup>; and

Whereas, in a joint letter to the public dated August 1, 2023, both the DEA and the FDA outlined steps the agencies were taking to mitigate the impact of the stimulant shortages<sup>5</sup>; and

Whereas, the stimulant shortage crisis continues with patients and families still unable to access stimulant medications; therefore be it

RESOLVED, that our American Medical Association will work with national specialty societies and other relevant stakeholders to advocate that the FDA, DEA, and other federal agencies take direct and prompt actions to alleviate current national shortages of stimulant medications (Directive to Take Action).

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

Received: 5/17/2024

## REFERENCES

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2. About ADHD: CHADD Factsheet, accessed April 19, 2024. <https://chadd.org/about-adhd/overview/>
3. Choi WS, Woo YS, Wang SM, Lim HK, Bahk WM. The prevalence of psychiatric comorbidities in adult ADHD compared with non-ADHD populations: A systematic literature review. PLoS One. 2022 Nov 4;17(11):e0277175. doi: 10.1371/journal.pone.0277175. PMID: 36331985; PMCID: PMC9635752.
4. Current Drug Shortage: Amphetamine Aspartate Monohydrate, Amphetamine Sulfate, Dextroamphetamine Saccharate, Dextroamphetamine Sulfate Tablet. [https://www.accessdata.fda.gov/scripts/drugshortages/dsp\\_ActiveIngredientDetails.cfm?AI=Amphetamine%20Aspartate%20Monohydrate,%20Amphetamine%20Sulfate,%20Dextroamphetamine%20Saccharate,%20Dextroamphetamine%20Sulfate%20Tablet&st=c#](https://www.accessdata.fda.gov/scripts/drugshortages/dsp_ActiveIngredientDetails.cfm?AI=Amphetamine%20Aspartate%20Monohydrate,%20Amphetamine%20Sulfate,%20Dextroamphetamine%20Saccharate,%20Dextroamphetamine%20Sulfate%20Tablet&st=c#). Published October 22, 2022. Accessed April 19, 2024.

5. FDA Actions to Address Shortages in Prescription Stimulants. <https://www.fda.gov/media/170736/download?attachment>. Published August 23, 2023. Accessed April 19, 2024.

## RELEVANT AMA POLICY

### National Drug Shortages H-100.956

1. Our American Medical Association considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.
5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.
6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces.
7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.
8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.
9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.
11. Our AMA urges the FDA to require manufacturers and distributors to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, any unpredicted changes in product demand, and provide more detailed information regarding the causes and anticipated duration of drug shortages.
12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.
13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.
14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.

15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.
16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.
17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.
18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.
19. Our AMA urges the Drug Enforcement Agency and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
20. Our AMA supports innovative approaches for diversifying the generic drug manufacturing base to move away from single-site manufacturing, increasing redundancy, and maintaining a minimum number of manufacturers for essential medicines.
21. Our AMA supports the public availability of FDA facility inspection reports to allow purchasers to better assess supply chain risk.
22. Our AMA opposes the practice of preferring drugs experiencing a shortage on approved pharmacy formularies when other, similarly effective drugs are available in adequate supply but otherwise excluded from formularies or coverage plans.
23. Our AMA shall continue to monitor proposed methodologies for and the implications of a buffer supply model for the purposes of reducing drug shortages and will report its findings as necessary.

CSAPH Rep. 2, I-11 Modified: CSAPH Rep. 7, A-12 Modified: CSAPH Rep. 2, I-12 Modified: CSAPH Rep. 8, A-13 Modified in lieu of Res. 912, I-13 Modified: CSAPH Rep. 3, A-14 Modified: CSAPH Rep. 2, I-15 Appended: CSAPH Rep. 04, I-17 Modified: CSAPH Rep. 02, A-18 Reaffirmed: CMS Rep. 08, A-19 Reaffirmed: Res. 105, A-19 Modified: CSAPH Rep. 1, I-20 Modified: Res. 503, A-22 Appended: CSAPH 1, I-22 Modified: CSAPH Rep. 1, I-23

#### **Non-Profit or Public Manufacturing of Drugs to Address Generic Drug Shortages H-100.942**

1. Our American Medical Association supports activities which may lead to the stabilization of the generic drug market by non-profit or public entities. Stabilization of the market may include, but is not limited to, activities such as government-operated manufacturing of generic drugs, the manufacturing or purchasing of the required active pharmaceutical ingredients, or fill-finish. Non-profit or public entities should prioritize instances of generic drugs that are actively, at-risk of, or have a history of being, in shortage, and for which these activities would decrease reliance on a small number of manufacturers outside the United States.
2. Our AMA encourages government entities to stabilize the generic drug supply market by piloting innovative incentive models for private companies which do not create artificial shortages for the purposes of obtaining said incentives.

CSAPH Rep. 1, I-23

#### **National Shortages of Lidocaine, Saline Preparation, and Iodinated Contrast Media D-120.925**

Our AMA will work with national specialty societies and other relevant stakeholders to advocate that the FDA take direct and prompt actions to alleviate current national shortages of lidocaine, normal saline preparations, and iodinated contrast media.

Res. 223, A-22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: LATE 1002  
(A-24)

Introduced by: New York

Subject: Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS

Referred to: Reference Committee B

Whereas, The Medical Society of the State of New York adopted policy 265.804 “Withdraw and Amend Virtual Credit Card Policy” and policy 120.891, Enforcement of Administrative Simplification Requirements – CMS; and

Whereas, the American Medical Association adopted policies CMS Administrative Requirements D-190.970, Virtual Credit Card Payments H-190.955, Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968; and

Whereas, despite the efforts of the American Medical Association and other groups, the sneaky practices and associated costs of virtual credit cards and EFT fees have not abated; and

Whereas, these possible violations of the HIPAA administrative simplification requirements have not been remedied; and

Whereas, enforcement of these laws preventing imposition of costs for EFT requires continued vigilance by the AMA, medical societies and physicians across the country; therefore be it

RESOLVED, that our American Medical Association report at the Interim 2024 Meeting on the progress of implementation of AMA Policies D-190.970, H-190.955, and D-190.968. (Directive to Take Action)

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

Received: 5/29/2024

### RELEVANT AMA POLICY

#### 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 HIPPPA 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.

**Amend Virtual Credit Card and Electronic Funds Transfer Fee Policy D-190.968**

1. Our American Medical Association will advocate for legislation or regulation that would prohibit the use of virtual credit cards (VCCs) for electronic health care payments.
2. Our AMA will advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs.
3. Our AMA will engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at: (a) the issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services, (b) CMS enforcement activities related to this issue, and (c) physician access to a timely no fee EFT option as an alternative to VCCs.

**Virtual Credit Card Payments H-190.955**

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.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: LATE 1003  
(A-24)

Introduced by: American Society of Transplant Surgeons

Subject: The HRSA – Organ Procurement and Transplantation Network (OPTN)  
Modernization Initiative

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, our American Medical Association, via numerous AMA policies, has endorsed  
2 principles to guide Congress and regulatory agencies in optimal practices benefiting patients  
3 and transplant physicians; and  
4

5 Whereas, last year the Health and Resources and Services Administration (HRSA) announced  
6 the Organ Procurement and Transplantation Network (OPTN) Modernization Initiative and  
7 Congress enacted the “Securing the US Organ Transplantation Network Act,” both of which are  
8 intended to facilitate competition and modernization of the transplant system by breaking up the  
9 monopoly that the United Network for Organ Sharing (UNOS) has held as the contractor  
10 selected by HRSA; and  
11

12 Whereas, while the AMA and member organizations, including the American Society of  
13 Transplant Surgeons (ASTS), support improvements to organ transplantation, the system of  
14 transplantation must retain a fully transparent, formally established, and legally sound public-  
15 private partnership between the OPTN and HRSA; and  
16

17 Whereas, the proposed revisions in OPTN structure would create an ill-defined association of  
18 government and non-government organizations, contrary to statute and federal regulation,  
19 without staff or members, devoid of sufficient and formal clinical expertise and patient group  
20 involvement, and without sufficient policymaking authority, marginalizing the future of the OPTN  
21 Board of Directors and Committees, impeding the practice of transplantation medicine and  
22 surgery, and subjecting the transplant system to political pressure and bias; therefore be it  
23

24 RESOLVED, that our American Medical Association affirm that the Health and Resources and  
25 Services Administration’s (HRSA) proposed changes to the Organ Procurement and  
26 Transplantation Network (OPTN) should not replace the existing public-private partnership  
27 between HRSA and the OPTN, and the OPTN should be maintained as a membership  
28 organization. (Directive to Take Action); and be it further  
29

30 RESOLVED, that our AMA support an Organ Procurement and Transplantation Network  
31 (OPTN) Board, per the National Organ Transplant Act (NOTA) regulations, that includes  
32 patients, living donors and donor families, transplant centers, organ procurement organizations  
33 (OPOs), patient and medical associations, and other transplant stakeholders to ensure  
34 experience, expertise, and knowledge from content experts; and should be elected by the  
35 membership rather than be appointed or elected by the government or its contractors which  
36 would result in politicizing medical care decisions (New HOD Policy); and be it further  
37

38 RESOLVED, that our AMA proactively advocate to the general public and encourage legislators  
39 and regulators to modernize the transplant system in a transparent, equitable, and efficient

1 manner within the structure outlined in National Organ Transplant Act (NOTA). (Directive to  
2 Take Action).  
3

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

Received: 6/4/2024

#### REFERENCES

1. HRSA OPTN Modernization Initiative. <https://www.hrsa.gov/optn-modernization>. Last updated June 2024.
2. Public Law 118 – 14. “Securing the Organ Procurement and Transplantation Network.” September 22, 2023. <https://www.congress.gov/118/plaws/publ14/PLAW-118publ14.pdf>
3. HRSA Letter to Dianne LaPointe Rudow, ANP-BC, DNP, FAAN, President, Organ Procurement and Transplantation Network – March 27, 2024. <https://www.hrsa.gov/sites/default/files/hrsa/about/optn-board-separation-plan-letter.pdf>
4. Letter from the Organ Procurement and Transplantation Network to the Transplant Community – May 28, 2024. <https://asts.org/docs/default-source/optn-unos/optn-letter-to-the-community-may-28-2024.pdf>
5. NOTA Statutory Reference Requiring OPTN Independent Board and Community Membership <https://uscode.house.gov/statutes/pl/98/507.pdf>
6. Letter to HRSA from Senators Wyden, Grassley, Young, Warren, and Moran. May 2, 2024. [https://www.grassley.senate.gov/imo/media/doc/wyden\\_grassley\\_et\\_al\\_to\\_hrsa\\_-\\_rfp.pdf](https://www.grassley.senate.gov/imo/media/doc/wyden_grassley_et_al_to_hrsa_-_rfp.pdf)

#### RELEVANT AMA POLICY

##### **H-270.959 AMA Stance on the Interference of the Government in the Practice of Medicine.**

1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
  2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
    - A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
    - B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
    - C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.
    - D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.
- [Res. 523, A-06 Appended: Res. 706, A-13 Reaffirmed: Res. 250, A-22]

##### **H-165.916 Government Controlled Medicine**

Our AMA strongly reaffirms its unwavering opposition against the encroachment of government in the practice of medicine as well as any attempts to covertly change the American health care system to a government program with the subsequent loss of precious personal freedoms, including the right of physicians and patients to contract privately for health care without government interference.  
[Res. 141, I-93 Reaffirmed: Sub. Res. 132, A-94 Reaffirmation A-97 Reaffirmation I-00 Reaffirmation A-01 Reaffirmation A-02 Reaffirmation I-07 Reaffirmation A-09 Reaffirmation I-09 Reaffirmed: CMS Rep. 01, A-19]

##### **H-390.985 CMS Consultation With Physicians**

The AMA encourages CMS to consult with clinically experienced practicing physicians on all determinations affecting medical practice and patient care.  
[Sub. Res. 71, I-84 Reaffirmed by CLRPD Rep. 3 - I-94 Reaffirmed: CMS Rep. 5, A-04 Reaffirmed: CMS Rep. 1, A-14']



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: LATE 1004  
(A-24)

Introduced by: American Thoracic Society

Subject: Regulation of Nicotine Analogue Products

Referred to: Reference Committee E

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1 Whereas, e-cigarette manufacturers have been experimenting with nicotine analogue molecules  
2 to include in e-cigarette products; and  
3

4 Whereas, nicotine analogue molecules are chemically similar to nicotine but are chemically  
5 unique from nicotine created by tobacco plants; and  
6

7 Whereas, Spree Bar – a U.S. company – is currently selling online and in brick and mortar  
8 stores an e-cigarette product that does not contain nicotine but instead contains a nicotine  
9 analogue – 6-methyl nicotine; and  
10

11 Whereas, as initial research suggests that the 6-methyl nicotine analogue is more addictive and  
12 more toxic than tobacco plant produced nicotine; and  
13

14 Whereas, the Food and Drug Administration (FDA) Center for Tobacco Products has indicated  
15 that it does not have the authority to regulate nicotine analogue products; and  
16

17 Whereas, the FDA Center for Drug Effectiveness and Research has not yet expressed  
18 regulatory authority over nicotine analogue products; and  
19

20 Whereas, Spree Bar is explicitly claiming that, because their product does not contain any pure  
21 nicotine, their product is exempt from all FDA tobacco product regulation including premarket  
22 approval, advertising limits and even state and federal tobacco excise taxes; and  
23

24 Whereas, if left unaddressed, the nicotine analogue loophole will likely lead to a proliferation of  
25 more nicotine analogue products that are potentially more addictive, more toxic and not  
26 addressed by any federal regulation; therefore be it  
27

28 RESOLVED, that our American Medical Association oppose the development, production  
29 market and sales of nicotine analogue consumer products (New HOD Policy); and be it further  
30

31 RESOLVED, that our AMA urge the Food and Drug Administration (FDA) Center for Drug  
32 Effectiveness and Research swiftly exert its authority to regulate all nicotine analogue products  
33 as drugs (Directive to Take Action).

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

Received: 6/5/2024

## **RELEVANT AMA POLICY**

### **Opposition to Exempting the Addition of Menthol to Cigarettes H-495.976**

Our AMA: (1) will continue to support a ban on the use and marketing of menthol in cigarettes as a harmful additive; and (2) encourages and will assist its members to seek state bans on the sale of menthol cigarettes.

BOT Action in response to referred for decision Res. 436, A-08 Modified: CSAPH Rep. 01, A-18

### **Opposition to Addition of Flavors to Tobacco Products H-495.971**

Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint and wintergreen flavors; (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products; and (3) encourages the FDA to prohibit the use of all flavoring agents in tobacco products, which includes electronic nicotine delivery systems as well as combustible cigarettes, cigars and smokeless tobacco.

CSAPH Rep. 01, A-18 Modified: Res. 916, I-18 Modified: Res. 918, I-19

## **ORDER OF BUSINESS**

Reference Committee on Amendments to Constitution and Bylaws (A-24)  
Emily Briggs, MD, Chair

June 8, 2024  
Grand Hall I/J  
[Zoom Meeting Link](#) (view only)

Hyatt Regency Chicago  
Chicago

1. BOT Rep. 02- New Specialty Organizations Representation in the House of Delegates
2. CCB Rep. 01 - AMA Bylaws—Nomination of Officers and Council Members
3. CCB Rep. 02 - AMA Bylaws—Run-Off and Tie Ballots
4. CCB Rep. 03 - AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)
5. CCB Rep. 04 - AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)
6. CEJA Rep. 01 - Short-Term Global Health Clinical Encounters
7. CEJA Rep. 02 – Research Handling of De-Identified Patient Data (D-315.969)
8. CEJA Rep. 03 - Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
9. CEJA Rep. 04 - Physicians' Use of Social Media for Product Promotion and Compensation
10. CEJA Rep. 05 - CEJA's Sunset Review of 2014 House Policies
11. Res 001 - Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
12. Res 002 - Removal of the Interim Meeting Resolution Committee
13. Res 003 - Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity
14. Res 004 - The Rights of Newborns that Survive Abortion
15. Res 005 - AMA Executive Vice President

Note: During the reference committee hearing, supplemental material may be sent to [ama.refcom.ccb@gmail.com](mailto:ama.refcom.ccb@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, 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.

16. Res 006 - Treatment of Family Members
17. Res 007 - AMA Supports a Strategy for Eliminating Nuclear Weapons
18. Res 008 - Consolidated Health Care Market
19. Res 023 - Change Healthcare Security Lapse—The FBI Must Investigate
20. Res 009 - Updating Language Regarding Families and Pregnant Persons
21. Res 012 - Ethical Pricing Procedures that Protect Insured Patients
22. Res 013 - Ethical Impetus for Research in Pregnant and Lactating Individuals
23. Res 014 - The Preservation of the Primary Care Relationship
24. Res 015 and Res 022 – Health and Racial Equity in Medical Education to Combat Workforce Disparities
25. Res 016 - Guiding Principles for the Healthcare of Migrants
26. Res 017 - Addressing the Historical Injustices of Anatomical Specimen Use
27. Res 018 - Opposing Violence, Terrorism, Discrimination, and Hate Speech
28. Res 019 - Supporting the Health of Our Democracy
29. Res 020 - Voter Protections During and After Incarceration
30. Res 021 - Opposition to Capital Punishment
31. Res 024 - Augmented Intelligence and Organized Medical Staff
32. *Res Late 1003 - The HRSA – Organ Procurement and Transplantation Network (OPTN) Modernization Initiative*

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**ORDER OF BUSINESS**

Reference Committee A (A-24)

Debra Perina, MD, Chair

June 9, 2024  
Regency A/B

Hyatt Regency  
Chicago, IL

1. Council on Medical Service Report 2 – Improving Affordability of Employment-Based Health Coverage
2. Council on Medical Service Report 3 – Review of Payment Options for Traditional Healing Services
3. Council on Medical Service Report 7 – Ensuring Privacy in Retail Health Care
4. Council on Medical Service Report 8 – Sustainable Payment for Community Practices
5. Resolution 101 – Infertility Coverage
6. Resolution 102 – Medicaid & CHIP Benefit Improvements
7. Resolution 103 – Medicare Advantage Plans
8. Resolution 104 – Medicaid Estate Recovery Reform
9. Resolution 105 – Medigap Patient Protections  
Resolution 111 – Protections for “Guarantee Issue” Medigap Insurance and Traditional Medicare
10. Resolution 115 – Payments by Medicare Secondary or Supplemental Plans
11. Resolution 106 – Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum  
Resolution 118 – Public and Private Payer Coverage of Diagnostic Interventions Associated with Colorectal Cancer Screening and Diagnosis
12. Resolution 107 – Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies
13. Resolution 108 – Requiring Payment for Physician Signatures

Amendments and supplemental materials MUST be sent to [AMARefComA@gmail.com](mailto: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, were late items, or originally listed under the “Do Not Consider” tab. 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://events.zoom.us/jv/AvXMrtV8WsqfZkydQFkEemS9jg6KGZXdDqmea\\_UGjW0n-ZcsCSga~Am2AhtTScYBDdXSLs1Xy4qRxwwgR7msT-40WVgB97raczA-iiESXjn-g](https://events.zoom.us/jv/AvXMrtV8WsqfZkydQFkEemS9jg6KGZXdDqmea_UGjW0n-ZcsCSga~Am2AhtTScYBDdXSLs1Xy4qRxwwgR7msT-40WVgB97raczA-iiESXjn-g). This link is view-only. Testimony cannot be accepted via Zoom.

14. Resolution 109 – Coverage for Dental Services Medically Necessary for Cancer Care
15. Resolution 110 – Coverage for Shoes and Shoe Modifications for Pediatric Patients Who Require Lower Extremity Orthoses
16. Resolution 112 – Private and Public Insurance Coverage for Adaptive Sports Equipment Including Prostheses and Orthoses
17. Resolution 113 – Support Prescription Medication Price Negotiation
18. Resolution 114 – Breast Cancer Screening/Clinical Breast Exam Coverage
19. Resolution 116 – Increase Insurance Coverage for Follow-Up Testing After Abnormal Screening Mammography
20. Resolution 117 – Insurance Coverage for Gynecologic Oncology Care

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A Zoom webinar link is provided here:

[https://events.zoom.us/jv/AvXMrtV8WsqfZkydQFkEemS9jg6KGZXdQmea\\_UGjW0n-ZcsCSga~Am2AhtTScYBDdXSLs1Xy4qRxwwgR7msT-40WVgB97raczA-iiESxn-g](https://events.zoom.us/jv/AvXMrtV8WsqfZkydQFkEemS9jg6KGZXdQmea_UGjW0n-ZcsCSga~Am2AhtTScYBDdXSLs1Xy4qRxwwgR7msT-40WVgB97raczA-iiESxn-g). This link is view-only. Testimony cannot be accepted via Zoom.

## **ORDER OF BUSINESS**

Reference Committee B – Annual 2024 Meeting

Peter Rheinstein, MD,JD, Chair

June 8, 2024

1:30pm CT

Zoom Link:

[https://events.zoom.us/j/AvXMrtV8WsgfZkydQFkEemS9jg6KGZXdDqmea\\_UGjW0n-ZcsCSga~Am2AhttTScYBDdXSLs1Xy4qRxwwgR7msT-40WVgB97raczA-iiESxjn-g](https://events.zoom.us/j/AvXMrtV8WsgfZkydQFkEemS9jg6KGZXdDqmea_UGjW0n-ZcsCSga~Am2AhttTScYBDdXSLs1Xy4qRxwwgR7msT-40WVgB97raczA-iiESxjn-g)

Items in *italics* are currently on the Reaffirmation Consent Calendar, or are late resolutions. The Chair will address these items at the start of the hearing.

1. BOT Report 09 – Council on Legislation Sunset Review of 2014 House Policies
2. BOT Report 19 – Attorneys’ Retention of Confidential Medical Records and Controlled Medical Expert’s Tax Returns After Case Adjudication
3. BOT Report 11 – Safe and Effective Overdose Reversal Medications in Educational Settings
4. BOT Report 16 – Support for Mental Health Courts
5. BOT Report 17 – Drug Policy Reform

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**Participants with technical issues should email [HODMeetingSupport@ama-assn.org](mailto: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.**

6. BOT Report 18 – Supporting Harm Reduction
7. Resolution 220 – Restorative Justice for the Treatment of Substance Use Disorders
8. Resolution 222 – Studying Avenues for Parity in Mental Health & Substance Use Coverage
9. Resolution 229 – Opposition to Legalization of Psilocybin
10. Resolution 238 – AMA Support Efforts to Fund Overdose Prevention Sites
11. BOT Report 13 – Prohibiting Covenants Not-to-Compete
12. Resolution 210 – Support for Physicians Pursuing Collective Bargaining and Unionization
13. Resolution 236 – Support of Physicians Pursuing Collective Bargaining and Unionization
14. BOT Report 14 – Physician Assistant Nurse Practitioner Movement Between Specialties
15. Resolution 201 – Research Correcting Political Misinformation and Disinformation on Scope of Practice
16. *Resolution 204 – Staffing Ratios in the Emergency Department*
17. *Resolution 211 – Deceptive Hospital Badging 2.0*
18. Resolution 230 – Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion
19. BOT Report 15 – Augmented Intelligence Development, Deployment, and Use in Health Care
20. Resolution 202 – Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims
21. Resolution 246 – Augmented Intelligence in Health Care
22. Resolution 235 – Establish a Cyber-Security Relief Fund
23. *Resolution 241 – Healthcare Cybersecurity Breaches*
24. *Resolution 203 – Medicaid Patient Accountability*
25. Resolution 219 – Bundling for Maternity Care Services

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26. *Resolution 221 – Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability*
27. *Resolution 227 – Medicare Reimbursement for Telemedicine*
28. *Resolution 232 – Medicare Advantage Part B Coverage*
29. *Resolution 247 – Prohibit Health Benefit Plans From Charging Cost Sharing for Covered Prostate Cancer Screening*
30. *Resolution 249 – Pediatric Specialty Medicaid Reimbursement*
31. *Resolution 251 – Streamline Payer Quality Metrics*
32. *Late Resolution 1002 – Update the Status of Virtual Credit Card Policy, EFT Fees, and Lack of Enforcement of Administrative Simplification Requirements by CMS*
33. *Resolution 207 – Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse*
34. *Resolution 234 – State Prescription Drug Affordability Boards - Study*
35. *Resolution 248 – Sustain Funding for HRSA (Health Resources Services and Administration) 340B Grant-Funded Programs*
36. *Resolution 213 – Access to Covered Benefits with an Out of Network Ordering Physician*
37. *Resolution 245 – Patient Access to Covered Benefits Ordered by Out-of-Network Physicians*
38. *Resolution 217 – Protecting Access to IVF Treatment*
39. *Resolution 226 – Protecting Access to IVF Treatment*
40. *Resolution 206 – Indian Health Services Youth Regional Treatment Centers*
41. *Resolution 208 – Improving Supplemental Nutrition Program*
42. *Resolution 209 – Native American Voting Rights*
43. *Resolution 215 – American Indian and Alaska Native Language Revitalization and Elder Care*
44. *Resolution 242 – Cancer Care in Indian Health Services Facilities*
45. *Resolution 244 – Graduate Medical Education Opportunities for American Indian and Alaska Native Communities*

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46. Resolution 218 – Designation of Descendants of Enslaved Africans in America
47. Resolution 243 – Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes
48. *Resolution 223 – Increase in Children’s Hospital Graduate Medical Education Funding*
49. Resolution 252 – Model Legislation Protecting the Future of Medicine
50. Resolution 225 – Humanitarian Efforts to Resettle Refugees
51. *Resolution 240 – Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas*
52. Resolution 205 – Medical-Legal Partnerships & Legal Aid Services
53. Resolution 212 – Advocacy Education Towards a Sustainable Medical Care System
54. Resolution 214 – Support for Paid Sick Leave
55. Resolution 216 – The AMA Supports H.R. 7225, the Bipartisan “Administrative Law Judges Competitive Service Restoration Act”
56. *Resolution 224 – Antidiscrimination Protections for LGBTQ+ Youth in Foster Care*
57. *Resolution 228 – Waiver of Due Process Clauses*
58. Resolution 231 – Supporting the Establishment of Rare Disease Advisory Councils
59. Resolution 233 – Prohibiting Mandatory White Bagging
60. *Resolution 237 – Encouraging the Passage of the Preventive Health Savings Act (S. 114)*
61. Resolution 239 – Requiring stores that sell tobacco products to display NYS Quitline information
62. Resolution 250 – Endorsement of the Uniform Health-Care Decisions Act
63. Resolution 253 – Addressing the Failed Implementation of the No Surprises Act IDR Process

**Note:** During the reference committee hearing, supplemental material may be sent to [RefComB@ama-assn.org](mailto:RefComB@ama-assn.org). 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 Forum or orally to the committee.

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## **ORDER OF BUSINESS**

Reference Committee C (A-24)  
Cheryl Hurd, MD, MA, Chair

Sunday, June 9, 2024  
Regency Ballroom C

Hyatt Regency Chicago  
[Zoom Hub registration](#)

1. Board of Trustees Report 31 - The Morrill Act and its Impact on the Diversity of the Physician Workforce
2. Resolution 319 - AMA Support of U.S. Pathway Programs
3. Resolution 303 - Amend Policy D-275.948 Title "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training". Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards
4. Council on Medical Education Report 01 - Council on Medical Education Sunset Review of 2014 House of Delegates' Policies
5. Resolution 301 - Fairness for International Medical Students
6. Resolution 309 - Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine
7. Resolution 315 - Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations
8. Resolution 308 - Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being
9. Resolution 304 - Spirituality in Medical Education and Practice
10. Resolution 320 - Anti-Racism Training for Medical Students and Medical Residents
11. Council on Medical Education Report 02 - The Current Match Process and Alternatives
12. Resolution 306 - Unmatched Graduating Physicians
13. Resolution 310 - Accountability & Transparency in GME funding with Annual Report
14. Resolution 305 - Public Service Loan Forgiveness Reform
15. Resolution 314 - Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule

16. Resolution 313 - CME for Rural Preceptorship
17. Resolution 317 - Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians
18. Resolution 302 - The Role of Maintenance of Certification
19. Resolution 316 - Reassessment of Continuing Board Certification Process
20. Resolution 312 - AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians
21. Resolution 318 - Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care
22. Resolution 307 - Access to Reproductive Health Services When Completing Physician Certification Exams
23. *Resolution 311 - Physician Participation in Healthcare Organizations*

Notes:

-Titles in italics represent items on Reaffirmation Consent Calendar or late items. The Chair will address these items at the start of the hearing.

-Amendments and supplemental material for Ref Com C must be sent to [meded@ama-assn.org](mailto:meded@ama-assn.org).

-Link to [business](#) documents (e.g., Preliminary Document, Handbook, Sat Tote).

-For technical assistance, email [HODMeetingSupport@ama-assn.org](mailto:HODMeetingSupport@ama-assn.org) or call 800-337-1599.

## **ORDER OF BUSINESS**

Reference Committee D (June 2024 Meeting)

Dale M. Mandel, MD, Chair

June 9, 2023

Regency Ballroom D

8:00 am – 12:00 pm Local Time (CDT)

Zoom link below (view only)

1. Council on Science and Public Health Report 13 – Decreasing Youth Access to E-Cigarettes
2. Resolution 420 - Equity in Dialysis Care
3. Resolution 418 - Early and Periodic Eye Exams for Adults
4. Resolution 434 - Universal Newborn Eye Screening
5. Resolution 410 - Access to Public Restrooms
6. *Resolution 413 - Sexuality and Reproductive Health Education*
7. Resolution 424 - LGBTQ+ Senior Health
8. Resolution 402 - Guardianship and Conservatorship Reform
9. Resolution 406 - Opposition to Pay-to-Stay Incarceration Fees
10. Resolution 427 - Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
11. Council on Science and Public Health Report 11 – Stand Your Ground Laws
12. Resolution 405 - Default Proceed Firearm Sales and Safe Storage Laws
13. *Resolution 431 - Combatting the Public Health Crisis of Gun Violence*
14. Council on Science and Public Health Report 3 - Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders
15. Resolution 421 - Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)
16. Resolution 426 - Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action
17. Resolution 433 - Improving Healthcare of Rural Minority Populations
18. Resolution 404 - Protections Against Surgical Smoke Exposure
19. Resolution 423 - HPV Vaccination to Protect Healthcare Workers over Age 45
20. Resolution 422 - Immunization Registry
21. Resolution 401 - Addressing Social Determinants of Health Through Closed Loop Referral Systems
22. Resolution 403 - Occupational Screenings for Lung Disease
23. Resolution 430 - Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages
24. Resolution 407 - Racial Misclassification
25. Resolution 408 - Indian Water Rights

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://events.zoom.us/j/AvXMrtV8WsqfZkydQFkEemS9jg6KGZXdDqmea\\_UGjW0n-ZcsCSga~Am2AhtTScYBDdXSLs1Xy4qRxwwgR7msT-40WVgB97raczA-iiESxjn-g](https://events.zoom.us/j/AvXMrtV8WsqfZkydQFkEemS9jg6KGZXdDqmea_UGjW0n-ZcsCSga~Am2AhtTScYBDdXSLs1Xy4qRxwwgR7msT-40WVgB97raczA-iiESxjn-g)

During the reference committee hearing, supplemental material may be sent to [ReferenceCommitteeD@gmail.com](mailto: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.

26. Resolution 411 - Missing and Murdered Indigenous Persons
27. Resolution 425 - Perinatal Mental Health Disorders among Medical Students and Physicians
28. Council on Science and Public Health Report 9 - Prescribing Guided Physical Activity for Depression and Anxiety
29. Council on Science and Public Health Report 10 – Teens and Social Media
30. Council on Science and Public Health Report 6 - Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases
31. Resolution 409 - Toxic Heavy Metals
32. Resolution 412 - Lithium Battery Safety
33. Resolution 417 - Reducing Job-Related Climate Risk Factors
- Resolution 419 - Addressing the Health Risks of Extreme Heat
34. Resolution 414 - Addressing the Health Sector's Contributions to the Climate Crisis
35. Resolution 415 - Building Environmental Resiliency in Health Systems and Physician Practices
36. Resolution 416 - Furthering Environmental Justice and Equity
37. Resolution 428 - Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals
38. Resolution 429 - Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants
39. Resolution 435 - Radiation Exposure Compensation
40. Resolution 432 - Resolution to Decrease Lead Exposure in Urban Areas

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Zoom link to hearing (view only webinar):

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**ORDER OF BUSINESS**

A-24 Reference Committee E  
Robert Panton, MD, Chair

**June 8, 2024, 1:30 PM – 6:00 PM**

**Regency C**

**Hyatt Regency**

For remote viewing, register [here](#) (note: those viewing remotely may not testify)

1. CSAPH Report 1 - Sunset Review of 2014 House Policies
2. CSAPH Report 2 – Comparative Effectiveness Research
3. CSAPH Report 7 – Androgen Deprivation in Incarceration
4. CSAPH Report 4 – Sex and Gender Differences in Medical Research
5. Resolution 502 – Tribally-Directed Precision Medicine Research
6. Resolution 505 - Mitigating the Harms of Colorism and Skin Bleaching Agents
7. Resolution 506 - Screening for Image Manipulation in Research Publications
8. Resolution 509 – Addressing Sarcopenia and its Impact on Quality of Life
9. Resolution 514 – Safety With Devices Producing Carbon Monoxide
10. Resolution 511 - National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling
11. \*\* Resolution 510 - Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”
12. Resolution 513 - Biotin Supplement Packaging Disclaimer
13. Resolution 501 – Fragrance Regulation
14. ^^CSAPH Report 5 – Biosimilar/Interchangeable Terminology  
^^Resolution 504 – FDA Regulation of Biosimilars
15. CSAPH Report 8 – Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing
16. ^^Late Resolution 1001 -- National Shortages of Stimulant Medication
17. \*\*Resolution 512 - Opioid Overdose Reversal Agents Where AED's Are Located
18. CSAPH Report 12 – Universal Screening for Substance Use and Substance Use Disorders during Pregnancy
19. Resolution 503 - Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)
20. Resolution 507 - Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies
21. \*\*Resolution 508 - AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis
22. Resolution 515 - Advocacy for More Stringent Regulations/Restrictions on the Distribution of Marijuana
23. ^^Late Resolution 1004 -- Regulation of Nicotine Analogue Products

*\*\* - indicates item was placed on the reaffirmation calendar and might not be heard*

*^^ -- indicates item was received Late, and might not be accepted as business*

*^^ - indicates items which will be heard as a combined, single item of business*

During the reference committee hearing, supplemental material may be sent to [ReferenceCommitteeE@gmail.com](mailto: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-24)  
Rebecca L. Johnson, MD, Chair

June 8, 2024  
Grand Ballroom

Hyatt Regency Chicago  
Chicago

Zoom Link:

<https://events.zoom.us/j/AvXMrtV8WsgfZkydQFkEemS9jg6KGZXdDqmeaUGjW0n-ZcsCSga~Am2AhtTScYBDdXSLs1Xy4qRxwwgR7msT-40WVgB97raczA-iiESxjn-g>

### **FINANCIAL**

1. Board of Trustees Report 1 - Annual Report
2. Board of Trustees Report 4 - AMA 2025 Dues
3. Report of the House of Delegates Committee on Compensation of the Officers

### **GOVERNANCE**

4. Board of Trustees Report 28 - Encouraging Collaboration Between Physicians and Industry in AI Development
5. Resolution 606 - Creation of an AMA Council with a Focus on Digital Health Technologies and AI
6. Council on Long Range Planning and Development Report 1 - Establishment of a LGBTQ+ Section
7. Board of Trustees Report 33 - Employed Physicians
8. Resolution 607 - Appealing to our AMA to Add Clarity to its Mission Statement to Better Meet the Need of Physicians, the Practice of Medicine and the Public Health
9. Resolution 608 - The American Medical Association Diversity Mentorship Program
10. Board of Trustees Report 35 – Mitigating the Cost of Medical Student Participation in AMA Meetings

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](mailto: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.



### HOUSE OF DELEGATES

11. Speakers' Report 1 - Report of the Resolution Modernization Task Force Update
12. Board of Trustees Report 21 - American Medical Association Meeting Venues and Accessibility
13. Board of Trustees Report 23 - United States Professional Association for Transgender Health Observer Status in the House of Delegates
14. Council on Constitution and Bylaws/Council on Long Range Planning and Development Report 1 - Joint Council Sunset Review of 2014 House Policies
15. Resolution 602 - Ranked Choice Voting
16. Resolution 609 - Standardization of the Endorsement Process

### ENVIRONMENTAL

17. Board of Trustees Report 25 - Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences
18. Resolution 605 - Walking the Walk of Climate Change

### DIVERSITY, EQUITY, AND INCLUSION

19. Board of Trustees Report 26 - Equity and Justice Initiatives for International Medical Graduates
20. Resolution 604 - Confronting Ageism in Medicine

### CIVIL AND HUMAN RIGHTS

21. Resolution 601 - Annual Holocaust Remembrance Event
22. Resolution 603 - End Attacks on Health and Human Rights in Israel and Palestine
23. Resolution 610 - Opposition to Collective Punishment

## **ORDER OF BUSINESS**

Reference Committee G (A-24)  
Yasser Zeid, MD, Chair

June 8, 2024  
Regency D

Hyatt Regency Chicago  
Chicago, IL

1. Board of Trustees Report 29 – Transparency and Accountability of Hospitals and Hospital Systems
2. Board of Trustees Report 30 – Proper Use of Overseas Virtual Assistants in Medical Practice
3. Council on Medical Service Report 1 – Sunset Review of 2014 House Policies
4. Council on Medical Service Report 5 – Patient Medical Debt
5. Council on Medical Service Report 6 – Economics of Prescription Medication Prior Authorization
6. Resolution 701 – Opposition to the Hospital Readmissions Reduction Program
7. Resolution 702 – The Corporate Practice of Medicine, Revisited
8. Resolution 710 – The Regulation of Private Equity in the Healthcare Sector
9. Resolution 703 – Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation
10. Resolution 704 – Pediatric Readiness in Emergency Departments
11. Resolution 705 – 20 Minute Primary Care Visits
12. Resolution 706 – Automatic Pharmacy-Generated Prescription Requests
13. Resolution 707 – Alternative Funding Programs
14. Resolution 708 – Medicolegal Death Investigations
15. Resolution 709 – Improvements to Patient Flow in the U.S. Healthcare System
16. Resolution 711 – Insurer Accountability When Prior Authorization Harms Patients  
Resolution 720 – The Hazards of Prior Authorization

Amendments and supplemental materials MUST be sent to [refcomg@gmail.com](mailto: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.

Note: Items in *italics* were originally placed on the reaffirmation consent calendar, were late items, or originally listed under the "Do Not Consider" tab. 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 [https://events.zoom.us/jv/AyXMrtV8WsgfZkydQFkEemS9jg6KGZXdDqmea\\_UGjW0n-ZcsCSga~Am2AhtTScYBDdXSLes1Xy4gRxwwgR7msT-40WVgB97raczA-iiESxjn-g](https://events.zoom.us/jv/AyXMrtV8WsgfZkydQFkEemS9jg6KGZXdDqmea_UGjW0n-ZcsCSga~Am2AhtTScYBDdXSLes1Xy4gRxwwgR7msT-40WVgB97raczA-iiESxjn-g). Registration is required to view the zoom. This link is view-only. Testimony cannot be accepted via Zoom.

17. *Resolution 712 – Full Transparency – Explanation of Benefits*
18. *Resolution 713 - Transparency – Non-Payment for Services to Patients with ACA Exchange Plans with Unpaid Premiums*
19. Resolution 714 – Automatic Downcoding of Claims
20. *Resolution 715 – Electronic Medical Records Submission*
21. Resolution 716 – Impact of Patient Non-adherence on Quality Scores
22. Resolution 717 – Mentorship to Combat Prior Authorization  
Resolution 721 - Developing Physician Resources to Optimize Practice Sustainability
23. Resolution 718 – Transparency at the Pharmacy Counter
24. Resolution 719 - Support Before, During, and After Hospital Closure or Reduction in Services

Amendments and supplemental materials MUST be sent to [refcomg@gmail.com](mailto: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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## **Reference Committee on Amendments to Constitution and Bylaws**

### **Report(s) of the Board of Trustees**

- 02 New Specialty Organizations Representation in the House of Delegates
- 36\* Specialty Society Representation in the House of Delegates -  
Five-Year Review

### **Report(s) of the Council on Constitution and Bylaws**

- 01 AMA Bylaws—Nomination of Officers and Council Members
- 02 AMA Bylaws—Run-Off and Tie Ballots
- 03 AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section  
Governing Council Members (D-610.997)
- 04 AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)

### **Report(s) of the Council on Ethical and Judicial Affairs**

- 01 Short-Term Global Health Clinical Encounters
- 02 Research Handling of De-Identified Patient Data (D-315.969)
- 03 Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
- 04 Physicians' Use of Social Media for Product Promotion and Compensation
- 05 CEJA's Sunset Review of 2014 House Policies

### **Resolutions**

- 001 Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
- 002 Removal of the Interim Meeting Resolution Committee
- 003 Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity
- 004 The Rights of Newborns that Survive Abortion
- 005 AMA Executive Vice President
- 006 Treatment of Family Members
- 007 AMA Supports a Strategy for Eliminating Nuclear Weapons
- 008 Consolidated Health Care Market
- 009 Updating Language Regarding Families and Pregnant Persons
- 012 Ethical Pricing Procedures that Protect Insured Patients
- 013 Ethical Impetus for Research in Pregnant and Lactating Individuals
- 014 The Preservation of the Primary Care Relationship
- 015 Health and Racial Equity in Medical Education to Combat Workforce Disparities
- 016 Guiding Principles for the Healthcare of Migrants
- 017 Addressing the Historical Injustices of Anatomical Specimen Use
- 018 Opposing Violence, Terrorism, Discrimination, and Hate Speech
- 019 Supporting the Health of Our Democracy
- 020 Voter Protections During and After Incarceration
- 021 Opposition to Capital Punishment
- 022 Health and Racial Equity in Medical Education to Combat Workforce Disparities
- 023\* Change Healthcare Security Lapse—The FBI Must Investigate
- 024\* Augmented Intelligence and Organized Medical Staff

## **Reference Committee A**

### **Report(s) of the Council on Medical Service**

- 02 Improving Affordability of Employment-Based Health Coverage
- 03 Review of Payment Options for Traditional Healing Services
- 07 Ensuring Privacy in Retail Health Care Settings
- 08 Sustainable Payment for Community Practices

### **Resolutions**

- 101 Infertility Coverage
- 102 Medicaid & CHIP Benefit Improvements
- 103 Medicare Advantage Plans
- 104 Medicaid Estate Recovery Reform
- 105 Medigap Patient Protections
- 106 Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum
- 107 Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies
- 108 Requiring Payments for Physician Signatures
- 109 Coverage for Dental Services Medically Necessary for Cancer Care
- 110 Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses
- 111 Protections for “Guarantee Issue” of Medigap Insurance and Traditional Medicare
- 112 Private and Public Insurance Coverage for Adaptive Sports Equipment including Prostheses and Orthoses
- 113 Support Prescription Medication Price Negotiation
- 114 Breast Cancer Screening/Clinical Breast Exam Coverage
- 115 Payments by Medicare Secondary or Supplemental plans
- 116\* Increase Insurance Coverage for Follow-Up Testing After Abnormal Screening Mammography
- 117\* Insurance Coverage for Gynecologic Oncology Care
- 118\* Public and Private Payer Coverage of Diagnostic Interventions Associated With Colorectal Cancer Screening and Diagnosis

## Reference Committee B

### Report(s) of the Board of Trustees

- 09 Council on Legislation Sunset Review of 2014 House P
- 11 Safe and Effective Overdose Reversal Medications in Educational Settings
- 13 Prohibiting Covenants Not-to-Compete
- 14 Physician Assistant and Nurse Practitioner Movement Between Specialties
- 15 Augmented Intelligence Development, Deployment, and Use in Health Care
- 16 Support for Mental Health Courts
- 17 Drug Policy Reform
- 18 Supporting Harm Reduction
- 19 Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication

### Resolutions

- 201 Research Correcting Political Misinformation and Disinformation on Scope of Practice
- 202 Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims
- 203 Medicaid Patient Accountability
- 204 Staffing Ratios in the Emergency Department
- 205 Medical-Legal Partnerships & Legal Aid Services
- 206 Indian Health Service Youth Regional Treatment Centers
- 207 Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse
- 208 Improving Supplemental Nutrition Programs
- 209 Native American Voting Rights
- 210 Support for Physicians Pursuing Collective Bargaining and Unionization
- 211 Deceptive Hospital Badging 2.0
- 212 Advocacy Education Towards a Sustainable Medical Care System
- 213 Access to Covered Benefits with an Out of Network Ordering Physician
- 214 Support for Paid Sick Leave
- 215 American Indian and Alaska Native Language Revitalization and Elder Care
- 216 The AMA Supports H.R. 7225, the Bipartisan "Administrative Law Judges Competitive Service Restoration Act"
- 217 Protecting Access to IVF Treatment
- 218 Designation of Descendants of Enslaved Africans in America
- 219 Bundling for Maternity Care Services
- 220 Restorative Justice for the Treatment of Substance Use Disorders
- 221 Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability
- 222 Studying Avenues for Parity in Mental Health & Substance Use Coverage
- 223 Increase in Children's Hospital Graduate Medical Education Funding
- 224 Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
- 225 Humanitarian Efforts to Resettle Refugees
- 226 Protecting Access to IVF Treatment
- 227 Medicare Reimbursement for Telemedicine
- 228 Waiver of Due Process Clauses
- 229 Opposition to Legalization of Psilocybin

- 230 Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion
- 231 Supporting the Establishment of Rare Disease Advisory Councils
- 232 Medicare Advantage Part B Drug Coverage
- 233 Prohibiting Mandatory White Bagging
- 234 State Prescription Drug Affordability Boards - Study
- 235 Establish a Cyber-Security Relief Fund
- 236 Support of Physicians Pursuing Collective Bargaining and Unionization
- 237 Encouraging the Passage of the Preventive Health Savings Act (S.114)
- 238 AMA Supports Efforts to Fund Overdose Prevention Sites
- 239 Requiring stores that sell tobacco products to display NYS Quitline information
- 240 Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas
- 241 Healthcare Cybersecurity Breaches
- 242 Cancer Care in Indian Health Services Facilities
- 243 Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes
- 244 Graduate Medical Education Opportunities for American Indian and Alaska Native Communities
- 245\* Patient Access to Covered Benefits Ordered by Out-of-Network Physicians
- 246\* Augmented Intelligence in Health Care
- 247\* Prohibit Health Benefit Plans From Charging Cost Sharing for Covered Prostate Cancer Screening
- 248\* Sustain Funding for HRSA (Health Resources Services and Administration) 340B Grant-Funded Programs
- 249\* Pediatric Specialty Medicaid Reimbursement
- 250\* Endorsement of the Uniform Health-Care Decisions Act
- 251\* Streamline Payer Quality Metrics
- 252\* Model Legislation to Protect the Future of Medicine

## **Reference Committee C**

### **Report(s) of the Board of Trustees**

- 31 The Morrill Act and Its Impact on the Diversity of the Physician Workforce

### **Report(s) of the Council on Medical Education**

- 01 Council on Medical Education Sunset Review of 2014 House of Delegates' Policies
- 02 The Current Match Process and Alternatives

### **Resolutions**

- 301 Fairness for International Medical Students
- 302 The Role of Maintenance of Certification
- 303 Amend Policy D-275.948 Title "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training". Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards.
- 304 Spirituality in Medical Education and Practice
- 305 Public Service Loan Forgiveness Reform
- 306 Unmatched Graduating Physicians
- 307 Access to Reproductive Health Services When Completing Physician Certification Exams
- 308 Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being
- 309 Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine
- 310 Accountability & Transparency in GME funding with Annual Report
- 311 Physician Participation in Healthcare Organizations
- 312 AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians
- 313 CME for Rural Preceptorship
- 314 Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule
- 315 Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations
- 316 Reassessment of Continuing Board Certification Process
- 317 Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians
- 318 Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care
- 319 AMA Support of U.S. Pathway Programs
- 320\* Anti-Racism Training for Medical Students and Medical Residents



## **Reference Committee D**

### **Report(s) of the Council on Science and Public Health**

- 03 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders
- 06 Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases
- 09 Prescribing Guided Physical Activity for Depression and Anxiety
- 10 Teens and Social Media
- 11 Stand Your Ground Laws
- 13 Decreasing Youth Access to E-Cigarettes

### **Resolutions**

- 401 Addressing Social Determinants of Health Through Closed Loop Referral Systems
- 402 Guardianship and Conservatorship Reform
- 403 Occupational Screenings for Lung Disease
- 404 Protections Against Surgical Smoke Exposure
- 405 Default Proceed Firearm Sales and Safe Storage Laws
- 406 Opposition to Pay-to-Stay Incarceration Fees
- 407 Racial Misclassification
- 408 Indian Water Rights
- 409 Toxic Heavy Metals
- 410 Access to Public Restrooms
- 411 Missing and Murdered Indigenous Persons
- 412 Lithium Battery Safety
- 413 Sexuality and Reproductive Health Education
- 414 Addressing the Health Sector's Contributions to the Climate Crisis
- 415 Building Environmental Resiliency in Health Systems and Physician Practices
- 416 Furthering Environmental Justice and Equity
- 417 Reducing Job-Related Climate Risk Factors
- 418 Early and Periodic Eye Exams for Adults
- 419 Addressing the Health Risks of Extreme Heat
- 420 Equity in Dialysis Care
- 421 Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)
- 422 Immunization Registry
- 423 HPV Vaccination to Protect Healthcare Workers over Age 45
- 424 LGBTQ+ Senior Health
- 425 Perinatal Mental Health Disorders among Medical Students and Physicians
- 426 Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action
- 427 Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
- 428 Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals
- 429 Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants
- 430 Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages
- 431 Combatting the Public Health Crisis of Gun Violence
- 432 Resolution to Decrease Lead Exposure in Urban Areas

- 433 Improving Healthcare of Rural Minority Populations
- 434\* Universal Newborn Eye Screening
- 435\* Radiation Exposure Compensation

## **Reference Committee E**

### **Report(s) of the Council on Science and Public Health**

- 01 Council on Science and Public Health Sunset Review of 2014 House Policies
- 02 Comparative Effectiveness Research
- 04 Sex and Gender Differences in Medical Research
- 05 Biosimilar/Interchangeable Terminology
- 07 Androgen Deprivation in Incarceration
- 08 Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing
- 12 Universal Screening for Substance Use and Substance Use Disorders during Pregnancy

### **Resolutions**

- 501 Fragrance Regulation
- 502 Tribally-Directed Precision Medicine Research
- 503 Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)
- 504 FDA Regulation of Biosimilars
- 505 Mitigating the Harms of Colorism and Skin Bleaching Agents
- 506 Screening for Image Manipulation in Research Publications
- 507 Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies
- 508 AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis
- 509 Addressing Sarcopenia and its Impact on Quality of Life
- 510 Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”
- 511 National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling
- 512 Opioid Overdose Reversal Agents Where AED’s Are Located
- 513 Biotin Supplement Packaging Disclaimer
- 514\* Safety With Devices Producing Carbon Monoxide
- 515\* Advocacy for More Stringent Regulations/Restrictions on the Distribution of Marijuana

## **Reference Committee F**

### **Report(s) of the Board of Trustees**

- 01 Annual Report
- 04 AMA 2025 Dues
- 21 American Medical Association Meeting Venues and Accessibility
- 23 United States Professional Association for Transgender Health Observer Status in the House of Delegates
- 25 Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences
- 26 Equity and Justice Initiatives for International Medical Graduates
- 28 Encouraging Collaboration Between Physicians and Industry in AI Development
- 33 Employed Physicians
- 35\* Mitigating the Cost of Medical Student Participation in AMA Meetings

### **Report(s) of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development**

- 01 Joint Council Sunset Review of 2014 House Policies

### **Report(s) of the Council on Long Range Planning and Development**

- 01 Establishment of a LGBTQ+ Section

### **Report of the House of Delegates Committee on the Compensation of the Officers**

- 01 Compensation Committee Report

### **Report(s) of the Speakers**

- 01 Report of the Resolution Modernization Task Force Update

### **Resolutions**

- 601 Annual Holocaust Remembrance Event
- 602 Ranked Choice Voting
- 603 End Attacks on Health and Human Rights in Israel and Palestine
- 604 Confronting Ageism in Medicine
- 605 Walking the Walk of Climate Change
- 606 Creation of an AMA Council with a Focus on Digital Health Technologies and AI
- 607 Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health
- 608 The American Medical Association Diversity Mentorship Program
- 609\* Standardization of the Endorsement Process
- 610\* Opposition to Collective Punishment

## **Reference Committee G**

### **Report(s) of the Board of Trustees**

- 29 Transparency and Accountability of Hospitals and Hospital Systems
- 30 Proper Use of Overseas Virtual Assistants in Medical Practice

### **Report(s) of the Council on Medical Service**

- 01 Council on Medical Service Sunset Review of 2014 House Policies
- 05 Patient Medical Debt
- 06 Economics of Prescription Medication Prior Authorization

### **Resolutions**

- 701 Opposition to the Hospital Readmissions Reduction Program
- 702 The Corporate Practice of Medicine, Revisited
- 703 Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation
- 704 Pediatric Readiness in Emergency Departments
- 705 20 Minute Primary Care Visits
- 706 Automatic Pharmacy-Generated Prescription Requests
- 707 Alternative Funding Programs
- 708 Medicolegal Death Investigations
- 709 Improvements to Patient Flow in the U.S. Healthcare System
- 710 The Regulation of Private Equity in the Healthcare Sector
- 711 Insurer Accountability When Prior Authorization Harms Patients
- 712 Full transparency - Explanation of Benefits
- 713 Transparency – non-payment for services to patients with ACA exchange plans with unpaid premiums
- 714\* Automatic Downcoding of Claims
- 715\* Electronic Medical Records Submission
- 716\* Impact of Patient Non-adherence on Quality Scores
- 717\* Mentorship to Combat Prior Authorization
- 718\* Transparency at the Pharmacy Counter
- 719\* Support Before, During, and After Hospital Closure or Reduction in Services
- 720\* The Hazards of Prior Authorization
- 721\* Developing Physician Resources to Optimize Practice Sustainability

## REPORT 31 OF THE BOARD OF TRUSTEES (A-24)

The Morrill Act and its impact on the diversity of the physician workforce

## EXECUTIVE SUMMARY

This report was written in response to Resolution 308 brought forth by the Medical Student Section at the 2022 Annual Meeting of the House of Delegates. This resolution was referred for decision due to concern about legal implications of the first resolve related to both federal and state laws regarding affirmative action, land grant status, and federal trust responsibilities. To inform this action, a management report was subsequently submitted to the Board of Trustees (BOT) entitled “University Land Grant Status in Medical School Admissions.” The management report summarized concerns about implementing original Resolution 308-A-22 due to unknown legal implications and potentially unintended and negative consequences for communities that have been historically excluded from medicine. Also, it emphasized the importance of improving the health status of American Indian and Alaska Native (AI/AN) communities and increasing the number of AI/AN physicians who are uniquely qualified to provide care to these communities as well as the need to better understand the Morrill Act and its impact on efforts to diversify the physician workforce. Thus, the management report recommended that in lieu of Resolution 308-A-22, the AMA “study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce.”

This report summarizes the extensive history of land acquisition, public education, federal recognition of tribes, the Morrill Act, economic impacts, and current physician workforce. It also reviews the role of the American Medical Association in that history as well as more recent improvement efforts. The report addresses concerns cited by the original author and notes the substantial role that medical education and organized medicine has played and can continue to play for the betterment of the physician workforce and AI/AN students and populations. Diversification of the physician workforce is imperative to meeting the health care needs in underserved communities across the U.S., particularly AI/AN populations. Medical education and organized medicine have much to learn from tribal nations, schools, and agencies to provide more culturally responsive information, understanding, and support. The report offers recommendations to strengthen its existing policies and provide leadership in more actionable efforts.

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 31-A-24

Subject: The Morrill Act and its impact on the diversity of the physician workforce

Presented by: Willie Underwood, MD, MSc, MPH, Chair

Referred to: Reference Committee C

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### INTRODUCTION

At the 2022 Annual Meeting of the House of Delegates, the Medical Student Section authored Resolution 308 that asked the American Medical Association (AMA) to:

(1) work with the Association of American Medical Colleges, Liaison Committee on Medical Education, Association of American Indian Physicians, and Association of Native American Medical Students to design and promulgate medical school admissions recommendations in line with the federal trust responsibility; and (2) amend Policy H-350.981, “AMA Support of American Indian Health Career Opportunities,” by addition to read as follows: (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals. These efforts should include, but are not limited to, priority consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and robust mentorship programs that support the successful advancement of these trainees. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect. (6) Our AMA will engage with the Association of Native American Medical Students and Association of American Indian Physicians to design and disseminate American Indian and Alaska Native medical education curricula that prepares trainees to serve AI/AN communities.

This resolution was referred for decision, due to concern about legal implications of the first resolve related to both federal and state laws regarding affirmative action, land grant status, and federal trust responsibilities. To inform this action, a management report was subsequently submitted to the Board of Trustees (BOT) entitled “University Land Grant Status in Medical School Admissions.” That report noted the central issue is improving the health status of AI/AN communities and the need to increase the number of AI/AN physicians who are uniquely qualified to provide culturally humble care to these communities. Further, it noted there may be risks associated with implementing original Resolution 308-A-22 due to unknown legal implications and potentially unintended and negative consequences for communities that have been historically

excluded from medicine. The management report identified a need to further understand all components of the Morrill Act that may impact efforts to diversify the physician workforce prior to developing any new policy recommendations. It recommended that in lieu of Resolution 308-A-22, the AMA:

1. Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Association of American Indian Physicians, and Association of Native American Medical Students to increase representation of American Indian physicians in medicine by promoting effective practices in recruitment, matriculation, retention and graduation of American Indian medical students. (Directive to Take Action)
2. Amend Policy H-350.981, “AMA Support of American Indian Health Career Opportunities,” by addition and deletion to read as follows:  
 (2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect. (Modify Current HOD Policy)
3. **Study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce. (Directive to Take Action)**

This BOT report is in response to Recommendation #3 above.

## BACKGROUND

To better understand the Morrill Act and its impact, it is important to review the history of land acquisition and public education as well as the federal recognition of tribes.

### *Public education and land acquisition*

Support for public education was realized early in the formation of the republic. According to the [Northwest Ordinance](#) of 1787, “Knowledge, being necessary to good government and the happiness of mankind, schools and the means of education shall forever be encouraged.”<sup>1</sup> Those who did receive instruction were primarily white children. Financing for early schools varied and often charged tuition. Thus, many children were not included, depending on income, race, ethnicity, gender, geographic location, and other reasons. Some rural areas had no schools. The nation’s leaders at the time “believed strongly that preserving democracy would require an educated population that could understand political and social issues and would participate in civic life, vote wisely (only white men could vote), protect their rights and freedoms, and resist tyrants



and demagogues.”<sup>2</sup> Free public education began to expand in the 1830s, with states taking on the provision of public education. Land acquisition, however, was key to implementing such education widely. The largest occupier and ‘owner’ of such land at the time were American Indians — the native and original caregivers of what is now the United States.

By 1887, American Indian tribes owned 138 million acres. However, the passage of the [General Allotment Act](#) of 1887 (The Dawes Act) greatly impacted such ownership as their land became subject to state and local taxation, of which many could not afford. By 1934, the total had dropped to 48 million acres.<sup>3</sup> [The Indian Reorganization Act](#) of 1934 (IRA) tamed this era of allotment and marked a shift toward the promotion of tribal self-government. Subsequent Congressional acts impacting tribes and their land — ownership, use, and development — include the following:

- [Indian Mineral Leasing Act](#): 1938
- [Indian Self-Determination and Education Assistance Act](#): 1975
- [Indian Mineral Development Act](#): 1982
- [Indian Tribal Energy Development and Self-Determination Act](#): 2005
- [Indian Tribal Energy Development and Self-Determination Act Amendments](#): 2017

There are approximately 2.4 billion acres in today’s United States.<sup>4</sup> About 56 million acres of that land (2.3%) is currently held in trust by the U.S. for various American Indian tribes and individuals, making up the majority of American Indian land.<sup>2</sup> With trust land, the federal government holds legal title but the beneficial interest remains with the individual or tribe. Trust lands held on behalf of individuals are known as allotments. Fee land, on the other hand, is purchased by tribes whereby the tribe acquires legal title under specific statutory authority.

#### *The Morrill Act and land-grant universities*

In 1862, Congress passed the [Morrill Act](#) named after Senator Justin Morrill of Vermont. “This act made it possible for states to establish public colleges funded by the development or sale of associated federal land grants. The original intention was to fund colleges of agriculture and mechanical arts.<sup>5</sup> Over 10 million acres provided by these grants were expropriated from tribal lands of Native communities. The new land-grant institutions, which emphasized agriculture and mechanic arts, opened opportunities to thousands of farmers and working people previously excluded from higher education.”<sup>6</sup> Much of this land was taken from American Indian tribes for the benefit of white people by way of treaties and agreements (many of which the federal government did not uphold its end) as well as seizure. In other words, “The government took the land for which it paid little or nothing, from tribes with little bargaining power, that were impoverished, and that were sometimes subject to threats to withhold rations and other benefits if they did not comply.”<sup>7</sup> These now ‘public lands’ were surveyed into townships, and sections were reserved for public schools; however, the land itself was often sold off, with proceeds used to fund the school program. “The system invited misuse by opportunists, and substantial portions of the educational land-grants never benefited education.”<sup>6</sup> Support for land-grants was a significant factor in providing education to white American children.

By way of the Morrill Act, the government granted each state 30,000 acres of public land, issued to its Congressional representatives and senators to be used in establishing a “land grant” university. Some of the land sales financed existing institutions while others chartered new schools. This allocation grew to over 100 million acres. The Morrill land grants put into place a national system of state colleges and universities. Examples of major universities that were chartered as land-grant schools are Cornell University, Washington State University, Clemson University, and University of Nebraska-Lincoln.

Following the Civil War, a [Second Morrill Act](#) was passed in 1890 to address the exclusion of Black individuals from these educational opportunities due to their race. “It required states to establish separate land-grant institutions for Black students or demonstrate that admission was not restricted by race. The act granted money instead of land.”<sup>6</sup> The [1890 Foundation](#) provides additional information about these 19 historically Black colleges and universities (HBCUs), which include Tuskegee University, Tennessee State University, and Alabama A&M University. In 1994, a third land-grant act was passed — the Equity in Educational Land-Grant Status Act — that bestowed land-grant status to American Indian tribal colleges. As a result, these colleges are referred to as the “1994 land-grants.”<sup>8</sup> Today’s land grant university (LGU) system is comprised of institutions resulting from the above-mentioned acts passed in 1862 (57 original), 1890 (19 HBCUs), and 1994 (35 Tribal). “LGUs are located in all 50 states as well as the District of Columbia and six U.S. territories. Of note, the “1994 institutions receive fewer federal funds administered by National Institute of Food and Agriculture — in total — than 1862 and 1890 institutions, and they are ineligible for certain grant types available to 1862 and 1890 institutions. Whereas the 1862 and 1890 institutions receive federal capacity funds specific to agricultural research and extension (which brings research to the public through nonformal education activities), 1994 institutions do not. Although 1994 institutions have more limited enrollment and offer fewer postsecondary degrees than 1862 and 1890 institutions, some argue that funding for agricultural research and extension at the 1994 institutions is insufficient and should be increased.”<sup>9</sup>

### *Education of American Indians*

The inaccurate perception of American Indians as unintelligent and uncivilized led Congress to pass the Indian Civilization Act in 1819 which paid missionaries to educate Natives and promote the government’s notion of civility. Most American Indian children at that time were forcefully relocated and brought to these schools to begin the assimilation into the “Western way of life” under the authority of that Act — thus beginning the troubled history of American Indian boarding schools that is still felt by current generations. One such school built in 1879, the Carlisle Indian Industrial School, coined the term “Kill the Indian to save the man” summarizing a belief system to erase Native culture through assimilation.<sup>10</sup> These children were forcibly separated from their families and not allowed to practice their spirituality, speak their language, or live according to their culture under threat of punishment. They were even given new names. These practices continued through the 1960s. In 1969, a Senate report of the Committee on Labor and Public Welfare, entitled “Indian Education: A National Tragedy--A National Challenge,” summarized the devastating effects of forced assimilation of Native children and the failures of the education system where students also experienced physical abuse, sexual violence, hunger, forced sterilizations, and exposure to diseases. The trauma associated with this contributes to a well-documented historical trauma that has been correlated to the high number of suicides and health inequities experienced by American Indians in the U.S.<sup>11</sup> This trauma has had a devastating impact on the potential number of students who consider enrollment in higher education due to a distrust of any system associated with the U.S. government. Many who have been directly affected by historical traumas have to overcome barriers like depression or other chronic diseases to participate in a system that still does not align to their way of knowing. There was little consideration for the higher education of American Indians (nor how to include a non-colonial perspective) until 1972 with the formation of the [American Indian Higher Education Consortium](#) (AIHEC). Through its network of tribal colleges and universities (TCUs), AIHEC “provides leadership and influences public policy on American Indian higher education issues through advocacy, research, and program

initiatives; promotes and strengthens indigenous languages, cultures, communities, and tribal nations; and through its unique position, serves member institutions and emerging TCUs.”<sup>12</sup>

#### *American Indian affairs and federal recognition of tribes*

In 1775, Congress created a Committee on Indian Affairs under the leadership of Benjamin Franklin. The [U.S. Constitution](#) (Article I, Section 8, Clause 3) gave Congress the power “to regulate commerce with foreign nations, and among the several States, and with the Indian tribes.” The [Bureau of Indian Affairs](#) (BIA) — known over the years as the Indian Office, the Indian Bureau, the Indian Department, and the Indian Service — was established in 1824 to oversee and carry out the government’s trade and treaty relations with the tribes. The BIA received statutory authority from Congress in 1832; in 1849, it was transferred to the newly created U.S. Department of the Interior.<sup>13</sup> “Over the years, the BIA has been involved in the implementation of federal laws that have directly affected all Americans. The General Allotment Act of 1887 opened tribal lands west of the Mississippi to non-Indian settlers, the [Indian Citizenship Act](#) of 1924 granted American Indians and Alaska Natives U.S. citizenship and limited rights to vote, and the New Deal and the Indian Reorganization Act of 1934 restored self-determination and dictated a model the United States expected tribal governments to use. The World War II period of relocation and the post-War termination era of the 1950s led to the activism of the 1960s and 1970s that saw the takeover of the BIA’s headquarters and resulted in the creation of the Indian Self-Determination and Education Assistance Act of 1975. This act as well as the [Tribal Self-Governance Act](#) of 1994 have fundamentally changed how the federal government and the tribes conduct business with each other.”<sup>13</sup> Although the BIA was once responsible for providing health care services to American Indians and Alaska Natives, that role was legislatively transferred to the U.S. Department of Health, Education, and Welfare (now known as the Department of Health and Human Services) in 1954.<sup>13</sup> It remains there under the auspices of the [Indian Health Service](#) (IHS). However, funding for this continues to be a problem. In 2019, IHS spending per capita was only \$4,078 while the national average spending per capita was \$9,726.<sup>14</sup> At that time, it was also reported that American Indians and Alaska Natives (AI/AN) had a life expectancy 5.5 years less than the U.S. all races population (73.0 years compared to 78.5 years) and “die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.”<sup>15</sup> Groups such as the [Tribal Sovereign Leaders on the national Tribal Budget Formulation Workgroup](#) (TBFWG) have provided, and continue to provide, significant insights to inform IHS budget requests.

According to the BIA, “a federally recognized tribe is an AI/AN tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the BIA. Furthermore, federally recognized tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal sovereignty) and are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States.”<sup>16</sup> Over the years, most of today’s federally recognized tribes received federal recognition status by way of treaties, acts of Congress, presidential executive orders or other federal administrative actions, or federal court decisions. In 1978, the Department of the Interior issued procedures for federal acknowledgment of Indian tribes to more uniformly handle requests — found in Part 83 of Chapter 25 of the [Code of Federal Regulations](#).<sup>17</sup> In 1994, Congress enacted the [Federally Recognized Indian Tribe List Act](#). It formally established three ways to achieve federal recognition: (1) by act of Congress, (2) by the administrative procedures under 25 C.F.R. Part 83, or (3) by decision of a United States court. Congress has the authority to terminate a relationship

with a tribe, and only Congress can restore its federal recognition. The act also requires the Secretary of the Interior to annually publish information on federally recognized tribal entities.<sup>18</sup>

As of January 2023, there were 574 federally recognized Tribal entities.<sup>19</sup> There are also many tribes that are not state or federally recognized. There are 324 federally recognized American Indian reservations where 13 percent of the AI/AN population lives. The 2020 Census indicates that 87 percent live outside of tribal statistical areas. It also shows that 9.1 million people identify as AI/AN alone or in combination (2.9 percent of total U.S. population).<sup>20</sup>

## DISCUSSION

### *Economic and educational impacts*

The Morrill Act, as well as the [Homestead Act](#) of 1862, had a significant impact on American expansion. The Homestead Act encouraged western migration by providing settlers with 160 acres of land. Such settlers were required to live on and cultivate the land. After five years, they were entitled to the property upon payment of a small filing fee. While they certainly fostered prosperity and educational opportunities for new American settlers, these came at the expense of the original people — American Indians. The economic significance of these acts cannot be understated. In 2019, sixteen land-grant universities retained over half a million acres of Indigenous lands, generating at least \$8.7 million.<sup>21</sup> See Appendix A for a table of remaining Morrill Act lands and revenue by university.

In addition to the economic impact, thousands of American Indian families were affected by the Indian Civilization Act and boarding schools. Given the lingering effects to this day, it stands to reason that many AI/AN students have a negative attitude toward the education system. According to the Bureau of Indian Education (BIE), “Native youth have the lowest high school graduation rate of students across all schools. Nationally, the AI/AN high school graduation rate is 69 percent, far below the national average of 81 percent.”<sup>22</sup> The BIE funds elementary and secondary schools on 64 reservations in 23 states, serving approximately 42,000 Indian students.<sup>23</sup> These BIE schools hold an average graduation rate of 53 percent. The BIE also serves AI/AN post-secondary students through higher education scholarships, supports funding for tribal colleges and universities, and directly operates two post-secondary institutions — Haskell Indian Nations University in Kansas and the Southwestern Indian Polytechnic Institute in New Mexico.

### *Medical education and the physician workforce*

Significant school dropout rates and lower enrollment in higher education have negatively impacted AI/AN representation in medical education and the physician workforce. According to 2022-2023 data from the Association of American Medical Colleges (AAMC), 174 AI/AN students were enrolled in MD-granting medical schools and 38 graduated.<sup>24</sup> This significant decline from enrollment to graduation is very concerning; medical education needs to figure out why and what to do about it. 2022-2023 data from the American Association of Colleges of Osteopathic Medicine (AACOM) indicated 107 AI/AN students were enrolled in DO-granting medical schools and 12 graduated.<sup>35,36</sup> This represents a 27.4 percent increase in AI/AN enrollment for 2022-2023. The entire educational pathway (PreK-12 and undergraduate) may need to be considered to help AI/AN students to prepare for their studies, promote a sense of belonging, and avail themselves of mentorship opportunities. Tribes have a vested interest in the training of AI/AN students, given they are more likely to return to and serve their own communities as physicians. Such efforts will ultimately foster tribal self-governance and self-determination.

Several universities have taken steps to increase AI/AN representation in medical schools. In 1973, the University of North Dakota launched the Indians Into Medicine (INMED) program, which has recruited, supported, and trained 250 AI/AN physicians. This program has served as a model for other health professions within the university as well as for other medical schools that receive IHS funding. Since many students face financial hardship, INMED offers a free summer program called Med Prep that provides students with stipends, and it helps its medical school students identify potential scholarship options. The university went one step further in 2020 to launch the country's first PhD. program in Indigenous health.<sup>25</sup> In 2020, the Oklahoma State University's College of Osteopathic Medicine (OSU-COM) at the Cherokee Nation established the first medical school established on a Native American reservation, which is a significant achievement among medical schools in relation to the AI/AN population. This medical school just graduated its first inaugural class of "nine Native graduates, who make up more than 20 percent of the class of 46 students".<sup>37</sup> Also, fifteen Native American students graduated from OSU-COM's Tulsa campus. "OSU-COM graduates include students from 14 different tribes including the Cherokee, Choctaw, Muscogee, Seminole, Chickasaw, Alaska Native, Caddo and Osage tribes".<sup>37</sup> Another example is Oregon Health & Science University (OHSU) School of Medicine and its Wy'east Pathway, a 10-month postbaccalaureate program for AI/AN students who unsuccessfully applied to medical school, have an MCAT score below a certain cutoff, or lack clinical experience. The program provides biomedical and MCAT classes as well as cultural support and skills-building to promote success in medical school.<sup>26</sup> Not only do programs like these directly support AI/AN students, but they also promote collaboration with and inclusion of non-indigenous allies. This combination can help to turn the tide on the workforce issue.

The impact of low representation in medical schools is evident when examining the diversity of physician workforce. In 2022, 0.3% of active physicians identified as AI/AN.<sup>27</sup> According to a 2018 [report](#) from the U.S. Government Accountability Office, the vacancy rate at IHS clinics among staff physician positions was about 29% across the eight IHS geographic regions; the highest vacancy was 46% in the areas servicing Bemidji, Minnesota, and Billings, Montana.<sup>28</sup> In addition to representation in practicing medicine, there are also deficits in AI/AN representation in academic positions. One study found that, compared with their white peers, AI/AN individuals had 48% lower odds of holding a full-time faculty position post residency.<sup>29</sup>

As mentioned in other parts of this report, there is distrust in colonial constructs (U.S. laws, policies, and institutions), but there may also be distrust in the colonial medicine through IHS because of the history of forced sterilization and because traditional forms of medicine were outlawed (as well as any religious/cultural beliefs associated with them). In fact, the Department of the Interior's 1883 Code of Indian Offenses noted that "any medicine man convicted of encouraging others to follow traditional practices was to be confined in the agency prison for not less than 10 days or until he could provide evidence that he had abandoned his beliefs."<sup>30</sup> This context has given rise to a distrust of medicine and medical education that continues today.

In June 2023, the Supreme Court of the U.S. (SCOTUS) issued a ruling on affirmative action that eliminated race as a consideration in college and universities' admission processes. This ruling should not change tribal colleges; however, will it likely impact AI/AN students who attend non-tribal institutions because most wrongly collect tribal identity as a racial category. "Most, if not all, mainstream colleges and universities rely entirely on self-reporting when it comes to determining tribal identity of students. This means if a Native student doesn't indicate they are a tribal citizen, then they are not counted as such."<sup>31</sup> This lack of data can impact the understanding of student enrollment as well as funding opportunities. It is critical to re-emphasize that "Native American" is



not only a racial category but also the designation which gives those who are enrolled in federally recognized tribes a protected classification by treaty and is not subject to the SCOTUS decision on race/ethnicity. Many schools may not include identifying Native Americans in their admissions consideration as they may fear violation of the SCOTUS decision.

*The AMA's role: accountability and restitution*

The AMA and its members play a complicated role in the history of American Indians. AMA members were party to the claiming of land in the “Western territories” in the mid-1850s, as described in the A-1857 report “[Report on the Fauna and Medical Topography of Washington Territory](#)”. AMA archives contain a 1865 report entitled “[On Some Causes Tending to Promote the Extinction of the Aborigines of America](#)” which details study of the Onondaga tribe, concluding “But those of us who pity and strive to arrest the downward course of this remnant of the original lords of the forest, may delay what we are wholly unable to prevent, for I much fear that before the poor Indian has learned the laws of his physical nature and how to obey them, economy of time and means, industry, and reliance upon his own muscles and broad acres for his support, instead of looking for the government to hire his teacher and physician, and for his wants to be met by others, without forecast and plan of us own — before these radical changes in his habits are effected — the waning remnant of the Onondagas will forever have passed away.”<sup>32</sup>

Physicians were involved in American Indian boarding schools, the development of the Indian Health Service, and the study of illnesses and healing practices on AI/AN tribes. Their works were published in JAMA and included:

- [The Medicine and Surgery of the Winnebago and Dakota Indians](#) (1883)
- [Improved Sanitary and Social Conditions of the Seminoles of Florida](#) (1896)
- [Indian Method of Treating Measles](#) (1903)
- [The Indian Medical Service](#) (1913)

Past harms also include the AMA's role in promulgating discriminatory practices resulting from the [Flexner Report](#), a landmark 1910 criticism of U.S. medical education resulting in a reduction in the number of medical schools including the closing of 5 out of the 7 historically black medical schools. Past decisions such as these continue to negatively impact populations in need. The AMA acknowledges that AI/AN populations experience significant health disparities up to the present including lower access to care and underfunding of public programs such as the Indian Health Service serving AI/AN communities. In addition, AI/AN persons continue to be severely underrepresented in the physician and healthcare workforce.

The AMA launched various supportive efforts such as:

- Asked the federal government to step in to stop the spread of trachoma in Native communities ([A-1924](#)) and provide better health services for the population ([A-1929](#));
- Issued AMA Statement on Infant Mortality ([A-1968](#));
- Advocated for the transfer of functions relating to health and hospitalization of American Indians from the Bureau of Indian Affairs to the U.S. Public Health Service ([I-1953](#));
- Appealed for more funding for hospitals and health services on reservations ([I-1957](#));
- Collaborated with the IHS on efforts related to health care delivery and health aide training programs ([I-1970](#));
- Led large-scale study of health care for American Indians that was used to guide the Senate's “Indian Health Care Improvement Act” of 1976 ([I-1973](#));

- 1 • Created Project USA to recruit physicians to medically underserved areas, including
- 2 AI/AN reservations ([I-1975](#));
- 3 • Sought to exempt Indian Health Services from competitive procurement practices
- 4 regulations ([A-1984](#));
- 5 • Initiated a project with the AAIP to improve health care for American Indians ([A-1995](#));
- 6 • With the National Medical Association, established the Commission to End Health Care
- 7 Disparities in 2004 – a collaboration of health care organizations to address racial and
- 8 ethnic health care disparities and diversity in the physician workforce.
- 9 • In 2013, the AMA launched its innovative “Accelerating Change in Medical Education”
- 10 initiative to rebuild medical education from the ground up. Now known as the
- 11 [ChangeMedEd](#) initiative, this effort has fostered collaborations with schools like Oregon
- 12 Health & Science University School of Medicine and the University of Washington School
- 13 of Medicine to increase the numbers of AI/AN students and faculty.

14  
15 Although the Commission was retired in 2016, a new effort emerged in 2018 through the adoption  
16 of policy calling for a strategic framework to address health equity on a national scale — resulting  
17 in the creation of the [AMA Center for Health Equity](#). Among other things, the Center is leading a  
18 task force that will “guide organizational transformation within and beyond the AMA toward  
19 restorative justice to promote truth, reconciliation, and healing in medicine and medical education.  
20 ...The task force will inform and advise the AMA on ways to establish restorative justice dialogues  
21 between AMA leaders, physicians from historically marginalized racial and ethnic groups and their  
22 physician associations, and other critical stakeholders.”<sup>33</sup>

23  
24 Recently, an AMA [article](#) from December 2023 addressed vacancies at the Indian Health Service.  
25 Also, an [AMA Update](#) on January 8, 2024 discussed how tribal medical education programs could  
26 solve the rural health care crisis. Featuring Oklahoma State University College of Osteopathic  
27 Medicine’s unique partnership with The Cherokee Nation, the discussion addressed the importance  
28 of physicians truly understanding the communities they serve.

29  
30 AMA Advocacy has been actively participating in efforts to support AI/AN populations and related  
31 physicians. Federal efforts in just the last two years include:

- 32 • May 2022: [Letter](#) sent to Senators Mastro and Murkowski in support of the Indian Health
- 33 Service Health Professions Tax Fairness Act (S.2874).
- 34 • April 2023: [Letter](#) sent to U.S. Department of Agriculture addressing Menu Planning
- 35 Options for American Indian and Alaska Native Students.
- 36 • October 2023: [Letter](#) sent to U.S. Department of Health and Human Services and Indian
- 37 Health Service to highlight the importance of high quality, timely care for American
- 38 Indians, Alaska Natives, and Native Hawaiians, particularly as it related to physician and
- 39 medical student members.
- 40 • February 2024: Multi-organizational [letter](#) sent to both the House Appropriations
- 41 Subcommittee on Interior and Senate Appropriations Subcommittee on Interior,
- 42 Environment, and Related Agencies, Environment, and Related Agencies. This letter
- 43 detailed support for the inclusion of \$30 million in new funding in the FY2025 Interior,
- 44 Environment, and Related Agencies appropriations bills to address chronic clinical staff
- 45 shortages across Indian Country through GME programming.

46  
47 The AMA Foundation (AMAF) funds the [Physicians of Tomorrow Program](#). This program  
48 distributes a \$10,000 tuition assistance scholarship to medical students approaching their final year  
49 of school with the goal of creating a diverse cohort of students who are dedicated to serving

underserved communities. The AMAF is also bringing attention to AI/AN issues in medical education, as seen in a 2022 [article](#) featuring AMA members. The [AMA Ed Hub](#)<sup>TM</sup> offers a variety of equity-related educational opportunities — from its panel discussion on [Truth and Reconciliation in Medicine](#) to its Prioritizing Equity series. Titles of relevance include:

- [For Us, By Us: Advocating for Change in Native Health Policy](#)
- [Getting to Justice in Education](#)
- [The Root Cause and Considerations for Health Care Professionals](#)
- [How the Past Informs the Present in Healthcare](#)

## RELEVANT AMA POLICIES

The AMA has several policies in support of AI/AN tribes and communities as well as students and trainees in order to foster diversity of the physician workforce in an effort to improve public health including AI/AN populations. For example:

- [AMA Support of American Indian Health Career Opportunities H-350.981](#) promotes recruitment of AI/AN into health careers including medicine and the concept of AI/AN self-determination.
- [Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980](#) establishes a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.
- [Underrepresented Student Access to US Medical Schools H-350.960](#) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination.
- [Strategies for Enhancing Diversity in the Physician Workforce H-200.951](#) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality.
- [Cultural Leave for American Indian Trainees H-350.957](#) recognizes the importance of cultural identity in fostering trainee success and supports accommodating cultural observances.

See Appendix B for the full policies. Additional policies can be accessed in the [AMA Policy Finder](#) database, which include:

- [Strategies for Enhancing Diversity in the Physician Workforce D-200.985](#)
- [Continued Support for Diversity in Medical Education D-295.963](#)
- [AMA Support of American Indian Health Career Opportunities H-350.981](#)
- [Indian Health Service H-350.977](#)
- [Desired Qualifications for Indian Health Service Director H-440.816](#)
- [Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987](#)
- [Improving Health Care of American Indians H-350.976](#)
- [Plan for Continued Progress Toward Health Equity H-180.944](#)

## SUMMARY AND RECOMMENDATIONS

This report illuminates these concerns as well as the substantial part that medical education and organized medicine has played and can continue to play for the betterment of the physician



workforce and AI/AN students and populations. Organizations like the [Association of American Indian Physicians](#) (AAIP) hold an esteemed role in such efforts. AAIP was established in 1971 by a group of 14 AI/AN physicians to support AI/AN communities and serve as an educational, scientific, and charitable nonprofit.

As stated in the AAMC's [2018 publication](#), Reshaping the Journey: American Indians and Alaska Natives in Medicine, "Medical schools are chiefly responsible for the development of what the physician workforce looks like today and what it will look like in the future.... We must view this issue as a national crisis facing not just the American Indian-Alaskan Native (AI/AN) communities, but all medical schools and teaching hospitals.... We need transformative thinking and a new systems-based approach if we are to resolve this crisis with a plausible solution."<sup>34</sup> Diversification of the physician workforce is imperative to meeting the health care needs in underserved communities across the U.S., particularly AI/AN populations. Also, medical education has much to learn from tribal nations, schools, and organizations to provide more culturally responsive information, understanding, and support.

The Board of Trustees therefore recommends that the following recommendations be adopted, and the remainder of this report be filed. That our AMA:

1. Amend [AMA Support of American Indian Health Career Opportunities H-350.981](#) by addition to read:
  - (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations to include training a workforce from and for these tribal nations.
  - (6) Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting land-grant university system, and the federal trust responsibility related to tribal nations.
2. Amend [AMA Support of American Indian Health Career Opportunities D-350.976](#) by deletion of clause (2) as having been accomplished by this report.
 

~~(2) study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce.~~
3. Amend [AMA Support of American Indian Health Career Opportunities D-350.976](#) by addition of a new clause to read:
 

Convene key parties, including but not limited to the Association of American Indian Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as Indian Health Service and National Indian Health Board, to discuss the representation of AI/AN physicians in medicine and promotion of effective practices in recruitment, matriculation, retention, and graduation of medical students.
4. Reaffirm the following policies:
  - a. [Indian Health Service H-350.977](#)
  - b. [Underrepresented Student Access to US Medical Schools H-350.960](#)
  - c. [Strategies for Enhancing Diversity in the Physician Workforce H-200.951](#)
  - d. [Continued Support for Diversity in Medical Education D-295.963](#)
  - e. [AMA Support of American Indian Health Career Opportunities D-350.976.](#)

1

2

3     Fiscal note: \$1,000

## APPENDIX A: Remaining Morrill Act lands and revenue by university

University	Total Morrill acres found	Endowment raised as of 1914	Remaining acres with surface rights	Surface royalties raised, FY 2019	Remaining acres with mineral rights	Mineral royalties raised, FY 2019
Colorado State University	89,321	\$185,956	19,130	\$77,526	42,572	\$662,596
Kansas State University	87,290	\$491,746	0	N/A	6,080	\$163,345
Montana State University	140,385	\$533,149	63,474	\$623,941	77,929	\$6,670
New Mexico State University	248,964	\$241,909	194,571	\$1,217,672	254,200	\$353,587
North Dakota State University	130,471	\$455,924	15,117	\$308,142	66,109	\$2,874,800
South Dakota State University	159,832	\$128,804	36,617	\$608,583	160,000	\$27,365
University of Arizona	143,684	\$450,000	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN
University of California	150,525	\$732,233	0	N/A	441.6	\$1,947
University of Idaho	87,445	\$129,615	33,527	\$358,258	70,000	\$1,188
University of Minnesota	94,631	\$579,430	0	N/A	240	\$0
University of Missouri	270,613	\$363,441	14,787	UNKNOWN	0	N/A
University of Nebraska	89,920	\$560,072	6,173	\$426,619	0	N/A
University of Wisconsin	235,690	\$303,594	0	N/A	6,400	\$0
University of Wyoming	89,849	\$73,355	71,066	UNKNOWN	UNKNOWN	UNKNOWN
Utah State University	198,837	\$194,136	27,577	\$83,769	51,724	\$943,843
Washington State University	90,081	\$247,608	71,147	\$4,250,000	86,657	\$1,936

[The land-grant universities still profiting off Indigenous homelands](#), High Country News, 2020.

## APPENDIX B – RELEVANT AMA POLICIES

### [AMA Support of American Indian Health Career Opportunities H-350.981](#)

AMA policy on American Indian health career opportunities is as follows:

(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

### [Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980](#)

Our AMA will establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

### [Underrepresented Student Access to US Medical Schools H-350.960](#)

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.

### [Strategies for Enhancing Diversity in the Physician Workforce H-200.951](#)

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in

better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

#### [Cultural Leave for American Indian Trainees H-350.957](#)

Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities.

#### [Strategies for Enhancing Diversity in the Physician Workforce D-200.985](#)

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: (a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; (b) Diversity or minority affairs offices at medical schools; (c) Financial aid programs for students from groups that are underrepresented in medicine; and (d) Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically underserved areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with their requirements for a diverse student body and faculty. 5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population. 6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity. 7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers. 8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs. 9. Our AMA will recommend that medical school admissions committees and residency/fellowship programs use holistic assessments of applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education with the goal of improving health care for all communities. 10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP). 11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities. 12. Our AMA unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population. 13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.

#### [Continued Support for Diversity in Medical Education D-295.963](#)

Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee

on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

#### [AMA Support of American Indian Health Career Opportunities H-350.981](#)

AMA policy on American Indian health career opportunities is as follows:

(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) ) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

#### [Indian Health Service H-350.977](#)

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian



care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs. (7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

#### [Desired Qualifications for Indian Health Service Director H-440.816](#)

Our AMA supports the following qualifications for the Director of the Indian Health Service:

1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.
6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs.

#### [Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987](#)

1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (IHS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.
6. Our AMA supports an increase to the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) and encourages state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally driven health improvement programs.

[Improving Health Care of American Indians H-350.976](#)

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens. (2) The federal government provide sufficient funds to support needed health services for American Indians. (3) State and local governments give special attention to the health and health-related needs of non-reservation American Indians in an effort to improve their quality of life. (4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs. (5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians. (6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents. (7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems. (8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians. (9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside. (10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians. (11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

[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.



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## REPORT OF THE BOARD OF TRUSTEES

B of T Report 35-A-24

Subject: Mitigating the Cost of Medical Student Participation in AMA Meetings  
(Resolution 617-A-22)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

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At the 2022 Annual Meeting, the House of Delegates (HOD) adopted Resolution 617, directing AMA to “study mechanisms to mitigate costs incurred by medical students, residents and fellows who participate at national in-person AMA conferences.” This report describes the costs of and funding opportunities for student travel to AMA meetings and explores current and future AMA efforts to mitigate meetings costs for medical students.

### BACKGROUND

#### *Involvement opportunities at in-person meetings*

Annual and Interim Section Meetings are the primary in-person AMA involvement opportunity for medical students. The Medical Student Section (MSS), whose meeting participants are a mixture of students formally representing their medical schools in policymaking and other business activities (~30 percent) and students attending to participate in non-business activities such as education sessions and networking (~70 percent), typically meets over the two days immediately before the opening of the HOD. Over the last several years, policymaking activities have accounted for a range of approximately 60 to 75 percent of MSS meeting time, with education sessions and other activities accounting for the balance, 25 to 40 percent, of meeting time. While all medical students are invited to attend the MSS meeting, the nature of the MSS representational structure sets the expectation that at least one representative from each medical school/campus attend the meeting. In-person attendance at MSS meetings has ranged from 350 to 400 since the post-pandemic return to in-person meetings at A-22.

In addition to participation in Section meetings, many students attend the HOD meeting as medical student regional delegates/alternates (52 in 2023, about 15 percent of all MSS meeting attendees). Travel funding for regional delegates and other student members of the HOD varies from no coverage to full funding, but typically is covered largely by the state medical societies endorsing these members and with whom they are seated in the HOD.

#### *Costs and funding for meeting participation*

To better understand the impact of meeting costs and the availability of funding on meeting participation, a survey was distributed to medical students and residents/fellows at the 2022 Interim Meeting and via other MSS and RFS communication channels. 265 completed surveys were received (75 percent medical students, 25 percent residents and fellows), with the following results noted:

- Among those who had never attended an AMA Annual or Interim Meeting (approximately one third of respondents), 80 percent cited lack of funding as a reason for not attending, and, unsurprisingly, nearly all indicated that they would be likely to attend if they did receive funding.
- Among those who had attended an AMA Annual or Interim Meeting (approximately two thirds of respondents), 70 percent received funding – primarily from a state or specialty medical society (50 percent) and/or a medical school/chapter (40 percent). While the level of funding varied, in most cases it covered a majority of meeting-related expenses, and only 10 percent of respondents estimated that they had spent more than \$1,000 to attend an AMA Annual or Interim meeting. 66 percent of these respondents said they would not attend AMA meetings if they did not receive funding.

To further assess the cost of meeting participation for medical students, a second survey was distributed to medical students who had registered to attend the 2023 MSS Annual Meeting and/or the 2023 MSS Interim Meeting. 408 individuals responded to the survey, of whom 263 were medical students who had attended at least one MSS meeting in 2023. Responses from 61 students who did not provide cost/funding information were excluded from analysis.

As a starting point, the analysis sought to ascertain cost and funding information for “rank-and-file” student members who do not serve in roles that traditionally are funded by the AMA or another third party. Accordingly, the primary analysis (Table 2) further excluded 72 students with 127 trips who were medical student regional delegates/alternates (whose trip costs typically are covered by the state medical societies that endorse them and with whom they are seated in the HOD<sup>1</sup>) or were MSS Governing Council members or student members of AMA Councils (whose trip costs are covered by AMA).

**Table 1: Summary of survey responses**

	Individual responses	Trips with cost/funding info
Total survey responses	408	
Excluded: Did not attend a meeting	-145	0
Attended at least one meeting	263	306
Excluded: Did not provide cost/funding info	-61	0
Excluded: GC/Council/HOD members	-72	-127
Final analyzable sample for primary funding analysis	130	179

Table 2 details what these 179 trips taken by non-GC/Council/HOD members (84 at A-23, 95 at I-23) cost and how they were funded. The average cost across all trips was \$971. 80 percent of trips were funded at least in part by one or more third parties, receiving an average of \$874 third-party funding per trip; the average self-funding for trips that received full or partial third-party support was \$204 per trip. By comparison, for the 20 percent of trips that were fully self-funded by the student (i.e., \$0 third-party funding received), the average out-of-pocket cost was substantially more, at \$547 per trip.

<sup>1</sup> See BOT Report 27-A-24 for further discussion of AMA funding of delegates/alternates representing state and specialty medical societies in the HOD.

**Table 2: Trip cost by manner of funding for non-GC/Council/HOD members**

Manner of funding	Portion of 179 trips funded in this manner	Average self-funding	Average third-party funding	Average total trip cost
Fully self-funded (n=36)	20%	\$547	\$0	\$547
Partially funded by third party (n=88)	49%	\$332	\$631	\$963
Fully funded by third party (n=55)	31%	\$0	\$1,262	\$1,262
<i>Partially or fully funded by third party (n=143)</i>	<i>80%</i>	<i>\$204</i>	<i>\$874</i>	<i>\$1,078</i>
<b>All trips (n=179)</b>	<b>100%</b>	<b>\$273</b>	<b>\$698</b>	<b>\$971</b>

1 Secondly, travel costs were analyzed for 127 trips taken by student GC/Council/HOD members,  
2 who were excluded from the primary analysis shown in Table 2. As detailed in Table 3, the survey  
3 found that 84 percent of trips taken by these student leaders were partially or fully funded by one or  
4 more third parties, receiving an average of \$1,118 third-party funding per trip; the average self-  
5 funding for trips that received full or partial third-party support was \$284 per trip. It should be  
6 noted that student GC/Council/HOD member roles typically require them to spend more nights at  
7 AMA/MSS meetings (up to seven nights for student members of the HOD who also attend the full  
8 MSS meeting) than students who attend only the MSS meeting (up to three nights). Consequently,  
9 direct comparison of trip costs and funding amounts between GC/Council/HOD members (Table 3)  
10 and non-GC/Council/HOD members (Table 2) should be avoided.

**Table 3: Trip cost by manner of funding for GC/Council/HOD members**

Manner of funding	Portion of 127 trips funded in this manner	Average self-funding	Average third-party funding	Average total trip cost
Fully self-funded (n=20)	16%	\$923	\$0	\$923
Partially funded by third party (n=65)	51%	\$468	\$1,109	\$1,577
Fully funded by third party (n=42)	33%	\$0	\$1,664	\$1,664
<i>Partially or fully funded by third party (n=107)</i>	<i>84%</i>	<i>\$284</i>	<i>\$1,327</i>	<i>\$1,611</i>
<b>All trips (n=127)</b>	<b>100%</b>	<b>\$385</b>	<b>\$1,118</b>	<b>\$1,503</b>

11 The 145 respondents who did not attend an MSS meeting in 2023 cited the following reasons for  
12 not attending. Note, the number and percentages exceed 145 and 100 percent, respectively, because  
13 respondents could select multiple reasons for not attending.

**Table 4: Reasons for not attending**

Reason for not attending	Portion of reason cited
Cost	77% (n=111)
Could not get time off to travel to meeting	33% (n=48)
Did not have defined role at meeting	15% (n=21)
Other students from school were attending	13% (n=19)
Did not want to travel to the meeting	5% (n=7)

Not yet an AMA member or new to MSS	4% (n=6)
-------------------------------------	----------

Taken together, these survey results indicate that medical students rely largely on third-party funding to attend MSS meetings. Third-party funding currently is available for a significant number of students. Where such third-party funding is available, out-of-pocket student spending is modest. But for those who cannot access third-party funding, travel costs may be a barrier to meeting attendance.

#### *AMA funding of student meeting participation*

AMA directly funds medical student travel to Annual/Interim meetings as follows:

- Since 2022, per a directive of the HOD, AMA has funded travel to Annual/Interim meetings for a select group of medical students who attend schools with historically low attendance at MSS meetings and who identify with groups that are underrepresented or disadvantaged in medicine. In 2024, AMA will award 28 such travel grants of up to \$500 each.
- Beginning with the 2022-2023 academic year, the AMA Section Involvement Grant (SIG) program has provided each local MSS section (i.e., medical school chapter) with up to two travel grants of up to \$250 each per academic year. Additionally, local MSS sections may use their AMA membership commission dollars (i.e., a portion of AMA membership revenue shared with them in exchange for recruiting new members) to fund member travel to Annual/Interim meetings.
- AMA/Section leaders are funded to attend Annual/Interim meetings, which amounts to a total of 18 trips per year for MSS GC members and 14 trips per year for student members of the AMA Councils.

In addition to direct travel funding, AMA provides a variety of resources to mitigate the out-of-pocket cost for members attending meetings—for example:

- AMA negotiates a discounted room block for medical student attendees at each Annual/Interim Meeting, as well as airline and rental car discounts available to all members. For the 2024 Annual Meeting, this hotel discount amounts to approximately \$100 per night.
- AMA provides lunch for all MSS Annual/Interim Meeting attendees.
- AMA offers a template letter that medical students can use to seek financial support from their medical schools and state medical societies.

These direct and indirect sources of assistance are detailed and organized on a meeting funding webpage published in advance of each meeting and linked to from the main MSS meeting page.

#### *Student efforts to mitigate travel costs*

Medical students who attend AMA meetings engage in a variety of activities to reduce travel costs for themselves and their peers. Perhaps most commonly, students share hotel rooms, which, given that lodging accounts for a substantial portion of overall trip cost, can make the difference between a student being financially unable or able to attend the meeting. Students further mitigate meeting attendance costs through transportation sharing, whether that be carpooling to the meeting, sharing taxis to and from the airport, and so forth. This cost sharing often takes the form of funded students



covering some costs for their unfunded peers – for example, by taking on roommates. In this way, unfunded students might benefit from funding received by others, without the overall pool of funding increasing.

## DISCUSSION

Medical students depend on funding from a variety of sources to attend AMA meetings, including their medical schools/local MSS sections, their state/specialty medical societies, and the AMA. For many members, there does seem to be outside travel funding available, and their out-of-pocket spending is modest. But there also appears to be a second population of students who would like to attend AMA meetings but do not because they do not have access to funding. While AMA has made available additional travel funding in the two years since the adoption of the policy directing this report, alternatives for funding student travel costs should be explored. This exploration must carefully consider factors such as tax implications for the AMA and for medical students and maintenance of critical ties between medical students and their Federation organizations. Additionally, AMA should pursue other means to mitigate the cost of medical student participation in AMA meetings, two of which are described here.

### *Attract more funding from medical schools*

Policymaking is the primary focus of AMA Annual and Interim Meetings. While MSS meetings also offer some education and networking opportunities, medical school administrators still view AMA meetings as policymaking meetings. Some administrators recognize the value of this work and are willing to fund medical student participation. But most leaders in medical education seek more tangible learning outcomes to justify funding meeting attendance for their trainees—for example, the opportunity to present research or other work, well-defined leadership development opportunities, and so forth.

To that end, AMA is developing two initiatives that expand AMA meetings to better demonstrate the value of AMA meeting attendance to medical school administrators and thereby increase their likelihood of providing financial support for students to attend AMA meetings:

- In response to a request from MSS leadership, AMA reinstated an in-person Poster Showcase at the 2023 Annual and Interim Meetings, providing an opportunity for medical students to present their research while networking with and learning from their peers and leaders in health sciences research.
- Pending scheduling and availability, AMA will produce a half-day, in-person “Distinguish Yourself Student Summit.” Featuring education sessions from industry leaders, workshops, networking opportunities, the continuation of the Poster Showcase described above, and more, this event will train medical students on how to be successful during their medical training and stand out from their peers in the residency application process.

### *Facilitate travel cost sharing*

As described earlier, medical students often share meeting costs, and, more specifically, students who receive travel funding often share that funding with their unfunded peers. Unfortunately, students who are not already well connected with other MSS members at the national level typically cannot benefit from such arrangements, accentuating the disparity between involved members who are more likely to receive funding and less involved members who do not. While it should not be viewed as an exclusive approach, AMA could potentially close this gap by facilitating travel cost sharing among MSS meeting attendees – for example, by providing a space for members to connect with potential roommates.



1  
2 CONCLUSION

3  
4 Medical students who attend AMA meetings receive travel funding from a variety of sources.  
5 Without this funding, many of these members would not be able to attend AMA meetings, and  
6 additional funding will be required if more medical students are to attend. AMA should promote  
7 the value of meeting attendance to incentivize institutional funding, explore opportunities for AMA  
8 to facilitate travel cost sharing among meeting attendees, explore alternate mechanisms to provide  
9 financial assistance to facilitate attendance at MSS meetings, and otherwise continue to explore  
10 mechanisms to mitigate the cost of meeting attendance for medical students.  
11

12 RECOMMENDATIONS

13  
14 The Board of Trustees recommends that the following be adopted and the remainder of the report  
15 be filed:  
16

- 17 1. That our AMA will promote the value of membership and meeting attendance to encourage  
18 financial support by medical schools and other funding sources.  
19
- 20 2. That our AMA will explore mechanisms to mitigate the cost of meeting attendance for  
21 medical students.  
22
- 23 3. That our AMA will explore alternate mechanisms to provide financial assistance to  
24 facilitate attendance at MSS meetings with a report back in A-26.  
25
- 26 4. That AMA policy G-615.103 (4) be rescinded.  
27

Fiscal note: Modest – Between \$1,000 and \$5,000

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 36-A-24

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

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 The Board of Trustees has completed its review of the specialty organizations seated in the House  
2 of Delegates (HOD) required to submit information and materials for the 2024 American Medical  
3 Association (AMA) Annual Meeting in compliance with the five-year review process established  
4 by the House of Delegates in Policy G-600.020, “Summary of Guidelines for Admission to the  
5 House of Delegates for Specialty Societies,” and AMA Bylaw 8.5, “Periodic Review Process.”

6  
7 Organizations are required to demonstrate continuing compliance with the guidelines established  
8 for representation in the HOD. Compliance with the five responsibilities of professional interest  
9 medical associations and national medical specialty organizations is also required as set out in  
10 AMA Bylaw 8.2, “Responsibilities of National Medical Specialty Societies and Professional  
11 Interest Medical Associations.”

12  
13 The following organizations were reviewed for the 2024 Annual Meeting:

14  
15 American Academy of Cosmetic Surgery  
16 American Association for Thoracic Surgery  
17 American Association of Gynecologic Laparoscopists  
18 American Association of Plastic Surgeons  
19 American Association of Public Health Physicians  
20 American College of Allergy, Asthma, and Immunology  
21 American College of Medical Quality  
22 American Society for Metabolic and Bariatric Surgery  
23 American Society of Cytopathology  
24 American Society of Interventional Pain Physicians  
25 Association of Academic Radiology (formerly Association of University Radiologists)  
26 Infectious Diseases Society of America  
27 Society for Laparoscopic and Robotic Surgeons

28  
29 The American Society for Reconstructive Microsurgery, American Society of Neuroimaging, and  
30 GLMA—Health Professionals Advancing LGBTQ+ Equality were also reviewed at this time  
31 because they failed to meet the requirements in June 2023.

32  
33 Each organization was required to submit materials demonstrating compliance with the guidelines  
34 and requirements along with appropriate membership information. A summary of each group’s  
35 membership data is attached to this report (Exhibit A). A summary of the guidelines for specialty  
36 society representation in the AMA HOD (Exhibit B), the five responsibilities of national medical  
37 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: American Academy of Cosmetic Surgery, American Association for Thoracic Surgery, American Association of Gynecologic Laparoscopists, American Association of Public Health Physicians, American College of Allergy, Asthma and Immunology, American College of Medical Quality, American Society for Reconstructive Microsurgery, American Society of Interventional Pain Physicians, Association of Academic Radiology, GLMA—Health Professionals Advancing LGBTQ+ Equality, Infectious Diseases Society of America, and Society of Laparoscopic and Robotic Surgeons 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 Association of Plastic Surgeons, American Society for Metabolic and Bariatric Surgery, American Society of Cytopathology, and American Society of Neuroimaging 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 American Academy of Cosmetic Surgery, American Association for Thoracic Surgery, American Association of Gynecologic Laparoscopists, American Association of Public Health Physicians, American College of Allergy, Asthma and Immunology, American College of Medical Quality, American Society for Reconstructive Microsurgery, American Society of Interventional Pain Physicians, Association of Academic Radiology, GLMA—Health Professionals Advancing LGBTQ+ Equality, Infectious Diseases Society of America, and Society of Laparoscopic and Robotic Surgeons retain representation in the AMA HOD. (Directive to Take Action)
2. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5, the American Association of Plastic Surgeons, American Society for Metabolic and Bariatric Surgery and American Society of Cytopathology be placed on probation and be given one year to work with AMA membership staff to increase their AMA membership. (Directive to Take Action)
3. Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in the AMA Bylaw B-8.5 at the end of the one-year grace period, the American Society of Neuroimaging lose representation in the AMA HOD but retain it for the AMA Specialty and Service Society (SSS) and may apply for reinstatement in the HOD, through the SSS, when they believe they can comply with all of the current guidelines for representation in the 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***

<b>Organization</b>	<b>AMA Membership of Organization's Total Eligible Membership</b>
American Academy of Cosmetic Surgery	217 of 651 (33%)
American Association for Thoracic Surgery	188 of 923 (20%)
American Association of Gynecologic Laparoscopists	1,370 of 3,663 (37%)
American Association of Plastic Surgeons	152 of 788 (19%)
American Association of Public Health Physicians	64 of 86 (74%)
American College of Allergy, Asthma, and Immunology	577 of 2,760 (21%)
American College of Medical Quality	54 of 128 (36%)
American Society for Metabolic and Bariatric Surgery	292 of 1,802 (16%)
American Society for Reconstructive Microsurgery	158 of 798 (20%)
American Society of Cytopathology	179 of 1,093 (16%)
American Society of Interventional Pain Physicians	605 of 2,816 (21%)
American Society of Neuroimaging	58 of 161 (36%)
Association of Academic Radiology	274 of 1,225 (22%)
GLMA—Health Professionals Advancing LGBTQ+ Equality	127 of 406 (31%)
Infectious Diseases Society of America	964 of 3,746 (26%)
Society for Laparoscopic and Robotic Surgeons	520 of 1,138 (46%)

***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.



## REPORT OF THE BOARD OF TRUSTEES

B of T Report JUN-24

Subject: Distinguished Service Award

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

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- 1 The Board of Trustees is pleased to nominate Mary S. Carpenter, MD, and Kenneth L. Mattox, MD,  
2 for the 2024 Distinguished Service Award.  
3
- 4 Dr. Carpenter has dedicated her life to promoting social, economic, educational, and political  
5 changes that ameliorate the suffering and threats to human health and well-being identified through  
6 her professional work and experience. She has been actively involved in advocating at the federal  
7 and state levels on key health care issues impacting patients and physicians.  
8
- 9 As Medicaid Medical Director, Dr. Carpenter applied her clinical knowledge and experience to  
10 Medicaid policy development, innovation, implementation, and analysis. She helped to articulate  
11 the clinical vision of our Medicaid program and provided clinical subject matter expertise for  
12 contract management, utilization review, quality improvement, formulary development, among  
13 other programs.  
14
- 15 One of the most recognized surgeons around the world, Dr. Mattox is Distinguished Service  
16 Professor of the Michael E. DeBakey Department of Surgery at Baylor College of Medicine and  
17 Chief of Staff/Chief of Surgery at the Ben Taub Hospital, Houston, Texas. He has made original  
18 and significant contributions in trauma resuscitation, trauma systems, thoracic trauma, vascular  
19 injury, autotransfusion, complex abdominal trauma and multi-system trauma.  
20
- 21 Dr. Mattox is an active participant in helping to formulate and pass legislation relating to improved  
22 care for the trauma patient on local, state, and national levels. Currently, Dr. Mattox serves as  
23 consultant to the Center for Biologic Evaluation and Research of the FDA. Additionally, he is the  
24 trauma consultant on the Best Doctors Medical Advisory Board.  
25
- 26 The Distinguished Service Award may be made to a member of the Association for meritorious  
27 service in the science and art of medicine, and your Board of Trustees believes that Mary S.  
28 Carpenter, MD, and Kenneth L. Mattox, MD, are most deserving nominees for this, our highest  
29 award.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 023  
(A-24)

Introduced by: Private Practice Physicians Section

Subject: Change Healthcare Security Lapse—The FBI Must Investigate

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, the Change Healthcare security compromise has as yet unknown long-term  
2 repercussions on the healthcare industry, with hundreds of thousands of affected third parties;  
3 and  
4

5 Whereas, the issue affects national self-interest, of significant relevance to third parties,  
6 including physicians, hospitals, and other healthcare providers as well as consumers, with close  
7 to half of the United States population affected, according to Change Healthcare; and  
8

9 Whereas, the mission of the Federal Bureau of Investigation is to protect the American people  
10 and uphold the Constitution of the United States; and  
11

12 Whereas, United Healthcare has a self-interest in minimizing its own culpability and the severity  
13 of the security breach which may preclude other parties from instituting adequate safeguards to  
14 prevent similar security incidents in the future; therefore be it  
15

16 Resolved, that our American Medical Association seek a directed investigation by appropriate  
17 authorities of the Change Healthcare cybersecurity breach that defines the cause, so as to  
18 minimize the chance of a future breach, as well as to determine any penalties for negligence,  
19 should that be a factor in the current episode (Directive to Take Action); and be it further  
20

21 Resolved, that our AMA monitor all ongoing investigations of the Change Healthcare  
22 cybersecurity breach with report back at Interim 2024, with recommendations as to further  
23 action the AMA itself should pursue (Directive to Take Action).

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

Received: 6/7/2024

## **RELEVANT AMA POLICY**

### **Indemnity for Breaches in Electronic Health Record Cybersecurity D-315.977**

Our AMA will advocate for indemnity or other liability protections for physicians whose electronic health record data and other electronic medical systems become the victim of security compromises.

Citation: Res. 221, I-15

### **3.3.3 Breach of Security in Electronic Medical Records**

When used with appropriate attention to security, electronic medical records (EMRs) promise numerous benefits for quality clinical care and health-related research. However, when a security breach occurs, patients may face physical, emotional, and dignitary harms.

Dedication to upholding trust in the patient-physician relationship, to preventing harms to patients, and to respecting patients' privacy and autonomy create responsibilities for individual physicians, medical practices, and health care institutions when patient information is inappropriately disclosed.

The degree to which an individual physician has an ethical responsibility to address inappropriate disclosure depends in part on his or her awareness of the breach, relationship to the patient(s) affected, administrative authority with respect to the records, and authority to act on behalf of the practice or institution.

When there is reason to believe that patients' confidentiality has been compromised by a breach of the electronic medical record, physicians should:

- (a) Ensure that patients are promptly informed about the breach and potential for harm, either by disclosing directly (when the physician has administrative responsibility for the EMR), participating in efforts by the practice or health care institution to disclose, or ensuring that the practice or institution takes appropriate action to disclose.
- (b) Follow all applicable state and federal laws regarding disclosure.

Physicians have a responsibility to follow ethically appropriate procedures for disclosure, which should at minimum include:

- (c) Carrying out the disclosure confidentially and within a time frame that provides patients ample opportunity to take steps to minimize potential adverse consequences.
- (d) Describing what information was breached; how the breach happened; what the consequences may be; what corrective actions have been taken by the physician, practice, or institution; and what steps patients themselves might take to minimize adverse consequences.
- (e) Supporting responses to security breaches that place the interests of patients above those of the physician, medical practice, or institution.
- (f) Providing information to patients to enable them to mitigate potential adverse consequences of inappropriate disclosure of their personal health information to the extent possible.

Citation: Issued 2016

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 024  
(A-24)

Introduced by: Organized Medical Staff Section

Subject: Augmented Intelligence and Organized Medical Staff

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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1 Whereas, artificial intelligence (AI)- and machine learning (ML)-based technologies have the  
2 potential to transform healthcare by deriving new and important insights from the vast amount of  
3 data generated during the delivery of healthcare every day<sup>1</sup>; and  
4

5 Whereas, the American Medical Association uses the term “augmented intelligence” as a  
6 conceptualization of artificial intelligence that focuses on AI’s assistive role, emphasizing that its  
7 design enhances human intelligence rather than replaces it<sup>2</sup>; and  
8

9 Whereas, as the number of AI-enabled health care tools continue to grow, it is critical they are  
10 designed, developed, and deployed in a manner that ethical, equitable, and responsible; the use  
11 of AI in health care must be transparent to physicians, patients, and stakeholders<sup>2</sup>; and  
12

13 Whereas, there is currently no national policy or governance structure in place to guide the  
14 development and adoption of non-device AI; While the Food and Drug Administration (FDA)  
15 regulates AI-enabled medical devices, many types of AI-enabled technologies fall outside the  
16 scope of FDA oversight, including AI that may have clinical applications, such as some clinical  
17 decision support functions<sup>3</sup>; and  
18

19 Whereas, while the Federal Trade Commission and the United States Health and Human  
20 Services Office for Civil Rights have oversight over some aspects of AI, their authorities are  
21 limited and not adequate to ensure appropriate development and deployment of AI generally,  
22 and specifically in the healthcare space<sup>3</sup>; and  
23

24 Whereas, in addition to the government, healthcare institutions, practices, and professional  
25 societies share some responsibility for appropriate oversight and governance of AI-enabled  
26 systems and technologies; Beyond government oversight or regulation, purchasers, users, and  
27 consumers of these technologies should have appropriate and sufficient policies in place to  
28 ensure AI processes are acting in accordance with and supporting the current standard of care<sup>4</sup>;  
29 and  
30

31 Whereas, healthcare AI requires a risk-based approach where the level of scrutiny, validation,  
32 and oversight should be proportionate to the potential harm and consequences (including  
33 unintended) the AI system might introduce<sup>5</sup>; and  
34

35 Whereas, healthcare practices and institutions should not utilize AI systems or technologies that  
36 introduce overall or disparate risk that is beyond their capabilities to mitigate; implementation  
37 and utilization of AI should avoid exacerbating clinician burden and should be designed and  
38 deployed in harmony with the clinical workflow while demonstrating positive medical benefit<sup>6</sup>;  
39 and

Whereas, medical societies, clinical experts, and informaticists are best positioned and should identify the most appropriate uses of AI-enabled technologies relevant to their clinical expertise and set the standard of care for AI usage in their specific domain<sup>7</sup>; and

Whereas, current AMA policy (H-223.957, Positions for Strengthening the Physician-Hospital Relationship) states “the organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff; and these activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations,” therefore be it

Resolved, that our American Medical Association modify policy H-225.957, “Principles for Strengthening the Physician-Hospital Relationship,” by addition:

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.  
(Modify Current HOD Policy); and be it further

Resolved, that our AMA recognizes that organized medical staff should be an integral part at the outset of choosing, developing and implementing augmented intelligence and digital health tools in hospital care. That consideration is consistent with organized medical staff’s primacy in overseeing safety of patient care, as well as assessing other negative unintended consequences such as interruption of, or overburdening, the physician in delivery of care. (New HOD Policy)

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

Received: 6/7/2024

#### REFERENCES

1. <https://www.fda.gov/media/122535/download>
2. <https://www.ama-assn.org/practice-management/digital/augmented-intelligence-medicine>
3. <https://www.ama-assn.org/system/files/ama-ai-principles.pdf>
4. <https://www.ama-assn.org/system/files/ama-ai-principles.pdf>
5. <https://policysearch.ama-assn.org/policyfinder/detail/H-480.939%20?uri=%2FAMADoc%2FHOD.xml-H-480.939.xml>
6. <https://www.ama-assn.org/system/files/ama-ai-principles.pdf>
7. <https://policysearch.ama-assn.org/policyfinder/detail/H-480.940?uri=%2FAMADoc%2FHOD.xml-H-480.940.xml>
8. <https://www.cms.org/articles/medical-staffs-bylaws-legal-standing-recognized-by-minnesota-supreme-court>

## **RELEVANT AMA POLICY**

### **Model Hospital Medical Staff Bylaws D-235.982**

1. Our AMA will continue to update the Physician's Guide to Medical Staff Organization Bylaws to address emerging issues in medical staff affairs, including relevant changes to medical staff regulatory and accreditation requirements, such as those outlined in the Medicare Hospital Conditions of Participation and in the accreditation standards of The Joint Commission and other hospital accrediting organizations.
2. Our AMA will develop guidance for physicians on key state-by-state differences in medical staff bylaws requirements and best practices, and work with state medical societies to catalog state-specific medical staff resources available to physicians.
3. Our AMA will pursue opportunities to improve the accessibility and usability of the content contained in the Physician's Guide to Medical Staff Organization Bylaws, including but not limited to development of supplemental materials such as education modules, checklists, and so forth.

Citation: BOT Rep. 35, A-18

### **Principles for Strengthening the Physician-Hospital Relationship H-225.957**

The following twelve principles are AMA policy:

#### **PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP**

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence-- with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.
5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self governance, which include but are not limited to:
  - a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
  - b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.

- c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
  - d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
  - e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
  - f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
  - g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
  - h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
  - i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.
  - j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
  - k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
  - l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
  - m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.
  - n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.
7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.

10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.

11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.

12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

Citation: Res. 828, I-07; Reaffirmed in lieu of: Res. 730, A-09; Modified: Res. 820, I-09; Reaffirmed: Res. 725, A-10; Reaffirmed: A-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 5, A-21

### **Organized Self-Governing Medical Staff H-235.990**

With respect to the responsibilities and functions of the hospital, its governing board and the medical staff, the AMA believes that: (1) the hospital has corporate responsibility for maintaining the necessary facilities, a safe environment, and a mechanism for the prudent selection of those who treat patients within the institution; (2) the governing board is responsible for the operation and management of the hospital and fulfilling its corporate responsibilities; (3) the organized medical staff and its members have a contractual obligation, entered into with the hospital, to carry out their professional medical responsibilities through the efficient operation of medical staff committees; the objective selection of professionally qualified members of the organized medical staff and disciplinary functions relating to their competent performance; and functioning as a self-governing body in promoting quality patient care within the hospital; and (4) members of the organized medical staff may likewise deal collectively, as an entity, with the hospital and its governing board with respect to professional matters involving their own interests, as distinguished from the functions the organized medical staff performs on behalf of the hospital.

Citation: BOT Rep. PP, A-84; Reaffirmed: CLRPD Rep. 3, I-94; Reaffirmed: Res. 725, A-10; Reaffirmed: CMS Rep. 01, A-20

### **Augmented Intelligence in Health Care H-480.940**

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
  - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
  - b. is transparent;
  - c. conforms to leading standards for reproducibility;
  - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
  - e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and



advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18

#### **Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935**

Our American Medical Association will: (1) study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24; (2) work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; (3) encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs; and (4) support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence.

Citation: Res. 246, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116  
(A-24)

Introduced by: Texas

Subject: Increase Insurance Coverage for Follow-Up Testing After Abnormal  
Screening Mammography

Referred to: Reference Committee A

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1 Whereas, breast cancer is the most common cancer and a leading cause of mortality in women,  
2 accounting for 30% of new cancer diagnoses in women each year in the United States; and  
3

4 Whereas, while incidence of invasive breast cancer has increased by 0.5% annually during the  
5 2000s, screening mammography has effectively reduced mortality from breast cancer, with  
6 mortality rates peaking among women in 1989 and declining by 43% as of 2020; and  
7

8 Whereas, in May 2023, the U.S. Preventive Services Task Force updated breast cancer  
9 screening recommendations, saying that all women should begin biannual breast cancer  
10 screening at age 40 rather than age 50, which could result in 19% more survival; and  
11

12 Whereas, despite significant breast cancer mortality reduction, mortality rates are 40% higher in  
13 Black and Hispanic women than in White women because of advanced disease at diagnosis;  
14 and  
15

16 Whereas, lack of or inadequate insurance and disparities in access to screening and treatment  
17 contribute to breast cancer disparities, resulting in delayed breast cancer detection and late-  
18 stage diagnosis, which disproportionately affects minority populations; and  
19

20 Whereas, out-of-pocket costs (OOPCs) for additional diagnostic testing after an abnormal result  
21 have increased since 2010, with patients who only undergo an initial screening mammogram  
22 paying on average \$1.13 out of pocket and those who undergo additional diagnostic imaging  
23 and procedures paying an average of \$75.24 in OOPCs; and  
24

25 Whereas, while the Affordable Care Act mandates coverage annually for screening  
26 mammograms for women aged 40-74 of average risk, largely eliminating screening OOPCs, the  
27 mandate does not include OOPCs for additional diagnostic testing; and  
28

29 Whereas, while Medicare Part B covers a baseline screening mammogram once for women  
30 aged 35-39 and annual screening mammograms for women 40 and over, there is a 20% copay  
31 of the Medicare-approved amount for diagnostic mammograms after meeting the deductible;  
32 and  
33

34 Whereas, implementation of Medicaid expansion was associated with reduction of two-year  
35 mortality rates from 45.6% to 35.8% in Hispanic, non-Hispanic Black, American Indian or Alaska  
36 Native, and Asian or Pacific Islander individuals with de novo stage IV cancer; and

Whereas, on March 8, 2023, the Wisconsin State Legislature introduced Senate Bill 121, which would require health insurance policies to provide coverage for supplemental breast cancer screening or diagnostic examinations for patients with an increased risk of breast cancer; and

Whereas, California Senate Bill 257 passed in the California Senate and, if signed into law, would require insurance coverage without patient cost sharing for medically necessary diagnostic testing following an abnormal mammography screening result; therefore be it

RESOLVED, that our American Medical Association support public and private payer coverage for screening mammography and follow-up testing after an abnormal screening mammography (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for legislation that ensures adequate funding for mammography services and follow-up testing after an abnormal screening mammography (Directive to Take Action); and be it further

RESOLVED, that our AMA promote health care community education and public awareness of services provided for women of low income. (Directive to Take Action)

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

Received: 5/10/2024

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#### RELEVANT AMA POLICY

##### Guidelines and Medicare Coverage for Screening Mammography H-525-986

Our AMA: (1) supports continuing to work with interested groups to facilitate the participation of all women eligible under Medicare in regular screening mammography; (2) supports the coordination of ongoing programs and encourages the development of new activities in quality assurance for mammography; and (3) supports monitoring studies addressing the issue of the appropriate interval for screening

mammography in women over 64 years of age. [BOT Rep. CC, A-91; Modified: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

#### **Screening Mammography H-525-993**

Our AMA: a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer. b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis. c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations. d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available. e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography. f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient. g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate. h. supports insurance coverage for screening mammography. i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy. j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians. [CSA Rep. F, A-88; Reaffirmed: Res. 506, A-94; Amended: CSA Rep. 16, A-99; Appended: Res. 120, A-02; Modified: CSAPH Rep. 6, A-12; Reaffirmed: Alt. Res. 803, I-18]

#### **Mammography Screening for Breast Cancer D-525-998**

In order to assure timely access to breast cancer screening for all women, our American Medical Association shall advocate for legislation that ensures adequate funding for mammography services. [Res. 120, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Reaffirmed: BOT Rep. 9, A-22]

#### **Safety and Performance Standards for Mammography H-525-985**

Our AMA actively encourages the development of new activities, and supports the coordination of ongoing activities, to ensure the following: (1) that the techniques used in performing mammograms and in interpreting mammograms meet high quality standards of performance, including evidence of appropriate training and competence for professionals carrying out these tasks; (2) that the equipment used in mammography is specifically designed and dedicated. The performance of mammography imaging systems is assessed on a regular basis by trained professionals; (3) that the American College of Radiology Breast Imaging Reporting and Database System is widely used throughout the United States and that mammography outcome data in this database are used to regularly assess the effectiveness of mammography screening and diagnostic services as they are provided for women in the United States; and (4) regular breast physical examination by a physician and regular breast self-examination should be performed in addition to screening mammography. [BOT Rep. JJ, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117  
(A-24)

Introduced by: Texas

Subject: Insurance Coverage for Gynecologic Oncology Care

Referred to: Reference Committee A

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1 Whereas, two types of gynecologic cancers, ovarian and uterine, are the fifth- and sixth-leading  
2 causes of cancer mortality, respectively, among females in the United States; and  
3

4 Whereas, evaluation by a gynecologic oncologist is the standard of care for patients with  
5 gynecologic cancers; and  
6

7 Whereas, treatment by a gynecologic oncologist has been shown to increase cancer survival  
8 among women with ovarian cancer; and  
9

10 Whereas, insurance coverage of gynecologic oncology has been associated with detection and  
11 treatment at earlier cancer stages; and  
12

13 Whereas, a third of women with gynecologic cancer never see a gynecologic oncologist; and  
14

15 Whereas, up to 40% and 33% of Medicare and private insurance plans, respectively, lack an in-  
16 network gynecologic oncologist; and  
17

18 Whereas, an estimated 50% of gynecologic oncology patients experience financial toxicity  
19 during the course of their treatment; and  
20

21 Whereas, the Centers for Medicare & Medicaid Services specifies the number and proximity  
22 requirements for medical, surgical, and radiation oncologists but does not include gynecologic  
23 oncology as part of the network adequacy standards; and  
24

25 Whereas, lack of coverage creates insurance-mediated disparities among women with  
26 gynecologic cancer who may be socioeconomically disadvantaged at baseline and are seven  
27 times more likely to report dangerous cost-coping strategies such as delaying or avoiding care,  
28 which have been linked with worse five-year mortality; therefore be it  
29

30 RESOLVED, that our American Medical Association support efforts to include gynecologic  
31 oncologists alongside other types of oncologists in network adequacy standards and  
32 requirements for public and private plans, including the Centers for Medicare & Medicaid  
33 Services standards (New HOD Policy).  
34

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

Received: 5/10/2024

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## RELEVANT AMA POLICY

### **Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971**

1. Our AMA supports programs to screen all at-risk individuals for breast and cervical cancer and that government funded programs be available for low income individuals; the development of public information and educational programs with the goal of informing all at-risk individuals about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income individuals for breast and cervical cancer and to assure access to definitive treatment.
2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.
3. Our AMA encourages the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies to ensure coverage is consistent with current evidence-based guidelines.
4. That our AMA support further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening. [CCB/CLRPD Rep. 3, A-14; BOT Action Sept 2023]

### **Cancer and Health Care Disparities Among Minority Women D-55.997**

Our American Medical Association encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment. [Res. 509, A-08; Modified: CSAPH Rep. 01, A-18]

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118  
(A-24)

Introduced by: Texas

Subject: Public and Private Payer Coverage of Diagnostic Interventions Associated With Colorectal Cancer Screening and Diagnosis

Referred to: Reference Committee A

Whereas, the U.S. Preventive Services Task Force (USPSTF) recommends regular colorectal cancer screening for average-risk people from ages 45 to 75; and

Whereas, screening colonoscopies reduce the relative risk of colorectal cancer by 52% and the risk of colorectal cancer-related death by 62%; and

Whereas, more than 40% of people over 50 have precancerous polyps in the colon; and

Whereas, insurance companies may consider screening colonoscopies that included polyp removal/biopsy as diagnostic colonoscopies and can charge the patient unexpected out-of-pocket costs because of this change in designation; and

Whereas, out-of-pocket costs for diagnostic colonoscopy ranged from \$99 to \$231 for patients with commercial or Medicare insurance, with additional costs when polypectomy was performed; and

Whereas, USPSTF has stated that cost sharing may not be imposed for services that are an integral part of colorectal screening, such as polyp removals and biopsies, as well as follow-up colonoscopies after a positive stool-based screening test; and

Whereas, implementation of Medicaid expansion efforts were associated with a significant increase in colorectal cancer screening, early-stage diagnoses, and overall survival; therefore be it

RESOLVED, that our American Medical Association advocate (through legislation and/or regulation, as appropriate) for adequate payment and the elimination of cost sharing in all health plans for the full range of colorectal cancer screening and all associated costs, including colonoscopy with a “diagnostic” intervention (i.e., the removal of a polyp or biopsy of a mass) and follow-up colonoscopy after a positive stool-based test. (Directive to Take Action)

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

Received: 5/10/2024

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## RELEVANT AMA POLICY

### Encourage Appropriate Colorectal Cancer Screening H-55.967

Our American Medical Association, in conjunction with interested organizations and societies, supports educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high-risk groups. [CSAH Rep. 8, A-23]

### Carcinoma of the Colon and Rectum H-55.981

Our AMA supports: (1) Recognizing colon cancer as a leading cause of cancer deaths in the United States and encouraging appropriate screening programs to detect colorectal cancer. (2) Persons at increased risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) receiving more intensive screening efforts. (3) Physicians becoming aware of genetic alterations that influence the development of CRC, and of diagnostic and screening tests that are available in this area. (4) Physicians engaging their patients in shared decision-making, including consideration of both clinical and financial patient impacts, to determine at what age to begin screening for colorectal cancer and which screening method (or sequence of methods) is most appropriate. [Sub. Res. 513, I-95; Appended: CSA Rep. 7, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CMS/CSAPH Joint Rep. 01, A-18]

### Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans H-185.960

1. Our AMA supports health plan coverage for the full range of **colorectal cancer** screening tests.  
2. Our AMA will seek to eliminate cost-sharing in all health plans for the full range of **colorectal cancer** screening and all associated costs, including colonoscopy that includes a “diagnostic” intervention (i.e. the removal of a polyp or biopsy of a mass), as defined by Medicare. To further this goal, the AMA will develop a coding guide to promote common understanding among health care providers, payers, health care information technology vendors, and patients. [Res. 726, I-04; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: Res. 123, A-17; Appended: CMS/CSAPH Joint Rep. 01, A-18]

### Improving the Prevention of Colon Cancer by Insuring the Waiver of the Co-Payment in all Cases H-330.877

1. Our AMA supports requiring Medicare to waive the coinsurance for **colorectal** screening tests, including therapeutic intervention(s) required during the procedure.  
2. Our AMA will continue to support Medicare coverage for **colorectal cancer** screenings consistent with ACA-compliant plan coverage requirements. [Res. 123, A-17; Appended: CMS/CSAPH Joint Rep. 01, A-18]



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245  
(A-24)

Introduced by: Texas

Subject: Patient Access to Covered Benefits Ordered by Out-of-Network Physicians

Referred to: Reference Committee B

Whereas, rising health care costs, employer-directed benefit design, and network adequacy are issues that impact patients' ability to access care from their preferred physicians; and

Whereas, the health care marketplace is increasingly hostile to solo, small, and independent practices through factors such as low payment rates that fail to keep up with inflation, increasing administrative burdens, the inability to find and retain staff, and exclusion from physician networks due to market consolidation and vertical integration; and

Whereas, as a means to sustain their practices, a growing number of independent physicians are employing new direct-contracting care delivery and payment models to offer efficient, evidence-based, quality care without accepting insurance as payment; and

Whereas, many health plans will not cover diagnostic studies, referrals, and/or prescription medications when ordered by out-of-network physicians although they are covered benefits delivered by physicians with long-standing patient relationships; and

Whereas, noncoverage of valid orders for covered health plan benefits is another attempt by health plans to restrict access to covered benefits and leads to delays in care, increased costs to patients, and redundancy and inefficiency in the health care system; therefore be it

RESOLVED, that our American Medical Association develop model legislation to protect patients managed by out-of-network physicians by prohibiting insurance plans from denying payment for covered services, based solely on the network participation of the ordering physician (Directive to Take Action); and be it further

RESOLVED, that our AMA develop resources, toolkits, and education to support out-of-network care models. (Directive to Take Action)

Fiscal Note: Resolve 1: Modest. Resolve 2: \$22,980 Develop a comprehensive portfolio of education, experts, and toolkits

Received: 5/10/2024

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## RELEVANT AMA POLICY

### Direct Primary Care H-385.912

1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty. [Res. 103, A-16; Appended: Res. 246, A-18; Reaffirmation: A-18; Reaffirmation: I-18 Appended: Res. 102, A-19]

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

1. Our AMA adopts the following principles related to unanticipated out-of-network care:
  - A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
  - B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
  - C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
  - D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
  - E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
  - F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
  - G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
  - H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges. [Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22; Reaffirmed: CMS Res., I-23; Reaffirmed: CMS Rep. 3, I-23]

**Out-of-Network Care D-285.962**

Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care. [Res. 108, A-17]

**Out-of-Network Restrictions of Physicians H-285.907**

Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it. [Res. 126, A-15]

**Out-of-Network Coverage Denials for Physician Prescriptions and Ordered Services D-285.963**

Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service. [Res. 119, A-15]

**Physician Penalties for Out-of-Network Services H-180.952**

Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services. [Res. 702, A-07; Reaffirmed: CMS Rep. 01, A-17]

**Subacute Care Standards for Physicians H-160.945**

AMA guidelines for physicians' responsibilities in subacute care include: (1) Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week. (2) Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care. (3) Physicians are responsible for coordinating care for their patients with other physicians including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings. (4) Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care. (5) Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations. (6) Physicians are responsible for: (a) Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care. (b) Identifying and appropriately utilizing subacute care facilities in their communities. (c) Oversight of physician credentialing in subacute settings (d) Promoting medical staff organization and by-laws that may be needed to support peer evaluations. (e) Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life. (7) Subacute units and/or programs need physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs. (8) Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care. (9) Attending physicians should: (a) make an on-site visit to review the interdisciplinary care plan within seventy two hours of admission. (b) Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly. (c) Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit. (10) Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care. [BOT Rep. 21, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15]

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 246  
(A-24)

Introduced by: Texas

Subject: Augmented Intelligence in Health Care

Referred to: Reference Committee B

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Whereas, with the rapid pace of change in artificial and augmented intelligence in health care, it is important for the American Medical Association to continually assess and update its policy principles at regular intervals; therefore be it

RESOLVED, that our American Medical Association amend its augmented intelligence policy to align with the following:

### Augmented Intelligence in Health Care

The American Medical Association supports the use of augmented intelligence (AI) when used appropriately to support physician decision-making, enhance patient care, improve administrative functions, and improve public health without reducing the importance of physician decision-making. Augmented intelligence also should be used in ways that reduce physician burden and increase professional satisfaction. Sufficient safeguards should be in place to assign appropriate liability inherent in augmented intelligence to the software developers and not to those with no control over the software content and integrity, such as physicians and other users. Ultimately, it is the physician's responsibility to uphold the standard of care.

The American Medical Association adopts the following principles for augmented intelligence in health care:

1. Augmented intelligence should be the preferred health care term over artificial intelligence as it should be used to augment care by providing information for consideration. Augmented intelligence, whether assistive or fully autonomous, is intended to co-exist with human decision-making and should not be used to replace physician reasoning and knowledge.
2. Physicians should not be mandated to use augmented intelligence without having input or feedback into how the tool is used either individually or as a medical staff.
3. Augmented intelligence must not replace or diminish the patient-physician relationship.
4. Algorithms developed to augment user intelligence must be designed for the benefit, safety, and privacy of the patient. The AMA should research opportunities to place practicing physicians on public and private panels, work groups, and committees that will evaluate products as they are developed.
5. Sellers and distributors of augmented intelligence should disclose that it has met all state and federal legal and regulatory compliance with regulations such as, but not limited to, those of HIPAA, the U.S. Department of Health and Human Services, and the U.S. Food and Drug Administration.
6. Use of augmented intelligence, machine learning, and clinical decision support has inherent known risks. These risks should be recognized, and legal and ethical responsibility for the use and output of these products must be assumed by, including but not limited to, developers, distributors, and users with each entity owning responsibility for its respective

1 role in the development, dissemination, implementation, and use of products used in clinical  
2 care.

- 3 7. Users should have clear guidelines for how and where to report any identified anomalies.  
4 Additionally, as with all technology, there should be a national database for reporting errors  
5 that holds developers accountable for correcting identified issues.
- 6 8. Before using augmented intelligence, physicians and all users should receive adequate  
7 training and have educational materials available for reference, especially in instances  
8 where the technology is not intuitive and there are periods of nonuse.
- 9 9. Physicians should inquire about whether the AI used is a “continuously learning system”  
10 versus a “locked system.” A locked system is more appropriate for clinical care, although a  
11 hybrid system may be appropriate as long as the clinical output is based on locked training  
12 sets. A locked system gives a predictable output, whereas a continuous learning system will  
13 change over time.
- 14 10. Algorithms and other information used to derive the information presented as augmented  
15 intelligence to physicians and other clinicians should:  
16
  - 17 a. Be developed transparently in a way that is accessible, explainable, and  
18 understandable to clinicians and patients and details the benefits and limitations of the  
19 clinical decision support, and/or augmented intelligence;
  - 20 b. Have reproducible and explainable outputs;
  - 21 c. Function in a way that promotes health equities while eliminating potential biases that  
22 exacerbate health disparities;
  - 23 d. Use best practices for user-centered design that allows for efficient and satisfactory use  
24 of the technology;
  - 25 e. Safeguard patient information by employing privacy and security standards that comply  
26 with HIPAA and state privacy regulations;
  - 27 f. Have a feedback loop that allows users who identify potential safety hazards to easily  
28 report problems and malfunctions as well as opportunities to report methods for  
29 improvements; and
  - 30 g. Contain a level of compatibility to allow use of information between hardware and  
31 software made by different manufacturers.
- 32
- 33 11. Medical students and residents need to learn about the opportunities and limitations of  
34 augmented intelligence as they are prepared for future medical practice.
- 35 12. The AMA will advocate, through legislation or regulation, for payment to physicians for  
36 utilization of artificial intelligence tools that have additional cost or require additional time.
- 37 13. Recognizing the rapid pace of change in augmented intelligence, it is important to  
38 continually assess and update the AMA’s principles at regular intervals.  
39 (Modify Current HOD Policy)

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

Received: 5/10/2024

## RELEVANT AMA POLICY

### 11.2.1 Professionalism in Health Care Systems

Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered—such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future—can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, decision support tools that rely on augmented intelligence, and other mechanisms intended to influence decision making, may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.

Physicians in leadership positions within health care organizations and the profession should:

- (a) Ensure that decisions to implement practices or tools for organizing the delivery of care are transparent and reflect input from key stakeholders, including physicians and patients.
- (b) Recognize that over reliance on financial incentives or other tools to influence clinical decision making may undermine physician professionalism.
- (c) Ensure that all such tools:
  - (i) are designed in keeping with sound principles and solid scientific evidence.
    - a. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles.
    - b. Practice guidelines, formularies, and similar tools should be based on best available evidence and developed in keeping with ethics guidance.
    - c. Clinical prediction models, decision support tools, and similar tools such as those that rely on AI technology must rest on the highest-quality data and be independently validated in relevantly similar populations of patients and care settings.
  - (ii) are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
  - (iii) are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
  - (iv) mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
- (d) Encourage, rather than discourage, physicians (and others) to:
  - (i) provide care for patients with difficult to manage medical conditions;
  - (ii) practice at their full capacity, but not beyond.
- (e) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
- (f) Ensure that the use of financial incentives and other tools is routinely monitored to:
  - (i) identify and address adverse consequences;
  - (ii) identify and encourage dissemination of positive outcomes.

All physicians should:

- (g) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
- (h) Advocate for changes in how the delivery of care is organized to promote access to high-quality care for all patients. [Issued: 2016; Amended: 2021; Amended: 2022]

### **H-295.857 Augmented Intelligence in Medical Education**

Our AMA encourages: (1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards; (2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI; (3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes; (4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules; (5)

stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems; (6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies; (7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients; (8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies; (9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and (10) close collaboration with and oversight by practicing physicians in the development of AI applications. [CME Rep. 04, A-19]

#### **H-480.935 Assessing the Potentially Dangerous Intersection Between AI and Misinformation**

Our American Medical Association will: (1) study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24; (2) work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; (3) encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs; and (4) support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence. [Res. 247, A-23]

#### **H-480.939 Augmented Intelligence in Health Care**

Our American Medical Association supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
  - a. clinical validation
  - b. alignment with clinical decision-making that is familiar to physicians; and
  - c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must
  - a. be informed by real world workflow and human-centered design principles;
  - b. enable physicians to prepare for and transition to new care delivery models;
  - c. support effective communication and engagement between patients, physicians, and the health care team;
  - d. seamlessly integrate clinical, administrative, and population health management functions into workflow; and
  - e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
  - a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
  - b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
  - a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
  - b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
  - c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations
  - a. Identify areas of medical practice where AI systems would advance the quadruple aim;
  - b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;
  - c. Outline new professional roles and capacities required to aid and guide health care AI systems; and
  - d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it. [BOT Rep. 21, A-19; Reaffirmation: A-22]

#### **H-480-940 Augmented Intelligence in Health Care**

As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
  - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
  - b. is transparent;
  - c. conforms to leading standards for reproducibility;
  - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
  - e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. [BOT Rep. 41, A-18]



**H-480-956 Augmented Intelligence for Prior Authorization**

Our American Medical Association advocates for greater regulatory oversight of the use of augmented intelligence for review of patient claims and prior authorization requests, including whether insurers are using a thorough and fair process that: (1) is based on accurate and up-to-date clinical criteria derived from national medical specialty society guidelines and peer reviewed clinical literature; (2) includes reviews by doctors and other health care professionals who are not incentivized to deny care and with expertise for the service under review; and (3) requires such reviews include human examination of patient records prior to a care denial. [Res. 721, A-23]

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 247  
(A-24)

Introduced by: Texas

Subject: Prohibit Health Benefit Plans From Charging Cost Sharing for Covered Prostate Cancer Screening

Referred to: Reference Committee B

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Whereas, about one in eight men will be diagnosed with prostate cancer during their lifetime; and

Whereas, prostate cancer screening with a prostate specific antigen (PSA) blood test can catch cancer before it metastasizes, which provides a better survival rate; and

Whereas, the rate of metastatic prostate cancer rises when prostate cancer screening decreases, which suggests that prostate cancer screening reduces the chance of getting metastatic prostate cancer; and

Whereas, screening for prostate cancer with PSA is at least as effective at preventing death as screening for breast cancer, and federal law already requires no-cost breast cancer screening; and

Whereas, other cancers for which federal law requires no-cost screening include cervical, colorectal, and lung cancer, and prostate cancer has a greater mortality rate than both cervical and colorectal cancer; and

Whereas, cost sharing is a barrier to patients for cancer screening; and

Whereas, Arkansas, Illinois, Maryland, New York, and Rhode Island (as of Dec. 31, 2023) have passed legislation requiring that health benefit plans may not charge any cost sharing for covered prostate cancer screening; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation requiring that health benefit plans may not charge any form of cost sharing for covered prostate cancer screening. (Directive to Take Action)

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

Received: 5/10/2024

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## RELEVANT AMA POLICY

### Clinical Guidelines and Evidence Regarding Benefits of Prostate Cancer Screening and Other Preventive Services D-450.957

Our AMA will: (1) continue to advocate for inclusion of relevant specialty societies and their members in guideline and performance measure development, including in technical expert panels charged with developing performance measures; (2) work with the federal government, specialty societies, and other relevant stakeholders to develop guidelines and clinical quality measures for the prevention or early detection of disease, such as prostate cancer, based on rigorous review of the evidence which includes expertise from any medical specialty for which the recommendation may be relevant to ultimately inform shared decision making; and (3) encourage scientific research to address the evidence gaps highlighted by organizations making evidence-based recommendations about clinical preventive services. [Res. 225, I-15; Appended: CMS Rep. 06, A-19]

### Preventive Prostate Cancer H-425-966

Our AMA encourages: (1) public and private payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making; and (2) national medical specialty societies to promote public education around the importance of informed physician-patient shared decision-making regarding medical services that are particularly sensitive to patient values and circumstances, such as prostate cancer screening. [CMS Rep. 06, A-19]

### Screening and Early Detection of Prostate Cancer H-425-980

Our AMA believes that: (1) All men who would be candidates for and interested in active treatment for prostate cancer should be provided with information regarding their risk of prostate cancer and the potential benefits and harms of prostate cancer screening, sufficient to support well-informed decision making. (2) Prostate cancer screening, if elected by the informed patient, should include both prostate-specific antigen testing and digital rectal examination. [Res. 726, I-04; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: CMS Rep. 01, A-17; Appended: CMS/CSAPH Joint Rep. 01, A-18]

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 248  
(A-24)

Introduced by: Texas

Subject: Sustain Funding for HRSA (Health Resources Services and Administration)  
340B Grant-Funded Programs

Referred to: Reference Committee B

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1 Whereas, the successful model of care for immunodeficiency virus (HIV) treatment has used an  
2 integrated funding approach, leveraging both government and private-sector funding; and  
3

4 Whereas, effective interventions have driven the number of new HIV infections in the United  
5 States to less than 35,000 per year; however, not everyone has benefited from these  
6 interventions; and  
7

8 Whereas, community-based clinics that use Ryan White HIV/AIDS Program funds achieve  
9 higher viral suppression rates despite focusing on low-income, uninsured, and medically  
10 underserved communities; and  
11

12 Whereas, novel HIV treatment strategies, including long-acting injectable treatments, have the  
13 potential to further drive lower infection rates and improve viral suppression in highly  
14 marginalized communities; and  
15

16 Whereas, without continued diligence towards funding, progress made towards ending the HIV  
17 epidemic will stop and quickly reverse; and  
18

19 Whereas, community health centers serve one in 11 people nationwide, which is more than 31  
20 million patients; and  
21

22 Whereas, Health Resources Services and Administration grantees are required to follow their  
23 grant regulations on how to use 340B Program savings, unlike hospitals; therefore be it  
24

25 RESOLVED, that our American Medical Association amend Policy H-110.985 340B Drug  
26 Discount Program by addition as follows:  
27

28 Our AMA: (1) will advocate for 340B Drug Discount Program (340B program) transparency,  
29 including an accounting of covered entities' 340B savings and the percentage of 340B savings  
30 used directly to care for underinsured patients and patients living on low-incomes; (2) will  
31 support recommendations to equip the Health Resources and Services Administration (HRSA)  
32 with more authority, resources and staff to conduct needed 340B program oversight; (3)  
33 recognizes the 340B program does not support the extent of care provided by ineligible  
34 physician practices to the medically indigent or underserved, and work with HRSA to establish  
35 340B eligibility for all practices demonstrating a commitment to serving low-income and  
36 underserved patients; (4) will support a revised 340B drug discount program covered entity  
37 eligibility formula, which appropriately captures the level of outpatient charity care provided by  
38 hospitals, as well as standalone community practices; and (5) will confer with national medical  
39 specialty societies on providing policymakers with specific recommended covered entity criteria

- 1 for the 340B drug discount program; and (6) supports 340B programs funded by HRSA grants
- 2 in their utilization of the program as legislatively intended.
- 3 (Modify Current HOD Policy)

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

Received: 5/10/2024

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#### RELEVANT AMA POLICY

##### **H-20.896 Support of National HIV/AIDS Strategy**

1. Our AMA supports the creation of a National HIV/AIDS strategy and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy. 2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission. (Citation: Sub Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19)

##### **H-20.922 HIV/AIDS as a Global Public Health Priority**

1. In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our American Medical Association strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic.
1. Our AMA supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care, and access to stable housing for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates.
2. Our AMA will join national and international campaigns for the prevention of HIV disease and care of persons with this disease.
3. Our AMA encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care.
4. Our AMA encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts.
5. Our AMA, in coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through the exchange of sex for money or goods.
6. Our AMA supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions.

7. Our AMA supports increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and be it further.
8. Our AMA supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.
9. Our AMA supports policies that promote stable housing for and encourage retention of homeless patients in HIV/AIDS treatment programs.
10. Our AMA recognizes that stable housing promotes adherence to HIV treatment. 340B Programs funded by HRSA grants in their utilization of the program as legislative intended. (Citation: CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation I-11; Appended: Res. 516, A-13; Reaffirmation I-13; Reaffirmed: Res. 916, I-16; Modified: Res. 003, I-17; Modified: Res. 414, A-23.)

**H-110.985 340B Drug Discount Program** Our AMA: (1) will advocate for 340B Drug Discount Program (340B program) transparency, including an accounting of covered entities' 340B savings and the percentage of 340B savings used directly to care for underinsured patients and patients living on low-incomes; (2) will support recommendations to equip the Health Resources and Services Administration (HRSA) with more authority, resources and staff to conduct needed 340B program oversight; (3) recognizes the 340B program does not support the extent of care provided by ineligible physician practices to the medically indigent or underserved, and work with HRSA to establish 340B eligibility for all practices demonstrating a commitment to serving low-income and underserved patients; (4) will support a revised 340B drug discount program covered entity eligibility formula, which appropriately captures the level of outpatient charity care provided by hospitals, as well as standalone community practices; and (5) will confer with national medical specialty societies on providing policymakers with specific recommended covered entity criteria for the 340B drug discount program. (Citation: Res. 255, A-18; Appended: BOT Rep. 08, I-18)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 249  
(A-24)

Introduced by: American College of Rheumatology, American Academy of Allergy, Asthma and Immunology, American Academy of Neurology, American Academy of Ophthalmology, American Urological Association, Association for Clinical Oncology

Subject: Pediatric Specialty Medicaid Reimbursement

Referred to: Reference Committee B

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1 Whereas, pediatric subspecialists play a critical role in providing specialized medical care to  
2 children with complex health needs; and  
3

4 Whereas, 39% of children in the United States receive health care coverage under the Medicaid  
5 program; and  
6

7 Whereas, Medicaid reimbursement rates for pediatric subspecialists are often significantly lower  
8 compared to private insurance and Medicare reimbursement rates, leading to financial  
9 challenges for healthcare providers and limited access to care for Medicaid-enrolled children;  
10 and  
11

12 Whereas, adequate reimbursement is essential to sustain pediatric subspecialty practices,  
13 recruit and retain skilled healthcare professionals, and maintain access to specialized care for  
14 children from low-income families; and  
15

16 Whereas, children enrolled in Medicaid are disproportionately affected by disparities in  
17 healthcare access and outcomes, and ensuring equitable reimbursement for pediatric  
18 subspecialists can help mitigate these disparities and promote health equity; and  
19

20 Whereas, timely access to specialized pediatric care is crucial for early diagnosis, intervention,  
21 and management of various medical conditions, which can ultimately improve health outcomes,  
22 reduce healthcare costs, and enhance quality of life for children and their families; therefore be  
23 it  
24

25 RESOLVED, that our American Medical Association make increasing Medicaid reimbursement  
26 for pediatric specialists a significant part of its plan for continued progress toward health equity  
27 (Directive to Take Action); and be it further  
28

29 RESOLVED, that our AMA include in its advocacy on budget neutrality that improvements in  
30 Medicaid payment rates are made without invoking budget neutrality (Directive to Take Action);  
31 and be it further  
32

33 RESOLVED, that our AMA work with pediatric specialty societies to develop a value-based  
34 payment model that makes pediatric specialist practices sustainable and promotes access to  
35 care and health equity among the pediatric patients (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA work with state stakeholders to support the implementation of the
- 2 value-based payment model for pediatric specialists in state Medicaid programs. (Directive to
- 3 Take Action)

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

Received: 5/15/2024

## RELEVANT AMA POLICY

### **Expanding AMA Payment Reform Work and Advocacy to Medicaid and Other Non-Medicare Payment Models for Pediatric Health Care and Specialty Populations H-385.901**

Our AMA will: 1) Support appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena, and 2) Extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts, and 3) Support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models, and 4) Consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care, and 5) Support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account.

Res. 817, I-23

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

Our AMA will work toward health equity, defined as optimal health for all, 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.

BOT Rep. 33, A-18Reaffirmed: CMS Rep. 5, I-21Reaffirmed: CMS Rep. 1, I-23



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 250  
(A-24)

Introduced by: Michigan

Subject: Endorsement of the Uniform Health-Care Decisions Act

Referred to: Reference Committee B

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1 Whereas, advance directives play a crucial role in ensuring that individuals' healthcare  
2 preferences are respected and upheld, particularly in instances where they may become  
3 incapacitated or unable to communicate their wishes; and  
4

5 Whereas, the American Medical Association (AMA) has a longstanding commitment to  
6 promoting patient autonomy and supporting the implementation of policies that facilitate  
7 informed decision-making in healthcare; and  
8

9 Whereas, the Uniform Health-Care Decisions Act (UHCDA), drafted and adopted by the  
10 National Conference of Commissioners on Uniform State Laws (NCCUSL) in 2023 to update the  
11 version of the UHCDA that the AMA House of Delegates approved in 1993, provides a  
12 comprehensive framework for the creation, execution, and recognition of advance directives  
13 across state jurisdictions; and  
14

15 Whereas, the UHCDA offers clarity and consistency in advance directive laws, thereby  
16 streamlining the process for patients, healthcare providers, and legal entities involved in  
17 healthcare decision-making; and  
18

19 Whereas, the UHCDA includes provisions for advance mental-health care directives, a topic  
20 lacking in most existing state laws; and  
21

22 Whereas, the UHCDA uses a modern, functional definition of "capacity" that recognizes a  
23 patient may lack capacity to make some decisions while retaining sufficient capacity to make  
24 other decisions; and  
25

26 Whereas, the UHCDA contains a sample form written in plain language designed to increase  
27 the number of people who complete an advance directive form and designate an agent under a  
28 health-care power of attorney; and  
29

30 Whereas, the UHCDA contains useful procedures to determine who is empowered to make  
31 decisions for a patient who has not designated an agent under a health-care power of attorney;  
32 and  
33

34 Whereas, the UHCDA clearly defines the duties of health-care providers with respect to  
35 advance directives and provides immunity for providers who act in good faith to comply with a  
36 patient's or surrogate's instructions; and  
37

38 Whereas, the endorsement and adoption of the UHCDA by the AMA would align with its mission  
39 to promote high-quality patient care, advance medical ethics, and facilitate effective  
40 communication between patients, families, and healthcare professionals; and

Whereas, collaboration with state medical societies to advocate for the adoption of the UHCDA at the state level would promote uniformity and reduce disparities in advance directive laws, ultimately enhancing patient-centered care and respecting individual autonomy; therefore be it

RESOLVED, that our American Medical Association amend policy D-140.968, "Standardized Advance Directives," to read as follows:

Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in 2023, and work with our state medical societies to advocate for its adoption in the states. (Modify Current HOD Policy)

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

Received: 5/16/2024

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5. Beauchamp, T. L., & Childress, J. F. (2012). Principles of biomedical ethics. Oxford University Press.
6. Jonsen, A. R., Siegler, M., & Winslade, W. J. (2015). Clinical ethics: A practical approach to ethical decisions in clinical medicine. McGraw Hill Professional.
7. American Medical Association. (2018). Code of medical ethics: Opinion 2.1.1 - Surrogate decision making. Retrieved from <https://www.ama-assn.org/delivering-care/ethics/surrogate-decision-making>.
8. National Conference of Commissioners on Uniform State Laws. (2023). Uniform Health-Care Decisions Act. < Health-Care Decisions Act - Uniform Law Commission (uniformlaws.org)>
9. Schneider, C. E., & Rothenberg, K. H. (2009). Implementing Advance Directives: A Case for a State Uniform Act. *American Journal of Law & Medicine*, 35(1), 57-88. doi:10.1177/009885880903500104

#### RELEVANT AMA POLICY

##### **Standardized Advance Directives D-140.968**

Our AMA will endorse the "Uniform Health-Care Decisions Act," which was drafted and adopted by the National Conference of Commissioners on Uniform State Laws (NCCUSL) in 1993, and work with our state medical societies to advocate for its adoption in the states.

##### **Informed Consent and Decision-Making in Health Care H-140.989**

(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.

(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.

(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.

#### **Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845**

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

#### **Advance Directives During Pregnancy H-85.952**

1. Our AMA vigorously affirms the patient-physician relationship as the appropriate locus of decision making and the independence and integrity of that relationship.

2. Our AMA will promote awareness and understanding of the ethical responsibilities of physicians with respect to advance care planning, the use of advance directives, and surrogate decision making, regardless of gender or pregnancy status, set out in the Code of Medical Ethics.

3. Our AMA recognizes that there may be extenuating circumstances which may benefit from institutional ethics committee review, or review by another body where appropriate.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 251  
(A-24)

Introduced by: Michigan

Subject: Streamline Payer Quality Metrics

Referred to: Reference Committee B

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Whereas, quality of patient care should be independent of the insurance carried by the patients;  
and

Whereas, Medicare and various third-party insurances currently use several quality benchmarks  
to assess the performance of primary care physicians; and

Whereas, these benchmarks often vary from year to year; and

Whereas, this inconsistency makes it particularly difficult for primary care practices, which are  
severely resource constrained, to track, analyze, and meet all of the required quality measures;  
and

Whereas, all of these performance benchmarks have an extreme impact on primary care  
physicians' bottom-lines and the financial sustainability of their practices; therefore be it

RESOLVED, that our American Medical Association work with the Centers for Medicare and  
Medicaid Services and major national insurance carriers to align each year's patient quality  
metrics across their respective programs. (Directive to Take Action)

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

Received: 5/16/2024

### RELEVANT AMA POLICY

#### **Pay-for-Performance Principles and Guidelines H-450.947**

##### PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and

technological barriers including costs of start-up.

4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

#### GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

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

##### Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality of care measures must be the primary measures used in any program.
  1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
  2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
  3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
  4. Performance measures should be scored against both absolute values and relative improvement in those values.
  5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.
  6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
  7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

##### Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
  1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

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

#### Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
  1. Programs should provide physicians with tools to facilitate participation.
  2. Programs should be designed to minimize financial and technological barriers to physician participation.
    - Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
    - Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
    - Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
    - Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

#### Physician Data and Reporting

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

promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

#### Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not financially penalize physicians based on factors outside of the physician's control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 252  
(A-24)

Introduced by: Young Physicians Section

Subject: Model Legislation to Protect the Future of Medicine

Referred to: Reference Committee B

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1 Whereas, patients marginalized due to race, ethnicity, ability status, gender, sexual orientation,  
2 national origin, religion, socioeconomic status, among others have worse healthcare outcomes<sup>1-  
3 3</sup>; and  
4

5 Whereas, diverse organizations perform better financially and have improved employee  
6 retention<sup>4,5</sup>; and  
7

8 Whereas, diverse healthcare organizations are linked to improved patient satisfaction and  
9 improved health outcomes<sup>6-11</sup>; and  
10

11 Whereas, patients from historically minoritized groups, who often experience health disparities,  
12 have better health outcomes when cared for by physicians more similar to them<sup>12-13</sup>; and  
13

14 Whereas, the Association of American Medical Colleges (AAMC), Accreditation Council for  
15 Graduate Medical Education (ACGME), and the American Medical Association, among many  
16 other medical organizations, have policy regarding the importance of diversity in the medical  
17 workforce<sup>14-16</sup>; and  
18

19 Whereas, there have been 65 anti-DEI (diversity, equity, and inclusion) bills introduced at the  
20 state level since 2023<sup>17</sup>; and  
21

22 Whereas, the Embracing Anti-Discrimination, Unbiased Curricula, and Advancing Truth in  
23 Education (EDUCATE) Act, a bill recently introduced to Congress, would ban DEI and related  
24 efforts in medical schools by restricting federal funding<sup>18</sup>; and  
25

26 Whereas, these bills represent an unacceptable overreach of politicians into medical education  
27 and set extremely dangerous and threatening precedents of politicians telling physicians how  
28 they are allowed to teach and practice medicine; and  
29

30 Whereas, the American Association of Medical Colleges (AAMC), Accreditation Council for  
31 Graduate Medical Education (ACGME), National Resident Matching Program (NRMP),  
32 Accreditation Council for Continuing Medical Education (ACCME), American Osteopathic  
33 Association (AOA), National Board of Medical Examiners (NBME), National Board of  
34 Osteopathic Medical Examiners (NBOME), American Board of Medical Specialties (ABMS),  
35 Council of Medical Specialty Societies (CMSS) and the AMA have released a joint statement  
36 opposed to the EDUCATE Act<sup>19</sup>; and



Whereas, an ounce of prevention is worth a pound of cure<sup>20</sup> – and it is better to be proactively on the offense rather than retroactively defensive; therefore be it

RESOLVED, that our American Medical Association create model state and national legislation to protect the ability of medical schools and residency/fellowship training programs to have diversity, equity, and inclusion (DEI) and related initiatives for their students, employees, and faculty. (Directive to Take Action)

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

Received: 6/7/2024

#### REFERENCES

- <sup>1</sup> [www.gallup.com/workplace/389990/healthcare-systems-time-DEI-checkup.aspx](http://www.gallup.com/workplace/389990/healthcare-systems-time-DEI-checkup.aspx)
- <sup>2</sup> [www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/](http://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/)
- <sup>3</sup> [www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/](http://www.kff.org/racial-equity-and-health-policy/issue-brief/health-and-access-to-care-and-coverage-for-lesbian-gay-bisexual-and-transgender-individuals-in-the-u-s/)
- <sup>4</sup> [altarum.org/RacialEquity2018](http://altarum.org/RacialEquity2018)
- <sup>5</sup> [pubmed.ncbi.nlm.nih.gov/30765101/](https://pubmed.ncbi.nlm.nih.gov/30765101/)
- <sup>6</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6626972/>
- <sup>7</sup> [https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2803898?utm\\_source=For\\_The\\_Media&utm\\_medium=referral&utm\\_campaign=ftm\\_links&utm\\_term=041423](https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2803898?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=041423)
- <sup>8</sup> <https://link.springer.com/article/10.1007/s11606-020-05646-z>
- <sup>9</sup> <https://pubmed.ncbi.nlm.nih.gov/21430577/>
- <sup>10</sup> <https://pubmed.ncbi.nlm.nih.gov/20571929/>
- <sup>11</sup> <https://pubmed.ncbi.nlm.nih.gov/30765101/>
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- <sup>20</sup> Benjamin Franklin

#### RELEVANT AMA POLICY

##### **D-295.962 Continued Support for Diversity in Medical Education**

Our AMA will: (1) publicly state and reaffirm its support for diversity in medical education and acknowledge the incorporation of DEI efforts as a vital aspect of medical training; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; (5) directly oppose any local, state, or federal actions that aim to limit diversity, equity, and inclusion initiatives, curriculum requirements, or funding in medical education; (6) advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed and student- and physician-guided as well as committed to longitudinal community engagement; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison

Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

#### **Racism as a Public Health Threat H-65.952**

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22

#### **Underrepresented Student Access to US Medical Schools H-350.960**

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979, (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.

Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21; Appended: Res. 305, I-22

#### **Encouraging LGBTQ+ Representation in Medicine D-200.972**

Our AMA: (1) will advocate for the creation of targeted efforts to recruit sexual and gender minority students in efforts to increase medical student, resident, and provider diversity; (2) encourages the inclusion of sexual orientation and gender identity data in all surveys as part of standard demographic variables, including but not limited to governmental, AMA, and the Association of American Medical Colleges surveys, given respondent confidentiality and response security can be ensured; and (3) will work with the Association of American Medical Colleges to disaggregate data of LGBTQ+ individuals in medicine to better understand the representation of the unique experiences within the LGBTQ+ communities and their overlap with other identities.

Res. 004, A-22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 253  
(A-24)

Introduced by: Private Practice Physicians Section

Subject: Addressing the Failed Implementation of the No Surprises Act IDR Process

Referred to: Reference Committee B

---

1 Whereas, in 2020, Congress passed the No Surprises Act (NSA) which removed patients from  
2 payment disputes between health insurance companies and out-of-network physicians providing  
3 services at in-network hospitals; and  
4

5 Whereas, the NSA banned physicians from “balance billing” and instead created a quick and fair  
6 independent dispute resolution (IDR) process by which physicians and insurers could resolve  
7 payment disputes; and  
8

9 Whereas, this federal IDR process is now critical for physicians to obtain or negotiate fair  
10 payments from private insurers, whether a physician is in- or out-of-network with a particular  
11 plan; and  
12

13 Whereas, the federal departments have failed to implement the IDR as called for by the NSA  
14 and physicians have already won four federal lawsuits (supported by the AMA) against federal  
15 agencies for unlawful implementation of the law; and  
16

17 Whereas, this failed implementation has driven many private physicians, particularly specialists,  
18 out of business, and has driven up typical charges of physician billing services from five percent  
19 of collections to as high as 25 percent; and  
20

21 Whereas, knowledge of the latest medical advances leavened by wisdom of experience holds  
22 the promise of more cost-effective, quality care; and  
23

24 Whereas, common problems with implementation of the IDR process include: (1) insurers  
25 refusing to make payments directly to the out-of-network provider as required by law; (2) CMS  
26 refusing to require insurers to clarify on the explanation of benefits whether the claim is IDR-  
27 eligible and in the state or federal venue, which clarification is necessary for the process to  
28 proceed in the allotted timeframes; (3) insurers sabotaging the IDR process by falsely claiming  
29 that the claim is ineligible because the physician was in-network; (4) insurers sabotaging the  
30 IDR process by falsely claiming that the claim is ineligible because the proper venue is a state  
31 process; (5) IDR entities closing claims because insurers state the claim was ineligible without  
32 requiring insurers to provide any confirmatory documentation; (6) CMS Refusing to certify an  
33 adequate number of IDR entities, as required by law, so disputes can be processed in the  
34 required timeframes; (7) CMS allocating the entire three business days of the “joint” three-  
35 business-day IDR selection process to the insurers, guaranteeing that the insurer gets their  
36 selection of IDR entity; (8) insurers and IDR entities sabotaging the law by endlessly requesting  
37 the same information from physicians that physicians have already submitted to the CMS portal;  
38 (9) insurers refusing to make payments to physicians within 30 days of losing at IDR, as  
39 required by law; therefore be it

1 Resolved, that our American Medical Association advocate for the federal departments to  
 2 immediately and correctly implement the fair and timely Independent Dispute Resolution (IDR)  
 3 process as stipulated by the No Surprises Act including advocating specifically for the following:

- 4
- 5 1. Specific requirements for insurers: Insurers must be required to make IDR loss  
 6 payments directly to physicians, clarify IDR eligibility on explanation of benefit forms, and  
 7 be prohibited from falsely claiming ineligibility due to network status or incorrect venue  
 8 claims;
- 9
- 10 2. Operational improvements in the IDR process: IDR entities must not close claims based  
 11 on unverified insurer claims, an adequate number of IDR entities must be certified, and a  
 12 structured timeline must be set for IDR entity selection and payment process

13 (Directive to Take Action).

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

Received: 6/7/2024

## **RELEVANT AMA POLICY**

### **Medicare Balance Billing D-390.985**

Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.

Citation: Res. 119, A-03; Reaffirmed: A-04; Reaffirmed: A-06; Reaffirmed per BOT action in response to referred decision Res. 236, A-06; Modified: CMS Rep. 01, A-16

### **Balance Billing H-385.991**

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

Citation: Sub Res. 128, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub Res. 704, A-01; Reaffirmed: A-04; Reaffirmed: A-05; Reaffirmed: A-06; Reaffirmed per BOT action in response to referred decision Res. 236, A-06; Modified: CMS Rep. 01, A-16

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

Our American Medical Association adopts the following principles related to unanticipated out-of-network care:

- a. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
- b. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
- c. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
- d. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
- e. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

- f. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
- g. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
- h. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.

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

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

Citation: Res. 108, A-17; Reaffirmed: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 255, I-18; Reaffirmed: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: SMC Rep. 5, A-21; Modified: Res. 236, A-22; Reaffirmed: CMS Rep. 3, I-23

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 320  
(A-24)

Introduced by: Michigan

Subject: Anti-Racism Training for Medical Students and Medical Residents

Referred to: Reference Committee C

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1 Whereas, the Liaison Committee on Medical Education (LCME) stated that faculty must teach  
2 students to recognize bias “in themselves, in others, and in the health care delivery process,”  
3 but does not explicitly require accredited institutions to teach about systemic racism in  
4 healthcare; and

5  
6 Whereas, the members of the Association of American Medical Colleges Medical Education  
7 Senior Leaders (AAMC MESL) “condemn the structures of racism that have allowed inequities  
8 in medicine and medical education to persist and are committed to combating racism in medical  
9 education by creating policies and changes that will support an antiracist learning environment  
10 and culture;” and

11  
12 Whereas, one of the long-term goals of the AAMC MESL is the provision of antiracism faculty  
13 and trainee development at least annually; and

14  
15 Whereas, medical students can recognize that racism has no place in healthcare, however, this  
16 knowledge does not translate to an understanding of how historical events, historical figures,  
17 and current events play a role in race in healthcare and how patient care and health equity  
18 efforts are impacted; and

19  
20 Whereas, further educating students with the knowledge of why inequalities and inequities exist  
21 in the modern day and modern medicine will allow them to speak out against structural issues  
22 and better treat their future patients; and

23  
24 Whereas, a significant amount of medical distrust exists amongst persons who have been  
25 historically marginalized due to past and present experiences of mistreatment and health  
26 disparities; and

27  
28 Whereas, medical distrust cannot be combated if future healthcare professionals are not  
29 properly trained in anti-racism and the root causes of existing race-based health disparities; and

30  
31 Whereas, involvement of anti-racism in medical school curriculum encourages students to be  
32 aware of their own biases and implement strategies to actively work against their biases for the  
33 betterment of patient care; and

34  
35 Whereas, racial discrimination has been linked to mental health issues (e.g., depression,  
36 substance use, PTSD), a variety of medical conditions (e.g., diabetes, hypertension, obesity)  
37 and dementia. It is common for marginalized individuals to experience racism in their daily lives  
38 and health care settings. Experiencing racism has also been shown to accelerate aging and  
39 affect brain circuitry that plays a role in regulating emotions and cognition. These have been

1 found to come from the social burdens placed on racial groups, rather than any biological or  
2 genetic factor; and  
3

4 Whereas, structural racism is a major factor that contributes to health disparities in marginalized  
5 populations; therefore be it  
6

7 RESOLVED, that our American Medical Association advocate that the Liaison Committee on  
8 Medical Education and Association of American Medical Colleges require, rather than  
9 encourage, anti-racism training for medical students and medical residents. (Directive to Take  
10 Action)

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

Received: 5/16/2024

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#### RELEVANT AMA POLICY

##### Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

**Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951**

Our AMA adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

**GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE**

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
  - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
  - Define expected and prohibited behavior.
  - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
  - Ensure privacy and confidentiality to the reporter.
  - Provide a confidential method for documenting and reporting incidents.
  - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
  - Taking every complaint seriously.
  - Acting upon every complaint immediately.
  - Developing appropriate resources to resolve complaints.
  - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
  - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
  - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
  - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
  - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs,



Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.

- Providing designated support person to confidentially accompany the person reporting an event through the process.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 434  
(A-24)

Introduced by: Michigan

Subject: Universal Newborn Eye Screening

Referred to: Reference Committee D

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1 Whereas, Red Reflex Testing (RRT) is the current standard of care for newborn eye screening  
2 in the United States; and  
3

4 Whereas, there are approximately 3.7 million live births in the United States per year and the  
5 American Academy of Pediatrics recommends that newborn infants be screened prior to  
6 discharge from the hospital; and  
7

8 Whereas, RRT is simple and inexpensive, it only evaluates approximately 6.5 percent of the  
9 retina (i.e., the optic disc and posterior pole) and leaves 95 percent of the retina unexamined;  
10 and  
11

12 Whereas, four prospective studies of RRT versus fundus imaging via Fundus Camera have  
13 demonstrated sensitivity of RRT to be 0-10 percent; and  
14

15 Whereas, camera based photographic screening for Retinopathy of Prematurity has been  
16 studied and found effective in telemedicine examinations for Retinopathy of Prematurity; and  
17

18 Whereas, wide-angle camera imaging covers 181 degrees of retina (six field, wide angle  
19 imaging per eye) and RRT covers approximately five degrees of retina; and  
20

21 Whereas, twenty papers have been published throughout the world that have shown that wide  
22 angle imaging studies performed within 72 hours of birth are much more sensitive and specific  
23 than RRT in detecting retinal/macular hemorrhages; and  
24

25 Whereas, multiple studies have been performed with wide-angle fundus imaging and have  
26 revealed that approximately 4.5 – 8 percent of all newborn eyes studied had some form of  
27 referral warranted abnormality including, foveal hemorrhages, retinoblastoma, optic nerve  
28 abnormalities, retinal detachments, cataract, developmental abnormalities, inherited retinal  
29 dystrophies and infectious chorioretinitis; and  
30

31 Whereas, the yield of positive results for referral warranted newborn eye screening (4.5-8  
32 percent) is greater than newborn screening for hearing deficits (1.6/1000 or 0.16 percent of live  
33 births; and  
34

35 Whereas, the Universal Photographic Newborn Eye Screening (U.N.E.S.) workflow consent  
36 protocol requires pharmacologic dilation, nursing and or technician photographers, six field,  
37 wide-angle imaging per eye, image interpretation and decision for follow up (U.N.E.S.  
38 taskforce); and

Whereas, the safety summary data has been published and shows “No ocular or systemic complications during or after eye examination;” therefore be it

RESOLVED, that our American Medical Association amend AMA policy, Standardization of Newborn Screening Programs H-245.973 by addition and deletion as follows:

Our AMA: (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations; (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases; ~~and~~ (3) supports screening for critical congenital heart defects for newborns following delivery prior to hospital discharge; and (4) endorses Universal Photographic Newborn Screening as a national practice for newborn children. (Modify Current HOD Policy)

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

Received: 5/16/2024

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#### RELEVANT AMA POLICY

##### Standardization of Newborn Screening Programs H-245.973

Our AMA: (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations; (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases; and (3) supports screening for critical congenital heart defects for newborns following delivery prior to hospital discharge.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 435  
(A-24)

Introduced by: Medical Student Section

Subject: Radiation Exposure Compensation

Referred to: Reference Committee D

---

1 Whereas, between 1945 and 1962, the US conducted nearly 200 nuclear weapon tests with  
2 mined/processed uranium, involving of tens of thousands of workers<sup>1</sup>; and  
3

4 Whereas, tests purportedly performed in “remote areas” affected many, including those  
5 downwind of the Trinity test site or those near open radioactive waste drums in St. Louis<sup>2-3</sup>; and  
6

7 Whereas, radiation exposure and nuclear waste disposal can lead to cancer and heart disease,  
8 place children and fetuses at risk, and contaminate nearby water, crops, and livestock<sup>4-6</sup>; and  
9

10 Whereas, lawsuits were later filed against the US for failure to warn about known radiation  
11 exposure, including contamination of groundwater<sup>1</sup>; and  
12

13 Whereas, the Radiation Exposure Compensation Act (RECA) of 1990 compensates individuals  
14 with cancer and other serious illnesses related to chronic radiation exposure, environmental  
15 contamination, or mining and uranium processing due to nuclear tests<sup>7-8</sup>; and  
16

17 Whereas, RECA is part of a network of federal programs compensating for past US nuclear  
18 harms, including the Nuclear Test Personnel Review (NTPR), National Radiation Exposure  
19 Screening and Education Program (RESEP), Energy Employees Occupational Illness  
20 Compensation Program Act (EEOICPA), and Veterans Affairs programs<sup>1</sup>; and  
21

22 Whereas, RECA originally only covered certain individuals in specified regions of 3 states and  
23 uranium workers in 5 states, but many other jurisdictions near nuclear tests—including Guam  
24 and the first ever nuclear test site at Trinity in New Mexico—are still not covered<sup>2,9-13</sup>; and  
25

26 Whereas, the legacy of nuclear weapons tests continues to harm 24 federally-recognized tribal  
27 nations in the Southwest who assisted with mining or experience uranium and heavy metal  
28 groundwater contamination<sup>1,14-16</sup>; and  
29

30 Whereas, RECA’s affected area covers land within multiple federally designated American  
31 Indian reservations, including the Navajo, Hopi, and White Mountain Apache reservations<sup>7</sup>; and  
32

33 Whereas, as of 2023, only 75% of the over 54,000 RECA claims filed have been approved, and  
34 around 14% of all claims and those awarded are from members of 24 Tribal nations<sup>7</sup>; and  
35

36 Whereas, RECA was last extended in 2022 but is set to expire in June 2024, despite estimated  
37 fiscal year (FY) 2024 needs at \$80 million, \$30 million more than FY 2023<sup>7</sup>; and

Whereas, the Senate passed a RECA reauthorization and expansion bill in March 2024, but the House has not yet passed their version despite expiration in June, with debate likely to extend into the summer and early fall<sup>17</sup>; therefore be it

RESOLVED, that our American Medical Association support continued authorization of federal radiation exposure compensation programs and expanded program eligibility to downwind individuals, communities, and tribes affected by the ongoing environmental harms of historic atomic weapons testing, including, but not limited to, residents of areas affected by the test of the first atomic bomb in New Mexico and uranium miners employed between 1942 through 1990. (New HOD Policy)

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

Received: 06/06/2024

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## **RELEVANT AMA POLICY**

### **Risks of Nuclear Energy and Low-Level Ionizing Radiation H-455.994**

Our AMA supports the following policy on nuclear energy and low-level ionizing radiation: (1) Usefulness of Nuclear Energy: Energy produced by nuclear reactors makes an important contribution to the generation of electricity in the US at present, and it will continue to do so in the foreseeable future. Investigation and research should continue in order to develop improved safety and efficiency of nuclear reactors, and to explore the potential of competing methods for generating electricity. The research should include attention to occupational and public health hazards as well as to the environmental problems of waste disposal and atmospheric pollution. [CSA Rep. A, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: CSAPH Rep. 4, A-13; Modified: CSAPH Rep. 8, A-23]

### **Treatment of Radiation Accident Victims H-455.993**

Our AMA (1) encourages all acute care facilities, through their medical staffs, to review and become familiar with radiation accident contingency plans required by the JCAHO, particularly those facilities in areas where major radiation-emitting equipment is located; and (2) supports the development of guidelines for training and preparedness of medical staffs, proper treatment regimens and the maintenance and use of decontamination equipment for use at the time of radiation accidents. [Res. 36, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

### **Low Level Radioactive Waste Disposal H-135.989**

The AMA (1) believes that each state should be responsible for providing capacity within or outside the state for disposal of commercial, non-military low level radioactive waste generated within its border; and (2) urges Environmental Protection Agency action to ensure capacity for disposal of low level radioactive waste. [Res. 48, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Modified: CSAPH Rep. 1, A-15]

### **Involvement of Physician Expertise in Non-Military Radiation Emergencies H-455.989**

The AMA encourages physicians to provide expertise on the health aspects of radiation incidents, emergencies and accidents to the public, the media and responsible government agencies. [Res. 74, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16]

### **Radon in Residential Dwellings and other Buildings H-455.986**

Our AMA (1) supports assuming a leadership role in educating physicians, others of the health care community, and the public concerning the significance of radon levels in residential dwellings and other buildings and the possible health effects of those levels; and (2) encourages the real estate community to increase transparency and disclosure of prior radon testing, and the most recent results of such testing. [CSA Rep. H, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 505, A-16]

### **Environmental Protection and Safety in Federal Facilities H-135.985**

The AMA urges physicians to contribute to the solution of environmental problems by serving as knowledgeable and concerned consultants to environmental, radiation, and public health protection agencies of state and local governments. [BOT Rep. T, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17]

### **Nuclear Test Ban H-520.994**

The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban. [Res. 90, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: Res. 524, A-15]

### **Low-Level Radioactive Waste Disposal Facility H-135.971**

Our AMA urges the Nuclear Regulatory Commission that any site for the disposal of low-level radioactive waste be rejected unless all applicable statutes and regulations are fully satisfied. [Res. 162, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

**Health Effects of Radon Exposure H-455.984**

It is the policy of the AMA: (1) to continue its surveillance of the growing understanding of the health risks of exposure to radon and contribute to this understanding wherever possible;

(2) that physicians continue to increase their knowledge about radon and its health effects and advise patients and the public in their communities on how to make intelligent decisions and take responsible actions on this issue;

(3) that physicians, when discussing the prevention of lung cancer, place greatest emphasis on the need to stop smoking; measures to decrease radon exposures should be encouraged if appropriate, but be placed in proper perspective, because smoking is a substantially more significant cause of lung cancer;

(4) to emphasize the need for more definitive data concerning the magnitude of the lung cancer risk from radon exposure and encourage the generation of these data as a needed public health measure; and

(5) to continue its efforts to help physicians understand the health risks associated with radon exposure and communicate this understanding to patients and the public. [CSA Rep. A, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

**Risks of a High-Level Radioactive Waste Repository H-135.961**

1. Our American Medical Association strongly encourages the U.S. Nuclear Regulatory Commission and the Nuclear Waste Technical Review Board of the National Research Council to include representatives of the appropriate state medical societies/associations, our AMA, and appropriate medical specialty groups with expertise in the field to advise and/or act as consultants to those entities.

2. Our AMA urges the U.S. Congress to establish a site for a high-level radioactive waste repository. [BOT Rep. A, I-92; Amended: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13; Reaffirmed: CSAPH Rep. 08, A-23]

**Safety from Nuclear Weapons and Medical Consequences of Nuclear War D-440.972**

1. Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed.

2. Our AMA will urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons and will collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war. [Res. 436, A-05; Appended: Res. 524, A-15]

**Navajo Birth Cohort Study D-460.969**

Our AMA recognizes the public health importance of the Navajo Birth Cohort Study for our Native American population and other populations exposed to uranium. [Res. 932, I-14]

**Evaluation of Canadian Underground Nuclear Waste Repository D-135.971**

Our American Medical Association, along with state and county medical societies, will urge Congress, the President, and the Secretary of State to invoke the participation of the International Joint Commission to evaluate the proposed underground nuclear waste repository in Ontario, Canada, and similar facilities. [Res. 523, A-15]

**Monitoring for Radiation in Seafood H-135.910**

Our American Medical Association calls for the United States government to continue to monitor and fully report the radioactivity levels of edible ocean species sold in the United States. [CSAPH Rep. 8, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514  
(A-24)

Introduced by: Texas

Subject: Safety With Devices Producing Carbon Monoxide

Referred to: Reference Committee E

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1 Whereas, unintentional carbon monoxide deaths in the United States (U.S.) rose from 393 in  
2 2015 to 543 in 2021; and

3  
4 Whereas, between 2017 and 2019, an average of 216 deaths per year in the U.S. were  
5 attributed to unintentional non-fire, carbon monoxide-producing consumer products; and

6  
7 Whereas, between 2003 and 2013, roughly 1,400 people were hospitalized each year in the  
8 U.S. because of non-fire-related carbon monoxide poisonings; and

9  
10 Whereas, 19 of the 246 deaths during the February 2021 winter storm in Texas were attributed  
11 to carbon monoxide poisoning; and

12  
13 Whereas, half of the carbon monoxide-related deaths following the Texas winter storm were  
14 caused by unsafe usage of generators; and

15  
16 Whereas, mortality related to unsafe use of carbon monoxide-producing devices increases  
17 following natural disasters; and

18  
19 Whereas, the U.S. Consumer Product Safety Commission has the authority to develop uniform  
20 safety standards for consumer products; and

21  
22 Whereas, generator manufacturers have shown resistance to adopting voluntary standards to  
23 reduce harm caused by carbon monoxide; therefore be it

24  
25 RESOLVED, that our American Medical Association support the United States Consumer  
26 Product Safety Commission in implementing higher safety standards for consumer products that  
27 produce carbon monoxide (New HOD Policy); and be it further

28  
29 RESOLVED, that our AMA support public education efforts to minimize harm caused by carbon  
30 monoxide poisoning produced in enclosed spaces or too close to exterior openings. (New HOD  
31 Policy)

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

Received: 5/10/2024



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**RELEVANT AMA POLICY****H-135.991 Clean Air**

(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect public health. [BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14]

**H-135.945 Encouraging Alternatives to PVC/Phthalate Products in Health**

Our AMA: (1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) products, especially those containing phthalates such as Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; (2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC products, especially those containing phthalates such as DEHP; (3) encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal sexual products as a source of phthalates; and (4) supports consumer education about the potential for exposure to toxic substances in adult personal sexual products. [BOT Action in response to referred for decision Res. 502, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 511, A-23]

**H-470.974 Athletic Helmets**

Our AMA urges the Consumer Product Safety Commission and other appropriate agencies and organizations to establish standards to ensure that athletic and recreational equipment produced or sold in the United States provide protection against head and facial injury. 2. Our AMA: (a) supports requiring

the use of head and facial protection by children and adolescents while engaged in potentially dangerous athletic and recreational activities; (b) encourages the use of head and facial protection for adults while engaged in potentially dangerous athletic and recreational activities; (c) encourages physicians to educate their patients about the importance of head and facial protection while engaged in potentially dangerous athletic and recreational activities; and (d) encourages the availability of rental helmets at all commercial settings where potentially dangerous athletic and recreational activities take place.[(Sub. Res. 16, I-88; Res. 419, A-93; Reaffirmed: CSA Rep. 8, A-03; Appended: Sub Res. 911, I-10; Modified: Res. 404, A-12; Reaffirmed: CSAPH Rep. 3, A-15]

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515  
(A-24)

Introduced by: Organized Medical Staff Section

Subject: Advocacy for More Stringent Regulations/Restrictions on the Distribution of Marijuana

Referred to: Reference Committee E

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1 Whereas, the number of people who are using marijuana continues to rise throughout the  
2 United States; and  
3

4 Whereas, the content of marijuana products has become a lot more potent and harmful over the  
5 years; and  
6

7 Whereas, more and more children are presenting with more serious side effects from marijuana,  
8 even in the pre-teen populations. The side effects are worse with earlier and chronic exposure  
9 and include difficulty thinking and problem-solving, problems with memory and learning,  
10 reduced coordination, difficulty maintaining attention, and problems with school and social life  
11 while medical problems for teenagers include depression, anxiety, temporary psychosis, and  
12 long-lasting mental problems such as schizophrenia; and  
13

14 Whereas, treatments for children affected by marijuana are becoming more challenging and  
15 costly for pediatric health professionals and services; and  
16

17 Whereas, patients with chronic marijuana use present more challenges for anesthesia, surgery,  
18 and pain management due to their needs for more and frequent dosing of potent medications.  
19 Cannabis use disorder (CUD) patients require higher anesthetic doses, have higher pain scores  
20 and opioid requirements postop, increased rates of postop nausea and vomiting, and high risk  
21 of perioperative morbidity and mortality; and  
22

23 Whereas, mechanisms of action of cannabis on different organ systems include respiratory  
24 irritation and airway hyperreactivity, vasospasm in coronary and cerebral vessels possibly  
25 contributing to myocardial infarction and strokes and immunosuppression possibly leading to  
26 increased infections and poor surgical wound healing; and  
27

28 Whereas, social consequences of marijuana use include educational failure, unemployment,  
29 and crime which are factors leading to higher rates of mental health disorders, which continue to  
30 worsen in the United States; and  
31

32 Whereas, the costs of caring for patients and the wellbeing of society are continuing to rise with  
33 more violence and crime as a result of the increasing popularity of marijuana use; therefore be it  
34

35 Resolved, that our American Medical Association study possible legislative, legal or regulatory  
36 means to make the cannabis industry responsible for increasing costs of medical and social  
37 care for people affected by the problems caused by cannabinoids similar to regulations for  
38 smoking cessation in the United States (Directive to Take Action).

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

Received: 6/7/2024

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#### RELEVANT AMA POLICY

##### Regulation of Cannabidiol Products H-120.926

Our AMA will: (1) encourage state controlled substance authorities, boards of pharmacy, and legislative bodies to take the necessary steps including regulation and legislation to reschedule U.S. Food and Drug Administration (FDA)-approved cannabidiol products, or make any other necessary regulatory or legislative change, as expeditiously as possible so that they will be available to patients immediately after approval by the FDA and rescheduling by the U.S. Drug Enforcement Administration; (2) advocate that an FDA-approved cannabidiol medication should be governed only by the federal and state regulatory provisions that apply to other prescription-only products, such as dispensing through pharmacies, rather than by these various state laws applicable to unapproved cannabis products; and (3) support comprehensive FDA regulation of cannabidiol products and practices necessary to ensure product quality, including identity, purity, and potency.

Citation: Res. 502, A-18; Appended: CSAPH Rep. 3, I-20

**Cannabis and Cannabinoid Research H-95.952**

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

Citation: CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of: Res. 902, I-10; Reaffirmed in lieu of: Res. 523, A-11; Reaffirmed in lieu of: Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 02, I-17; Reaffirmed in lieu of: Res. 434, A-19; Appended: Res. 913, I-19; Reaffirmed: A-22; Reaffirmed: Res. 212, A-23; Reaffirmed: CSAPH Rep. 6, I-23

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 609  
(A-24)

Introduced by: Texas

Subject: Standardization of the Endorsement Process

Referred to: Reference Committee F

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1 Whereas, the American Medical Association has put more emphasis on creating an equal  
2 playing field for all candidates for elected positions by changing a slew of election policies over  
3 the past couple of years to help elect candidates based upon merit above anything else; and  
4

5 Whereas, the standardization of the election process has not included the endorsement process  
6 overall; and  
7

8 Whereas, those groups with more available resources have a slight advantage in handling the  
9 burden of work to gather the information, which changes every election cycle, needed to seek  
10 an endorsement from the plethora of entities that give endorsements in the House of Delegates  
11 (HOD); and  
12

13 Whereas, the HOD appears to believe that endorsements are worth the time and effort to seek  
14 and could potentially gain voters; and  
15

16 Whereas, creating a process that provides information about every group that endorses  
17 candidates could help lessen the burden on smaller candidate campaign teams and create a  
18 more fair election environment; and  
19

20 Whereas, the amount of time wasted seeking an endorsement from a group that actually  
21 doesn't endorse a certain race could have been spent better elsewhere; therefore be it  
22

23 RESOLVED, that our American Medical Association require all groups that endorse candidates  
24 turn in information about their endorsement process, the deadline, and a staff contact for  
25 applications in a timely and streamlined manner (New HOD Policy); and be it further  
26

27 RESOLVED, that our AMA then post this information on the election website in a timely manner,  
28 with the information being easily digestible and accessible (Directive to Take Action); and be it  
29 further  
30

31 RESOLVED, that our AMA not allow any group that fails to provide this information in a timely  
32 manner to offer an endorsement during that election cycle (New HOD Policy); and be it further  
33

34 RESOLVED, that our AMA create a specific period (similar to virtual elections) during which  
35 endorsements may be sought. (New HOD Policy)  
36

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

Received: 5/10/2024

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 610  
(A-24)

Introduced by: Resident and Fellow Section, Medical Student Section

Subject: Opposition to Collective Punishment

Referred to: Reference Committee F

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1 Whereas, a United Nations (UN) report found that nearly 828 million individuals were impacted  
2 by hunger and food insecurity in 2021<sup>1</sup>; and  
3

4 Whereas, the Integrated Food Security Phase Classification (IPC) offers the most widely  
5 accepted definition of famine as “at least 20% of households facing an extreme lack of food, at  
6 least 30% of children suffering from acute malnutrition, and two people for every 10,000 dying  
7 each day due to outright starvation or to the interaction of malnutrition and disease”<sup>2</sup>; and  
8

9 Whereas, a UN report of the Special Rapporteur on the right to food published in December  
10 2022 identified conflict and violence as the primary causes of hunger, malnutrition, and famine<sup>3</sup>;  
11 and  
12

13 Whereas, the UN report identifies starvation as intentionally utilizing famine as a method of  
14 warfare and may trigger laws of war as it serves as an attempt to “annihilate or weaken a  
15 population by depriving people of food, water and other essentials for survival, including the  
16 means to produce and procure food”<sup>3</sup>; and  
17

18 Whereas, in warfare, far more deaths occur as a result of humanitarian crises created by a  
19 conflict (e.g. sieges, starvation) than from the hostilities themselves<sup>4</sup>; and  
20

21 Whereas, article 4 in Section I of the Geneva Conventions recognizes sick persons, wounded  
22 persons, and civilians as protected persons in the context of conflict and warfare<sup>5</sup>; and  
23

24 Whereas, article 33 in Section IV of the Geneva Conventions prohibits the punishment of a  
25 protected person for an offense they have not personally committed, further prohibiting  
26 collective penalties, measures of intimidation, pillage, and reprisals against protected persons  
27 and their property<sup>6</sup>; and  
28

29 Whereas, a 2018 UN Security Council resolution reaffirmed the “obligation of all parties to an  
30 armed conflict to comply with international humanitarian law”, recognized the unique relationship  
31 between hunger and armed conflict while acknowledging the complexity of hunger in holistic  
32 and systemic terms<sup>7</sup>; and  
33

34 Whereas, the IPC Famine Review Committee (FRC) released a report on the Gaza Strip in  
35 March 2024 which found that 95% of the analyzed population is at emergency-level food  
36 insecurity or higher and that famine is imminent<sup>8</sup>; and  
37

38 Whereas, the U.S. Agency for International Development (USAID) declared an ongoing famine  
39 in parts of Gaza during a congressional hearing in April 2024<sup>9</sup>; and

Whereas, the IPC FRC report identified the destruction of food, health, and water systems as well as restricted humanitarian access as key drivers of the current state of food insecurity in Gaza, which has largely been a result of the ongoing crisis between Palestine and Israel<sup>8</sup>; and

Whereas, food entering Gaza meets only approximately 7% of daily caloric needs of the civilians with water production at 5% of normal levels<sup>10</sup>; and,

Whereas, on March 28th, 2024, The World Court of the International Court of Justice unanimously ordered Israel to take all necessary and effective action to ensure basic food supplies to the enclave's Palestinian population and halt spreading famine<sup>11</sup>; and

Whereas, nearly \$806 billion of United States (US) taxpayer money has been distributed to the National Defense budget in 2023<sup>12</sup>; and

Whereas, following the events of October 7th, the US government has approved an additional \$2 billion in addition to the standing \$3.8 billion of aid to Israel<sup>13,14</sup>; and

Whereas, in November of 2023 the Biden administration requested an additional \$14 billion in aid towards Israel<sup>15</sup>; and

Whereas, the Code of Medical Ethics of the American Medical Association reaffirmed in 2023 in "A Declaration of Professional Responsibility H-140.900" specifically adopted declaration number two, "Refrain from supporting or committing crimes against humanity and condemn any such acts"; and

Whereas, AMA policy D-65.984 "Humanitarian and Medical Aid Support to Ukraine" specifies that our AMA will advocate for "continuous support of organizations providing humanitarian missions and medical care"; and

Whereas, international relief agencies such as the United Nations Reliefs and Works Agency for Palestinian Refugees in the Near East (UNRWA) and the United Nations High Commissioner for Refugees (UNHCR) provide on the ground support to refugees displaced by actions of war<sup>16,17</sup>; therefore be it

RESOLVED, that our American Medical Association oppose collective punishment tactics—including restrictions on access to food, water, electricity, and healthcare—as tools of war (New HOD Policy); and be it further

RESOLVED, that our AMA oppose the use of United States funding to any entities that (1) do not uphold international law; or (2) commit or condone war crimes (New HOD Policy); and be it further

RESOLVED, that our AMA condemn the use of United States resources to enforce collective punishment on civilians, including in Gaza (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for federal funding and support for national and international agencies and organizations that provide support for refugees, such as the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Reliefs and Works Agency for Palestinian Refugees in the Near East (UNRWA). (Directive to Take Policy)

Fiscal note: Moderate – between \$5,000 - \$10,000

Received: 6/7/2024



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## RELEVANT AMA POLICY:

### A Declaration of Professional Responsibility H-140.900

Our AMA adopts the Declaration of Professional Responsibility

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE's SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

**Declaration**

We, the members of the world community of physicians, solemnly commit ourselves to:

- (1) Respect human life and the dignity of every individual.
- (2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
- (3) Treat the sick and injured with competence and compassion and without prejudice.
- (4) Apply our knowledge and skills when needed, though doing so may put us at risk.
- (5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
- (6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
- (7) Educate the public and polity about present and future threats to the health of humanity.
- (8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
- (9) Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor. [CEJA Rep. 5, I-01; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17; Reaffirmed: Res. 215, A-23]

**Humanitarian and Medical Aid Support to Ukraine D-65.984**

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 714  
(A-24)

Introduced by: Texas

Subject: Automatic Downcoding of Claims

Referred to: Reference Committee G

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1 Whereas, in recent years there has been a sharp increase in health plans using third-party  
2 software, algorithms, artificial intelligence, or some other automated process to deny or  
3 downcode evaluation and management (E/M) service levels based solely on the diagnosis  
4 code(s), Current Procedural Terminology/Healthcare Common Procedure Coding System  
5 code(s), or modifiers submitted on a claim; and  
6

7 Whereas, a review of the medical record is necessary to determine if the E/M service level billed  
8 should be denied or downcoded; and  
9

10 Whereas, these software programs and algorithms should not be used as the sole determinant  
11 of E/M service level denials or downcoding; and  
12

13 Whereas, the explanation of benefits, remittance advice documents, or other claim adjudication  
14 notices do not provide the physician notice that a service was downcoded; therefore be it  
15

16 RESOLVED, that our American Medical Association vigorously oppose health plans exclusively  
17 relying on software, algorithms, or other methodologies excluding review of the patient's medical  
18 record to deny or downcode evaluation and management services, other than correct coding  
19 protocol denials, based solely on the Current Procedural Terminology/Healthcare Common  
20 Procedure Coding System codes, International Classification of Diseases, 10th Revision, codes,  
21 and/or modifiers submitted on the claim (New HOD Policy); and be it further  
22

23 RESOLVED, that our AMA support that, after review of the patient's medical record and  
24 determination that a lower level of evaluation and management code is warranted, the  
25 explanation of benefits, remittance advice documents, or other claim adjudication notices  
26 provide notice that clearly indicates a service was downcoded using the proper claim  
27 adjustment reason codes and/or remittance advice remark codes (New HOD Policy); and be it  
28 further  
29

30 RESOLVED, that our AMA advocate for legislation to provide transparency and prohibit  
31 automated denials, other than National Correct Coding Initiative denials, or downcoding of  
32 evaluation and management services based solely on the Current Procedural  
33 Terminology/Healthcare Common Procedure Coding System codes, International Classification  
34 of Diseases, 10th Revision, codes, or modifiers submitted on the claim (Directive to Take  
35 Action); and be it further  
36

37 RESOLVED, that our AMA further evaluate what legislative and/or legal action is needed to  
38 prevent insurers from automatic downcoding and to provide transparency on all methodology of  
39 processing claims. (Directive to Take Action)  
40

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

Received: 5/10/2024

#### REFERENCES

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2. X12. [Claim Adjustment Reason Codes](https://x12.org/codes/claim-adjustment-reason-codes). Updated: 3/1/2024. <https://x12.org/codes/claim-adjustment-reason-codes>.

#### RELEVANT AMA POLICY

##### **H-70.937 Bundling and Downcoding of CPT Codes**

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers; (2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards; (3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and (4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers. [Res. 802, I-98; Reaffirmed: Res. 814, A-00; Modified: Sub. Res. 817; Reaffirmed: BOT Rep. 8, I-00; Reaffirmation I-01; Reaffirmation I-04; Reaffirmation A-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 715  
(A-24)

Introduced by: Texas

Subject: Electronic Medical Records Submission

Referred to: Reference Committee G

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1 Whereas, physicians are required to submit to insurers upon request medical records for pre-  
2 and post-payment audits, the Healthcare Effectiveness Data and Information Set (HEDIS), risk  
3 adjustment functions, and other insurer processes; and  
4

5 Whereas, insurers and their third parties often do not allow electronic submission of the  
6 requested medical records and require them to be faxed or mailed; and  
7

8 Whereas, these requests for medical records have become more frequent, thereby interrupting  
9 patient care, creating additional uncompensated administrative burden and inefficient use of  
10 staff time and resources, and resulting in significant mailing and postage fees; and  
11

12 Whereas, medical records faxed or mailed are often lost, misplaced, or separated, resulting in  
13 claims denials and adverse determinations on appeals and audits concluding with loss of  
14 revenue or recoupment of large sums of money; and  
15

16 Whereas, insurers require physicians to conduct most business electronically (e.g., claims  
17 submission, prior authorization, appeals and reconsiderations), and many no longer  
18 communicate with physicians by mail (remittances, determinations, changes in policy, provider  
19 bulletins, and the like); and  
20

21 Whereas, physicians have been required to adopt electronic medical records at a substantial  
22 cost; therefore be it  
23

24 RESOLVED, that our American Medical Association support requiring insurers and their third  
25 parties to provide a secure, standardized, no-cost, easily accessible, and user-friendly  
26 mechanism to allow physicians to submit requested medical records and other documents  
27 electronically on an online portal, in addition to any fax and mail options (New HOD Policy); and  
28 be it further  
29

30 RESOLVED, that our AMA support physicians' ability to track and see the status of the medical  
31 record request on the portal (New HOD Policy); and be it further  
32

33 RESOLVED, that our AMA advocate for legislation requiring insurers to accept electronic  
34 submission of medical records requested by insurers and/or their third parties using an  
35 accessible, standardized, and user-friendly mechanism that also makes available tracking and  
36 status of the request. (Directive to Take Action)  
37

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

Received: 5/10/2024

## **RELEVANT AMA POLICY**

### **Insurers Excessive Documentation Requirements and Claims Submission D-70.991**

Our AMA will: (1) communicate with insurers that requires submission of medical record documentation for all Level 4 or Level 5 E & M codes that this practice is unacceptable and should be rescinded immediately; and (2) seek, if necessary, legal and governmental intervention to prevent any organization from requiring automatic and mandatory submission of medical record documentation for all CPT codes except unlisted procedures and codes with modifier-22. [Res. 827, A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20]

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 716  
(A-24)

Introduced by: Michigan

Subject: Impact of Patient Non-adherence on Quality Scores

Referred to: Reference Committee G

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1 Whereas, patient non-adherence is a very complex phenomenon; and

2  
3 Whereas, patients refuse preventative screening programs such as breast cancer screening;  
4 and

5  
6 Whereas, patients or parents can refuse necessary vaccinations; and

7  
8 Whereas, patients may not follow advice or recommendations given by their primary care  
9 physicians; and

10  
11 Whereas, such decisions adversely affect the health of the patients and subsequently, the  
12 quality metrics tracked by Medicare and various third-party insurers; therefore be it

13  
14 RESOLVED, that our American Medical Association study the issue of patients and parents not  
15 adhering to primary care physicians' recommendations such as preventive screenings and  
16 vaccinations resulting in a deficiency of quality metrics by primary care physicians for which the  
17 physicians are penalized, identify equitable and actionable solutions, and report back at Annual  
18 2025. (Directive to Take Action)

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

Received: 5/16/2024

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### RELEVANT AMA POLICY

#### Quality Management H-450.966

The AMA:

- (1) continues to advocate for quality management provisions that are consistent with AMA policy;
- (2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures;
- (3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures;
- (4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts;

(5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and

(6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.

#### **Quality Patient Care Measures H-410.960**

Our AMA encourages all physicians to be open to the development and broader utilization of evidence-based quality improvement guidelines (pathways, parameters) and indicators for measurement of quality practice.

#### **Pay-for-Performance Principles and Guidelines H-450.947**

##### **PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS**

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality of care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP program rewards.
2. Foster the patient/physician relationship - Fair and ethical PFP programs support the patient/physician relationship and overcome obstacles to physicians treating patients, regardless of patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.
3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of non-participating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.
4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results prior to the use of the results for programmatic reasons and any type of reporting.
5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

##### **GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS**

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

#### **Quality of Care**

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective



across the health care delivery system, rather than to achieve monetary savings.

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

1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.

2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.

3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.

4. Performance measures should be scored against both absolute values and relative improvement in those values.

5. Performance measures must be subject to the best-available risk- adjustment for patient demographics, severity of illness, and co-morbidities.

6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.

7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties.

Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.

- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

#### Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

- Programs must not create conditions that limit access to improved care.

1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.

- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

#### Physician Participation

- Physician participation in any PFP program must be completely voluntary.

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

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).

1. Programs should provide physicians with tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.
  - Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
  - Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
  - Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
  - Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

#### Physician Data and Reporting

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

#### Program Rewards

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

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

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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 717  
(A-24)

Introduced by: Private Practice Physicians Section

Subject: Mentorship to Combat Prior Authorization

Referred to: Reference Committee G

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1 Whereas, principles of our American Medical Association include preservation of public health  
2 and the sustainability of medical practice; and  
3

4 Whereas, proliferation of prior authorization procedures has intruded into the routine practice of  
5 medicine; and  
6

7 Whereas, the only justification for prior authorization is for curtailing excessive expense in  
8 providing medical care and should not impair routine and appropriate management; and  
9

10 Whereas, contemporary medical education in the United States emphasizes  
11 comprehensiveness of diagnosis and treatment, often the use of tests and procedures that  
12 individually and in aggregate become expensive for low probability targets; and  
13

14 Whereas, experienced clinicians usually develop the perspective as to which tests and  
15 treatments are most relevant and/or effective and which may be deferred or omitted; and  
16

17 Whereas, knowledge of the latest medical advances leavened by wisdom of experience holds  
18 the promise of more cost-effective, quality care; and  
19

20 Whereas, ongoing education of all physicians in the pragmatic economics of clinical healthcare  
21 could ethically be integrated into clinical decision-making and help to argue against external  
22 constraints of prior authorization, returning control to the level of the doctor-patient relationship;  
23 and  
24

25 Whereas, factors in the equation of cost of healthcare also include threats of litigation for failure  
26 to diagnose or use all available means of treatment, as well as delays due to nuisance prior  
27 authorization requirements (e.g. for low-cost, off-label treatments and/or related to preferred  
28 pharmacy benefit management contracts); and  
29

30 Whereas, a novel approach that satisfies society's primary directive to contain healthcare costs  
31 may attract legislative and regulatory support to mitigate the above factors and other matters;  
32 therefore be it  
33

34 Resolved, that our American Medical Association study the development of a template for a  
35 mentorship program for early career physicians as a means to reduce excessive healthcare  
36 costs, with a report back by Annual 2025 (Directive to Take Action); and be it further  
37

38 Resolved, that our AMA develop modules of education centered on the economics of utilization  
39 of testing, pharmaceuticals, and procedures in various categories of common and exceptional  
40 medical care (Directive to Take Action); and be it further

- 1 Resolved, that our AMA work with affected stakeholders, including government legislators and
- 2 regulators, pharmaceutical and business interests, healthcare systems, and patient
- 3 representatives as well as physicians on substitution of mentorship for frequent prior
- 4 authorization requests. (Directive to Take Action)

Fiscal Note: \$100,000 - Ed Hub modules; development of template.

Date Received: 6/7/2024

## **RELEVANT AMA POLICY**

### **Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

Citation: CME Rep. 1< i-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13;

Modified: CME Rep. 01, A-16; Reaffirmed: A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 718  
(A-24)

Introduced by: Private Practice Physicians Section

Subject: Transparency at the Pharmacy Counter

Referred to: Reference Committee G

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1 Whereas, insurance companies routinely interfere with the patient-doctor relationship by failing  
2 to cover the medication, dose, and duration as prescribed; and  
3

4 Whereas, pharmacies often fail to inform patients about the actual medication, dose, and  
5 duration prescribed if not covered by the health plan; and  
6

7 Whereas, pharmacies often fail to inform patients about the option of purchasing the prescribed  
8 medications out-of-pocket and to provide the associated out-of-pocket costs when insurance  
9 does not cover or covers only part of the prescribed regimen; and  
10

11 Whereas, prescriptions are written for three months, but insurance may only allow dispensing of  
12 one month's supply; a prescription may only be prescribed for two weeks, but insurance  
13 mandates a three-month fill; a prescription may be written for two weeks, but insurance may  
14 only allow five days' worth of medication; therefore be it  
15

16 Resolved, that our American Medical Association advocate for legislation or regulation that  
17 mandates that pharmacies, whether physical or mail-order, must inform patients about their  
18 prescriptions, to include at a minimum:

- 19 a) The dosage and schedule of treatments as written by the prescriber
- 20 b) Any restriction or alteration of the prescriber's intent due to third party or pharmacy  
21 intervention, with the stated justification
- 22 c) Details of other avenues to obtain the original prescription, including out of pocket  
23 options, with comparative costs

24 (Directive to Take Action).

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

Received: 6/7/2024

### RELEVANT AMA POLICY

#### AMA Response to Pharmacy Intrusion Into Medical Practice H-35.961

Our AMA deems inappropriate inquiries from pharmacies to verify the medical rationale behind prescriptions, diagnoses, and treatment plans to be an interference with the practice of medicine and unwarranted.

Citation: CSAPH Rep. 8, A-23

**Price of Medicine H-110.991**

Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.

Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmed: A-19; Appended: Res. 126, A-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 719  
(A-24)

Introduced by: Organized Medical Staff Section

Subject: Support Before, During, and After Hospital Closure or Reduction in Services

Referred to: Reference Committee G

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1 Whereas, the mission of our American Medical Association is to promote the art and science of  
2 medicine and the betterment of public health by representing physicians with a unified voice in  
3 courts and legislative bodies across the nation, removing obstacles that interfere with patient  
4 care, and confronting public health crises<sup>1</sup>; and

5  
6 Whereas, in recent months and years, there has been increasingly frequency of hospital  
7 closures and/or reduction in services, both of independent facilities and those within extended  
8 healthcare systems; and

9  
10 Whereas, a search of the AMA Policy Finder reveals existing policy addressing the needs of  
11 resident and fellow physicians<sup>6,7</sup> and conserving the credentialing information of practicing  
12 physicians<sup>8</sup> in the event of a hospital closure but it does not yield any general approach to the  
13 crisis of a closure or reduction in services of a hospital poses to patients (as well as physicians)  
14 and community access to care, whether addressing preventive or consequence management;  
15 and

16  
17 Whereas, the Massachusetts Medical Society has such a policy<sup>9</sup> which may serve as a template  
18 nationally; therefore be it

19  
20 Resolved, that our American Medical Association will work with appropriate federal and state  
21 bodies to assure that whenever there is a threatened, or actual, hospital closure a process be  
22 instituted to safeguard the continuity of patient care and preserve the physician-patient  
23 relationship. Such a process should:

- 24 a) Assure adequate capacity exists in the immediate service area surrounding the  
25 hospital closure, including independent health resources, physicians, and support  
26 personnel to provide for the citizens of that area;  
27 b) Allow that in said circumstances, restrictive covenants, records access, and financial  
28 barriers which prevent the movement of physicians and their patients to surrounding  
29 hospitals should be waived for an appropriate period of time (Directive to Take  
30 Action);

31 and be it further

32  
33 Resolved, that our AMA will proactively offer support to physicians, residents and fellows,  
34 patients, and civic leaders affected by threatened or actual healthcare facility closures or  
35 significant reductions in services via provision of information, resources, and effective,  
36 actionable advocacy. (Directive to Take Action)

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

Received: 6/7/2024



## References:

1. AMA Website, <https://www.ama-assn.org/search?search=mission+statement>
2. <https://www.aha.org/news/headline/2022-09-08-aha-report-rural-hospital-closures-threaten-patient-access-care>
3. <https://www.cleveland.com/news/2023/03/600-hospitals-in-danger-of-closing-per-study-is-yours-on-the-list.html>
4. <https://www.beckershospitalreview.com/finance/61-hospitals-closing-departments-or-ending-services.html>
5. <https://www.hsph.harvard.edu/news/features/maternity-obstetric-closure-health-disparities/>
6. Closing of Residency Programs H-310.943
7. Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948
8. Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records H-230.956
9. [https://www.massmed.org/Governance-and-Leadership/Policies,-Procedures-and-Bylaws/MMS-Policy-Compendium-\(pdf\)/](https://www.massmed.org/Governance-and-Leadership/Policies,-Procedures-and-Bylaws/MMS-Policy-Compendium-(pdf)/)

## RELEVANT AMA POLICY

### Closing of Residency Programs H-310.943

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.

2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty

choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;

B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;

C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and

D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:

A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;

B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and

C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

Citation: Sub. Res. 328, A-94; Appended: CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, -06; Appended: Res. 926, I-12; Modified: CME Rep. 1, A-15; Appended: Res. 310, I-19; Modified: CME Rep. 3, I-20; Reaffirmed: CME Rep. 01, I-22

### **Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948**

Our AMA will:

1. ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;

2. encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine

(AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;

3. encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;

4. work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;

5. encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will

ensure professional liability coverage for residents in the event of an institution or program closure; and

6. continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by nonprofit and for-profit entities and their effect on medical education.

Citation: CME Rep. 3, I-10; Modified: CME Rep. 01, I-22; Modified: Res. 301, I-23

**Hospital, Ambulatory Surgery Facility, Nursing Home, or Other Health Care Facility Closure: Physician Credentialing Records H-230.956**

1. AMA policy regarding the appropriate disposition of physician credentialing records following the closure of hospitals, ambulatory surgery facilities, nursing homes and other health care facilities, where in accordance with state law and regulations is as follows:

A. Governing Body to Make Arrangements: The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility.

B. Transfer to New or Succeeding Custodian: Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.

C. Documentation of Physician Credentials: The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.

D. Maintenance and Retention: Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records.

E. Access and Fees: The new custodian of the records shall provide access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.

2. Our AMA advocates for the implementation of this policy with the American Hospital Association.

Citation: Res. 808, I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: BOT Rep. 09, I-18

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 720  
(A-24)

Introduced by: Organized Medical Staff Section

Subject: The Hazards of Prior Authorization

Referred to: Reference Committee G

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1 Whereas, delays in timely procedures have led to significant morbidity and even mortality with  
2 many of these delays due to failure of insurance carriers to provide timely prior authorization;  
3 and  
4

5 Whereas, many carriers require prior authorizations for even low-cost minor procedures like  
6 electrocardiogram, echocardiogram, exercise tolerance test, or chest x-ray, which if allowed to  
7 be performed can allow for prompt risk stratification; and  
8

9 Whereas, there is no uniformity with regard to prior authorizations between different insurance  
10 carriers; and  
11

12 Whereas, many excess hours are spent by physicians and staff to get prior authorizations  
13 approved; and  
14

15 Whereas, many physician offices have a dedicated full-time employee just to obtain prior  
16 authorization; therefore be it  
17

18 Resolved, that our American Medical Association advocates that low-cost noninvasive  
19 procedures that meet existing standard Medicare guidelines should not require prior  
20 authorization (Directive to Take Action); and be it further  
21

22 Resolved, that our AMA support that physicians be allowed to bill insurance companies for all  
23 full time employee hours required to obtain prior authorization (New HOD Policy); and be it  
24 further  
25

26 Resolved, that our AMA support that patients be allowed to sue insurance carriers which  
27 preclude any and all clauses in signed contracts should there be an adverse outcome as a  
28 result of an inordinate delay in care. (New HOD Policy)

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

Received: 6/7/2024

### REFERENCES:

1. AMA et al. Prior authorization and utilization management reform principles. Accessed 4/29/2024: <https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf>

## **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; Reaffirmed: 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; Reaffirmed: A-22

### **Fair Reimbursement for Administrative Burdens D-320.978**

Our AMA will: (1) continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices; (2) continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes; (3) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials.

Citation: Res. 701, 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.2. Our AMA advocates for the implementation of this policy with the American Hospital Association.

Citation: Res. 704, A-19; Reaffirmed: A-22

### **Utilization Review, Medical Necessity Determination, Prior Authorization Decisions D-320.977**

Our AMA will advocate: (a) for implementation of a federal version of a prior authorization "gold card" law, which aims to curb onerous prior authorization practices by many state-regulated health insurers and health maintenance organizations; and (b) that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization, including a "gold-card" or "preferred provider program."

Citation: Res. 727, A-22; CEJA Rep. 01, A-23

### **Approaches to Increase Payer Accountability H-320.968**

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: BOT Rep. M, I-90; Reaffirmed: Res. 716, A-95; Reaffirmed: CMS Rep. 4, A-95; Reaffirmed: I-96; Reaffirmed: Rules and Cred, I-97; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: I-98; Reaffirmed: A-99; Reaffirmed: I-99; Reaffirmed: A-00; Reaffirmed in lieu of: Res. 839, I-08; Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmed: A-11; Reaffirmed in lieu of: Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 424, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmed: A-17; Reaffirmed: I-17; Reaffirmed: A-18; Reaffirmed: A-19; Reaffirmed: Res. 206, I-20; Reaffirmed: A-22

### **Processing Prior Authorization Decisions D-320.979**

Our AMA will advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends.

Citation: Res. 712, I-20; Reaffirmed: 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; Reaffirmed: A-02; Reaffirmed: I-08; Reaffirmed: I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of: Res. 719, A-11; Reaffirmed in lieu of: Res. 721, A-11; Reaffirmed: A-11; Reaffirmed in lieu of: Res. 822, I-11; Reaffirmed in lieu of: Res. 711, A-14; Reaffirmed: Res. 811, I-19; Reaffirmed: A-22

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 721  
(A-24)

Introduced by: Organized Medical Staff Section

Subject: Developing Physician Resources to Optimize Practice Sustainability

Referred to: Reference Committee G

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1 Whereas, principles of our American Medical Association include preservation of public health  
2 and the sustainability of medical practice; and  
3

4 Whereas, proliferation of prior authorization procedures has intruded into the routine practice of  
5 medicine; and  
6

7 Whereas, the only justification for prior authorization is for curtailing excessive expense in  
8 providing medical care and should not impair routine and appropriate management; and  
9

10 Whereas, contemporary medical education in the United States emphasizes  
11 comprehensiveness of diagnosis and treatment, often the use of tests and procedures that  
12 individually and in aggregate become expensive for low probability targets; and  
13

14 Whereas, experienced clinicians usually develop the perspective as to which tests and  
15 treatments are most relevant and/or effective and which may be deferred or omitted; and  
16

17 Whereas, knowledge of the latest medical advances leavened by wisdom of experience holds  
18 the promise of more cost-effective, quality care; and  
19

20 Whereas, ongoing education of all physicians in the pragmatic economics of clinical healthcare  
21 could ethically be integrated into clinical decision-making and help to argue against external  
22 constraints of prior authorization, returning control to the level of the doctor-patient relationship;  
23 and  
24

25 Whereas, factors in the equation of cost of healthcare also include threats of litigation for failure  
26 to diagnose or use all available means of treatment, as well as delays due to nuisance prior  
27 authorization requirements (e.g. for low-cost, off-label treatments and/or related to preferred  
28 pharmacy benefit management contracts); and  
29

30 Whereas, a novel approach that satisfies society's primary directive to contain healthcare costs  
31 may attract legislative and regulatory support to mitigate the above factors and other matters;  
32 therefore be it  
33

34 Resolved, that our American Medical Association develop a toolkit for physicians as a means to  
35 reduce excessive healthcare costs as well as improve physician practice sustainability and  
36 wellbeing, with a report back by Annual 2025. (Directive to Take Action)

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

Received: 6/7/2024



**RELEVANT AMA POLICY****Strategies for Enhancing Diversity in the Physician Workforce H-200.951**

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

Citation: CME Rep. 1< i-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13;

Modified: CME Rep. 01, A-16; Reaffirmed: A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

## SUMMARY OF FISCAL NOTES (A-24)

### Report(s) of the Board of Trustees

01	Annual Report	Informational Report
02	New Specialty Organizations Representation in the House of Delegates	Minimal
03	2023 Grants and Donations	Informational Report
04	AMA 2025 Dues	Minimal
05	Update on Corporate Relationships	Informational Report
06	Redefining AMA's Position on ACA and Health Care Reform	Informational Report
07	AMA Performance, Activities, and Status in 2023	Informational Report
08	Annual Update on Activities and Progress in Tobacco Control: March 2023 through February 2024	Informational Report
09	Council on Legislation Sunset Review of 2014 House P	Minimal
10	American Medical Association Health Equity Annual Report	Informational Report
11	Safe and Effective Overdose Reversal Medications in Educational Settings	Minimal
12	AMA Efforts on Medicare Payment Reform	Informational Report
13	Prohibiting Covenants Not-to-Compete	Minimal
14	Physician Assistant and Nurse Practitioner Movement Between Specialties	Minimal
15	Augmented Intelligence Development, Deployment, and Use in Health Care	Minimal
16	Support for Mental Health Courts	Minimal
17	Drug Policy Reform	Minimal
18	Supporting Harm Reduction	Minimal
19	Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication	TBD
20	Criminalization of Providing Medical Care	Informational Report
21	American Medical Association Meeting Venues and Accessibility	Minimal
22	AMA Public Health Strategy: Update	Informational Report
23	United States Professional Association for Transgender Health Observer Status in the House of Delegates	Minimal
24	Report on the Preservation of Independent Medical Practice	Informational Report
25	Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences	\$20,000
26	Equity and Justice Initiatives for International Medical Graduates	Minimal

## SUMMARY OF FISCAL NOTES (A-24)

27	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	Informational Report
28	Encouraging Collaboration Between Physicians and Industry in AI Development	Minimal
29	Transparency and Accountability of Hospitals and Hospital Systems	Minimal
30	Proper Use of Overseas Virtual Assistants in Medical Practice	Moderate
31	The Morrill Act and Its Impact on the Diversity of the Physician Workforce	Minimal
32	Independent Medical Evaluation	Informational Report
33	Employed Physicians	Minimal
34	Demographic Report of the House of Delegates and AMA Membership	Informational Report
35	Mitigating the Cost of Medical Student Participation in AMA Meetings	Minimal
36	Specialty Society Representation in the House of Delegates - Five-Year Review	Minimal

### Report(s) of the Council on Constitution and Bylaws

01	AMA Bylaws—Nomination of Officers and Council Members	Minimal
02	AMA Bylaws—Run-Off and Tie Ballots	Minimal
03	AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)	Minimal
04	AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)	Minimal

### Report(s) of the Council on Ethical and Judicial Affairs

01	Short-Term Global Health Clinical Encounters	Minimal
02	Research Handling of De-Identified Patient Data (D-315.969)	Minimal
03	Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices	Minimal
04	Physicians' Use of Social Media for Product Promotion and Compensation	Minimal
05	CEJA's Sunset Review of 2014 House Policies	Minimal
06	Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report	Informational Report

### Reports(s) of the Council on Long Range Planning and Development

01	Establishment of a LGBTQ+ Section	\$16,000 per annum
02	Scenarios on Collective Action and Physician Unions	Informational Report

## SUMMARY OF FISCAL NOTES (A-24)

### Report(s) of the Council on Medical Education

01	Council on Medical Education Sunset Review of 2014 House of Delegates' Policies	Minimal
02	The Current Match Process and Alternatives	Minimal

### Report(s) of the Council on Medical Service

01	Council on Medical Service Sunset Review of 2014 House Policies	Minimal
02	Improving Affordability of Employment-Based Health Coverage	Minimal
03	Review of Payment Options for Traditional Healing Services	Minimal
04	Health System Consolidation	Informational Report
05	Patient Medical Debt	Minimal
06	Economics of Prescription Medication Prior Authorization	Minimal
07	Ensuring Privacy in Retail Health Care Settings	Minimal
08	Sustainable Payment for Community Practices	Minimal

### Report(s) of the Council on Science and Public Health

01	Council on Science and Public Health Sunset Review of 2014 House Policies	Minimal
02	Comparative Effectiveness Research	Minimal
03	Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders	Minimal
04	Sex and Gender Differences in Medical Research	Minimal
05	Biosimilar/Interchangeable Terminology	Minimal
06	Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases	Modest
07	Androgen Deprivation in Incarceration	Minimal
08	Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing	Minimal
09	Prescribing Guided Physical Activity for Depression and Anxiety	Minimal
10	Teens and Social Media	Moderate
11	Stand Your Ground Laws	Minimal
12	Universal Screening for Substance Use and Substance Use Disorders during Pregnancy	Modest
13	Decreasing Youth Access to E-Cigarettes	Minimal

### Joint Report(s) of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development

01	Joint Council Sunset Review of 2014 House Policies	Minimal
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## SUMMARY OF FISCAL NOTES (A-24)

### Report(s) of the HOD Committee on Compensation of the Officers

01	Compensation Committee Report	\$4,500 if all non-leadership board members were reimbursed to the secretarial reimbursement maximum
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### Report(s) of the Speakers

01	Report of the Resolution Modernization Task Force Update	Modest
02	Report of the Election Task Force 2	Informational Report
03	Updated Parliamentary Authority	Informational Report

### Resolutions

001	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout	Modest
002	Removal of the Interim Meeting Resolution Committee	Minimal
003	Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity	Minimal
004	The Rights of Newborns that Survive Abortion	Minimal
005	AMA Executive Vice President	Minimal
006	Treatment of Family Members	Modest
007	AMA Supports a Strategy for Eliminating Nuclear Weapons	Minimal
008	Consolidated Health Care Market	Moderate
009	Updating Language Regarding Families and Pregnant Persons	Minimal
010	Withdrawn	NA
011	Withdrawn	NA
012	Ethical Pricing Procedures that Protect Insured Patients	Modest
013	Ethical Impetus for Research in Pregnant and Lactating Individuals	Modest
014	The Preservation of the Primary Care Relationship	Moderate
015	Health and Racial Equity in Medical Education to Combat Workforce Disparities	Moderate
016	Guiding Principles for the Healthcare of Migrants	Moderate
017	Addressing the Historical Injustices of Anatomical Specimen Use	Moderate
018	Opposing Violence, Terrorism, Discrimination, and Hate Speech	Modest
019	Supporting the Health of Our Democracy	Moderate
020	Voter Protections During and After Incarceration	Moderate

## SUMMARY OF FISCAL NOTES (A-24)

021	Opposition to Capital Punishment	Minimal
022	Health and Racial Equity in Medical Education to Combat Workforce Disparities	Moderate
023	Change Healthcare Security Lapse—The FBI Must Investigate	Moderate
024	Augmented Intelligence and Organized Medical Staff	Minimal
101	Infertility Coverage	Modest
102	Medicaid & CHIP Benefit Improvements	Modest
103	Medicare Advantage Plans	Modest
104	Medicaid Estate Recovery Reform	Minimal
105	Medigap Patient Protections	Minimal
106	Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum	Modest
107	Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies	Minimal
108	Requiring Payments for Physician Signatures	Minimal
109	Coverage for Dental Services Medically Necessary for Cancer Care	Modest
110	Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses	Minimal
111	Protections for “Guarantee Issue” of Medigap Insurance and Traditional Medicare	Moderate
112	Private and Public Insurance Coverage for Adaptive Sports Equipment including Prostheses and Orthoses	Moderate
113	Support Prescription Medication Price Negotiation	Modest
114	Breast Cancer Screening/Clinical Breast Exam Coverage	Modest
115	Payments by Medicare Secondary or Supplemental plans	Moderate
116	Increase Insurance Coverage for Follow-Up Testing After Abnormal Screening Mammography	Moderate
117	Insurance Coverage for Gynecologic Oncology Care	Minimal
118	Public and Private Payer Coverage of Diagnostic Interventions Associated With Colorectal Cancer Screening and Diagnosis	Modest
201	Research Correcting Political Misinformation and Disinformation on Scope of Practice	\$330,526: Comprehensive literature review; Field research through focus groups and surveys.

## SUMMARY OF FISCAL NOTES (A-24)

202	Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims	Minimal
203	Medicaid Patient Accountability	Modest
204	Staffing Ratios in the Emergency Department	Modest
205	Medical-Legal Partnerships & Legal Aid Services	Minimal
206	Indian Health Service Youth Regional Treatment Centers	Minimal
207	Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse	Modest
208	Improving Supplemental Nutrition Programs	Minimal
209	Native American Voting Rights	Minimal
210	Support for Physicians Pursuing Collective Bargaining and Unionization	\$43,308; Consult experts and coordinate with medical societies to identify and communicate ways to aid physicians in collective bargaining efforts
211	Deceptive Hospital Badging 2.0	Modest
212	Advocacy Education Towards a Sustainable Medical Care System	Modest
213	Access to Covered Benefits with an Out of Network Ordering Physician	Resolved 1: Modest Resolved 2: \$22,980. Develop a comprehensive portfolio of education, experts, and toolkits.
214	Support for Paid Sick Leave	Minimal
215	American Indian and Alaska Native Language Revitalization and Elder Care	Moderate
216	The AMA Supports H.R. 7225, the Bipartisan “Administrative Law Judges Competitive Service Restoration Act”	Minimal
217	Protecting Access to IVF Treatment	Modest
218	Designation of Descendants of Enslaved Africans in America	Moderate
219	Bundling for Maternity Care Services	Modest
220	Restorative Justice for the Treatment of Substance Use Disorders	Modest

## SUMMARY OF FISCAL NOTES (A-24)

221	Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability	Minimal
222	Studying Avenues for Parity in Mental Health & Substance Use Coverage	Modest
223	Increase in Children's Hospital Graduate Medical Education Funding	Modest
224	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care	Minimal
225	Humanitarian Efforts to Resettle Refugees	Minimal
226	Protecting Access to IVF Treatment	Modest
227	Medicare Reimbursement for Telemedicine	Minimal
228	Waiver of Due Process Clauses	Modest
229	Opposition to Legalization of Psilocybin	Minimal
230	Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion	Modest
231	Supporting the Establishment of Rare Disease Advisory Councils	Minimal
232	Medicare Advantage Part B Drug Coverage	Moderate
233	Prohibiting Mandatory White Bagging	Modest
234	State Prescription Drug Affordability Boards - Study	Modest
235	Establish a Cyber-Security Relief Fund	Moderate
236	Support of Physicians Pursuing Collective Bargaining and Unionization	\$43,308; Consult experts and coordinate with medical societies to identify and communicate ways to aid physicians in collective bargaining efforts
237	Encouraging the Passage of the Preventive Health Savings Act (S.114)	Modest
238	AMA Supports Efforts to Fund Overdose Prevention Sites	Minimal
239	Requiring stores that sell tobacco products to display NYS Quitline information	Modest
240	Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas	Minimal
241	Healthcare Cybersecurity Breaches	Moderate
242	Cancer Care in Indian Health Services Facilities	Moderate



## SUMMARY OF FISCAL NOTES (A-24)

243	Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes	\$59,000: Implementation of data collection and advocacy called for
244	Graduate Medical Education Opportunities for American Indian and Alaska Native Communities	Minimal
245	Patient Access to Covered Benefits Ordered by Out-of-Network Physicians	Resolve 1: Modest Resolve 2: \$22,980 Develop a comprehensive portfolio of education, experts, and toolkits
246	Augmented Intelligence in Health Care	Minimal
247	Prohibit Health Benefit Plans From Charging Cost Sharing for Covered Prostate Cancer Screening	Modest
248	Sustain Funding for HRSA (Health Resources Services and Administration) 340B Grant-Funded Programs	Minimal
249	Pediatric Specialty Medicaid Reimbursement	Moderate
250	Endorsement of the Uniform Health-Care Decisions Act	Minimal
251	Streamline Payer Quality Metrics	Moderate
252	Model Legislation to Protect the Future of Medicine	Moderate
253	Addressing the Failed Implementation of the No Surprises Act IDR Process	Modest
301	Fairness for International Medical Students	Minimal
302	The Role of Maintenance of Certification	Minimal
303	Amend Policy D-275.948 Title “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”. Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards.	\$14,354: Creation of an AMA Task Force
304	Spirituality in Medical Education and Practice	Minimal
305	Public Service Loan Forgiveness Reform	Modest
306	Unmatched Graduating Physicians	Minimal
307	Access to Reproductive Health Services When Completing Physician Certification Exams	Minimal
308	Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being	Minimal
309	Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine	Minimal
310	Accountability & Transparency in GME funding with Annual Report	Minimal

## SUMMARY OF FISCAL NOTES (A-24)

311	Physician Participation in Healthcare Organizations	Minimal
312	AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians	Modest
313	CME for Rural Preceptorship	Modest
314	Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule	Modest
315	Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations	Minimal
316	Reassessment of Continuing Board Certification Process	Minimal
317	Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians	Minimal
318	Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care	Modest
319	AMA Support of U.S. Pathway Programs	\$1,141,821: Convene advisory board, travel and meetings over 3 years, membership and grants, summit presentation of research outcomes.
320	Anti-Racism Training for Medical Students and Medical Residents	Minimal
401	Addressing Social Determinants of Health Through Closed Loop Referral Systems	Modest
402	Guardianship and Conservatorship Reform	Modest
403	Occupational Screenings for Lung Disease	Minimal
404	Protections Against Surgical Smoke Exposure	Minimal
405	Default Proceed Firearm Sales and Safe Storage Laws	Minimal
406	Opposition to Pay-to-Stay Incarceration Fees	Modest
407	Racial Misclassification	Minimal
408	Indian Water Rights	Modest
409	Toxic Heavy Metals	Modest
410	Access to Public Restrooms	Minimal
411	Missing and Murdered Indigenous Persons	Minimal
412	Lithium Battery Safety	Modest
413	Sexuality and Reproductive Health Education	Minimal
414	Addressing the Health Sector's Contributions to the Climate Crisis	Minimal

## SUMMARY OF FISCAL NOTES (A-24)

415	Building Environmental Resiliency in Health Systems and Physician Practices	Minimal
416	Furthering Environmental Justice and Equity	Minimal
417	Reducing Job-Related Climate Risk Factors	Minimal
418	Early and Periodic Eye Exams for Adults	Minimal
419	Addressing the Health Risks of Extreme Heat	Minimal
420	Equity in Dialysis Care	Modest
421	Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)	\$252,347 Annually to convene an annual meeting of Federation partners on obesity
422	Immunization Registry	Modest
423	HPV Vaccination to Protect Healthcare Workers over Age 45	Modest
424	LGBTQ+ Senior Health	\$122,712 Contract with third-parties to develop educational content and training for physicians
425	Perinatal Mental Health Disorders among Medical Students and Physicians	Modest
426	Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action	Modest
427	Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals	Moderate
428	Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals	\$51,420 Development of continuing medical education module to be hosted on AMA EdHub
429	Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants	Modest
430	Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages	Modest
431	Combatting the Public Health Crisis of Gun Violence	Modest
432	Resolution to Decrease Lead Exposure in Urban Areas	Moderate
433	Improving Healthcare of Rural Minority Populations	Moderate
434	Universal Newborn Eye Screening	Minimal
435	Radiation Exposure Compensation	Minimal
501	Fragrance Regulation	Moderate

## SUMMARY OF FISCAL NOTES (A-24)

502	Tribally-Directed Precision Medicine Research	Minimal
503	Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)	Modest
504	FDA Regulation of Biosimilars	Minimal
505	Mitigating the Harms of Colorism and Skin Bleaching Agents	Minimal
506	Screening for Image Manipulation in Research Publications	Minimal
507	Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies	Minimal
508	AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis	Modest
509	Addressing Sarcopenia and its Impact on Quality of Life	\$101,420: Contract with third-parties to develop educational content; advertise beyond standard AMA channels
510	Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”	Minimal
511	National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling	Minimal
512	Opioid Overdose Reversal Agents Where AED’s Are Located	Minimal
513	Biotin Supplement Packaging Disclaimer	Minimal
514	Safety With Devices Producing Carbon Monoxide	Minimal
515	Advocacy for More Stringent Regulations/Restrictions on the Distribution of Marijuana	Moderate
601	Annual Holocaust Remembrance Event	Moderate
602	Ranked Choice Voting	Modest
603	End Attacks on Health and Human Rights in Israel and Palestine	Minimal
604	Confronting Ageism in Medicine	\$47,934 Initial cost to review and report back on existing policy and develop educational session for CME, plus annual costs for continued advocacy and education
605	Walking the Walk of Climate Change	Moderate

### SUMMARY OF FISCAL NOTES (A-24)

606	Creation of an AMA Council with a Focus on Digital Health Technologies and AI	\$330,000 Annually: Average direct cost of an AMA Council plus staff support.
607	Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health	Minimal
608	The American Medical Association Diversity Mentorship Program	Moderate
609	Standardization of the Endorsement Process	Modest
610	Opposition to Collective Punishment	Moderate
701	Opposition to the Hospital Readmissions Reduction Program	Minimal
702	The Corporate Practice of Medicine, Revisited	Modest
703	Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation	Minimal
704	Pediatric Readiness in Emergency Departments	Modest
705	20 Minute Primary Care Visits	Modest
706	Automatic Pharmacy-Generated Prescription Requests	Minimal
707	Alternative Funding Programs	Moderate
708	Medicolegal Death Investigations	Modest
709	Improvements to Patient Flow in the U.S. Healthcare System	Moderate
710	The Regulation of Private Equity in the Healthcare Sector	Modest
711	Insurer Accountability When Prior Authorization Harms Patients	Modest
712	Full transparency - Explanation of Benefits	Moderate
713	Transparency – non-payment for services to patients with ACA exchange plans with unpaid premiums	Moderate
714	Automatic Downcoding of Claims	Moderate
715	Electronic Medical Records Submission	Modest
716	Impact of Patient Non-adherence on Quality Scores	Moderate
717	Mentorship to Combat Prior Authorization	\$100,000; Ed Hub modules, development of template, etc.
718	Transparency at the Pharmacy Counter	Moderate
719	Support Before, During, and After Hospital Closure or Reduction in Services	Moderate

## SUMMARY OF FISCAL NOTES (A-24)

720	The Hazards of Prior Authorization	Modest
721	Developing Physician Resources to Optimize Practice Sustainability	Moderate

**Minimal - less than \$1,000**

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

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