DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2024 Annual Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-24)

Report of Reference Committee B

Peter Rheinstein, MD, JD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 11 — Safe and Effective Overdose Reversal Medications in Educational Settings
2. Board of Trustees Report 19 — Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication
3. Resolution 205 — Medical-Legal Partnerships & Legal Aid Services
4. Resolution 209 — Native American Voting Rights
5. Resolution 212 — Advocacy Education Towards a Sustainable Medical Care System
6. Resolution 221 — Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability
7. Resolution 223 — Increase in Children's Hospital Graduate Medical Education Funding
8. Resolution 227 — Medicare Reimbursement for Telemedicine
9. Resolution 228 — Waiver of Due Process Clauses
10. Resolution 230 — Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion
11. Resolution 231 — Supporting the Establishment of Rare Disease Advisory Councils
12. Resolution 232 — Medicare Advantage Part B Drug Coverage
13. Resolution 235 — Establish a Cyber-Security Relief Fund
14. Resolution 238 — AMA Supports Efforts to Fund Overdose Prevention Sites
15. Resolution 248 — Sustain Funding for HRSA (Health Resources Services and Administration) 340B Grant-Funded Programs
16. Resolution 250 — Endorsement of the Uniform Health-Care Decisions Act

RECOMMENDED FOR ADOPTION AS AMENDED

17. Board of Trustees Report 09 — Council on Legislation Sunset Review of 2014 House Policies
18. Board of Trustees Report 12 – AMA Efforts on Medicare Payment Reform
19. Board of Trustees Report 14 — Physician Assistant and Nurse Practitioner Movement Between Specialties

20. Board of Trustees Report 16 — Support for Mental Health Courts
21. Board of Trustees Report 17 — Drug Policy Reform
22. Board of Trustees Report 18 — Supporting Harm Reduction
23. Resolution 201 — Research Correcting Political Misinformation and Disinformation on Scope of Practice
24. Resolution 204 — Staffing Ratios in the Emergency Department
25. Resolution 206 — Indian Health Service Youth Regional Treatment Centers
26. Resolution 207 — Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse
27. Resolution 208 — Improving Supplemental Nutrition Programs
28. Resolution 214 – Support for Paid Sick Leave
29. Resolution 215 — American Indian and Alaska Native Language Revitalization and Elder Care
30. Resolution 216 — The AMA Supports H.R. 7225, the Bipartisan "Administrative Law Judges Competitive Service Restoration Act"
31. Resolution 219 — Bundling for Maternity Care Services
32. Resolution 220 — Restorative Justice for the Treatment of Substance Use Disorders
33. Resolution 222 — Studying Avenues for Parity in Mental Health & Substance Use Coverage
34. Resolution 224 — Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
35. Resolution 229 — Opposition to Legalization of Psilocybin
36. Resolution 233 — Prohibiting Mandatory White Bagging
37. Resolution 234 — State Prescription Drug Affordability Boards – Study
38. Resolution 239 — Requiring stores that sell tobacco products to display NYS Quitline information
39. Resolution 242 — Cancer Care in Indian Health Services Facilities
40. Resolution 247 — Prohibit Health Benefit Plans From Charging Cost Sharing for Covered Prostate Cancer Screening
41. Resolution 249 — Pediatric Specialty Medicaid Reimbursement
42. Resolution 252 – Model Legislation to Protect the Future of Medicine
43. Resolution 253 – Addressing the Failed Implementation of the No Surprises Act IDR Process

RECOMMENDED FOR ADOPTION IN LIEU OF

44. Board of Trustees Report 13 — Prohibiting Covenants Not-to-Compete
45. Resolution 210 — Support for Physicians Pursuing Collective Bargaining and Unionization
    Resolution 236 — Support of Physicians Pursuing Collective Bargaining and Unionization
46. Resolution 213 — Access to Covered Benefits with an Out of Network Ordering Physician
    Resolution 245 — Patient Access to Covered Benefits Ordered by Out-of-Network Physicians
47. Resolution 217 — Protecting Access to IVF Treatment
    Resolution 226 — Protecting Access to IVF Treatment
48. Resolution 251 — Streamline Payer Quality Metrics

RECOMMENDED FOR REFERRAL

49. Board of Trustees Report 15 — Augmented Intelligence Development, Deployment, and Use in Health Care
    Resolution 202 — Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims
    Resolution 246 — Augmented Intelligence in Health Care
50. Resolution 218 — Designation of Descendants of Enslaved Africans in America
51. Resolution 243 — Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes

RECOMMENDED FOR NOT ADOPTION

52. Resolution 225 — Humanitarian Efforts to Resettle Refugees

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

53. Resolution 237 — Encouraging the Passage of the Preventive Health Savings Act (S.114)
54. Resolution 244 — Graduate Medical Education Opportunities for American Indian and Alaska Native Communities

Amendments

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

RECOMMENDED FOR ADOPTION

(1) BOARD OF TRUSTEES REPORT 11 — SAFE AND EFFECTIVE OVERDOSE REVERSAL MEDICATIONS IN EDUCATIONAL SETTINGS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 11 be adopted and that the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 11 adopted and the remainder of the Report filed.

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

1. Existing American Medical Association (AMA) policy entitled, "Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications" (Policy H42 95.932), be reaffirmed, and (Reaffirm HOD Policy)
2. The third resolve of Policy H-95.908, "Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings" be rescinded and that the policy be updated as noted. (Modify Current HOD Policy)

1. Our AMA will encourage states, communities, and educational settings to adopt legislative and regulatory policies that allow schools to make safe and effective overdose reversal medications readily accessible to staff and teachers to prevent opioid overdose deaths in educational settings.
2. Our AMA will encourage states, communities, and educational settings to remove barriers to students carrying safe and effective overdose reversal medications.
3. ~~Our AMA will study and report back on issues regarding student access to safe and effective overdose reversal medications.~~

Your Reference Committee heard supportive testimony for the recommendations of Board of Trustees Report 11. Your Reference Committee agrees that our AMA must continue efforts to support increased access to naloxone and other overdose reversal medications and reduce the stigma directed toward individuals who use drugs. Therefore, your Reference Committee recommends that Board of Trustees Report 11 be adopted, and that the remainder of the report be filed.

(2) BOARD OF TRUSTEES REPORT 19 — ATTORNEYS' RETENTION OF CONFIDENTIAL MEDICAL RECORDS AND CONTROLLED MEDICAL EXPERT'S TAX RETURNS AFTER CASE ADJUDICATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 19 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 19 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following be adopted in lieu of Resolution 240-A-23 and the remainder of this report be filed:

1. That our American Medical Association advocate that attorneys' discovery requests for the personal tax returns of a medical expert for the opposing party should usually be limited to 1099-MISC forms (miscellaneous income) (New HOD Policy); and

2. RESOLVED, That our AMA support through legislative or other relevant means the proper return or destruction of client medical records and medical expert's personal tax returns by attorneys within sixty days of the conclusion of the litigation (New HOD Policy).

Your Reference Committee heard supportive testimony on the recommendations of Board of Trustees Report 19. Your Reference Committee heard that seeking a medical expert's entire personal income tax returns is, in most instances, overly broad and unnecessarily invades the expert's privacy. Testimony supported limiting personal tax return discovery of a medical expert to miscellaneous income (1099-MISC forms), as it strikes a reasonable balance between allowing the probing for potential bias and protecting the expert's privacy and burdens. However, there was minimal testimony provided that noted that amendments should be made to the report to reflect that most contract EM physicians only receive a 1099 for all of their professional physician payments which would not adequately protect them from having to disclose the majority of their taxable income when testifying as an expert in a case. Your Reference Committee also heard that during litigation, certain documents that contain sensitive or confidential information, such as client medical records and tax returns, of medical experts are provided for the court and that there should be a reasonable timeframe after which such documents are destroyed. Therefore, your Reference Committee recommends that Board of Trustees Report 19 be adopted, and the remainder of the report be filed.

(3) RESOLUTION 205 — MEDICAL-LEGAL PARTNERSHIPS & LEGAL AID SERVICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 205 be adopted.

HOD ACTION: Resolution 205 adopted.

RESOLVED, that our American Medical Association support the establishment and funding of medical-legal partnerships and civil legal aid services to meet patients' legal needs. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony for Resolution 205. Testimony indicated that Medical-Legal Partnerships (MLPs) had a proven track record of success in addressing issues concerning social determinates of health and advancing the goals of health equity. Testimony also noted numerous organizations, including the American Bar Association, that support the growth and effectiveness of Medical-Legal Partnerships. Very minimal testimony opposed the resolution noting a lack of understanding surrounding how these asks would be funded. In response to the testimony noting funding concerns additional testimony stated that this resolution was not intended to require our AMA to fund MLPs, and instead represented an opportunity for a collaboration between our AMA, the American Bar Association, and the Association of American Medical Colleges, as well as other interested organizations in advancing MLPs. Given the predominantly positive testimony, your Reference Committee recommends that Resolution 205 be adopted.

(4) RESOLUTION 209 — NATIVE AMERICAN VOTING RIGHTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 209 be adopted.

HOD ACTION: Resolution 209 adopted.

RESOLVED, that our American Medical Association support Indian Health Service, Tribal, and Urban Indian Health Programs becoming designated voter registration sites to promote nonpartisan civic engagement among the American Indian and Alaska Native population. (New HOD Policy)

Your Reference Committee heard testimony in support of Resolution 209. Your Reference Committee heard that it is important that our AMA support the designation of Indian Health Service, Tribal, and Urban Indian (ITU) Health Programs as official voter registration sites to promote nonpartisan civic engagement among American Indian and Alaska Native communities. Your Reference Committee further heard that civic engagement via voting can have a significant impact on social/structural determinants of health, and that this resolution is consistent with AMA policy that acknowledges that voting is a social

determinant of health. Testimony also stated that medical schools, teaching hospitals, and other federal agencies such as the Veterans Health Administration are recognized as designated voter registration sites, therefore, ITU health programs deserve the same designation to promote increased engagement in voting by Native peoples, especially given their close proximity to Native communities. Therefore, your Reference Committee recommends that Resolution 209 be adopted.

(5) RESOLUTION 212 — ADVOCACY EDUCATION TOWARDS A SUSTAINABLE MEDICAL CARE SYSTEM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 212 be adopted.

HOD ACTION: Resolution 212 adopted.

RESOLVED, that our American Medical Association explore innovative opportunities for engaging the public in advocacy on behalf of an improved healthcare environment. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony on Resolution 212. Your Reference Committee heard that AMA policy addresses the education of medical students and physicians on advocacy techniques and encourages their involvement in AMA advocacy efforts. Testimony also noted that our AMA believes that better-informed and more active citizens will result in better legislators, better government, and better health care. Your Reference Committee further heard that our AMA already has robust grassroots activities that include outreach to engage patient advocates through its Patient Advocate Network (PAN), and that PAN has been active on issues including Medicare, drug pricing, and prior authorization. Your Reference Committee also heard testimony that greater involvement of the public in AMA advocacy efforts potentially could make our AMA more effective in its advocacy on behalf of patients and the profession. Therefore, your Reference Committee recommends that Resolution 212 be adopted.

(6) RESOLUTION 221 — REFORMING MEDICARE PART B DRUG REIMBURSEMENT TO PROMOTE PATIENT AFFORDABILITY AND PHYSICIAN PRACTICE SUSTAINABILITY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 221 be adopted.

HOD ACTION: Resolution 221 adopted.

RESOLVED, that our American Medical Association support the creation of a new reimbursement model for Part B drugs that 1) Disentangles reimbursement from the drug price, or any weighted market average of the drug price, by reimbursing physicians for the actual cost of the drug, and 2) Ensures adequate compensation for the cost of acquisition,

inventory, storage, and administration of clinically-administered drugs that is based on physician costs, not a percent of the drug price (New HOD Policy); and be it further

RESOLVED, that our AMA maintain the principles that any revised Part B reimbursement models should promote practice viability, especially for small physician practices, practices in rural and/or underserved areas, and practices with a significant proportion of Medicare patients, to promote continued treatment access for patients. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 221. Your Reference Committee heard that Resolution 221 addresses important needs for restructuring Medicare Part B drug reimbursement to better reflect the actual costs physicians incur in acquiring, storing, and administering drugs. Your Reference Committee heard that the resolution emphasizes ensuring adequate compensation for physicians, particularly focusing on the sustainability of small practices and those in rural or underserved areas. Therefore, your Reference Committee recommends that Resolution 221 be adopted.

(7) RESOLUTION 223 — INCREASE IN CHILDREN'S HOSPITAL GRADUATE MEDICAL EDUCATION FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 223 be adopted.

HOD ACTION: Resolution 223 adopted.

RESOLVED, that our American Medical Association collaborate with other relevant medical organizations to support and advocate for increased funding for the Children's Hospitals Graduate Medical Education program, recognizing the vital role it plays in shaping the future of pediatric healthcare in the United States. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 223. Your Reference Committee heard about how important consistent, and increased, funding is for Children's Hospital Graduate Medical Education (CHGME) programs as well as the important work undertaken by CHGME. Further testimony noted that CHGME is funded separately from other GME funding and receives considerably less funding than other GME programs leading to an inability to sustain growth in residency programs. Testimony also highlighted that our AMA has policy in line with this resolution and noted that our AMA has signed onto letters this year and last year asking for more CHGME funding, and consistently advocates for holistic funding increases for GME. Therefore, your Reference Committee recommends that Resolution 223 be adopted.

(8) RESOLUTION 227 — MEDICARE REIMBURSEMENT FOR TELEMEDICINE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 227 be adopted.

HOD ACTION: Resolution 227 adopted.

RESOLVED, that our American Medical Association support removal of the December 31, 2024 "sunset" date currently set for Medicare to cease reimbursement for services provided via telemedicine, such that reimbursement of medical services provided by telemedicine be continued indefinitely into the future, consistent with what would be determined by the Relative Value Update Committee ("RUC"). (New HOD Policy)

Your Reference Committee heard strong supportive testimony on Resolution 227. Testimony reflected that a permanent telehealth solution is undebated at this juncture as it has provided vast improvement in access to care for both rural, urban, and underserved populations such as the environmental benefits due to decreased travel for medical appointments. An amendment was proposed to adopt more flexible telehealth reimbursement models, suggesting the need for adaptability in valuing these services. However, testimony also overwhelmingly noted that our AMA has been active in its advocacy efforts as part of the AMA Recovery Plan for America's Physicians and has consistently urged Congress to implement a permanent solution to supplant the flexibility granted by the public health emergency's waivers. Therefore, given the strong support and compelling benefits discussed, your Reference Committee recommends that Resolution 227 be adopted.

(9) RESOLUTION 228 — WAIVER OF DUE PROCESS CLAUSES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 228 be adopted.

HOD ACTION: Resolution 228 adopted as amended to read as follows:

RESOLVED, that our AMA will engage in advocacy for adoption of such legislation to eliminate waiver of due process clauses at the federal level.

RESOLVED, that our American Medical Association advocate that waiver of due process clauses be eliminated from all employment agreements between employed physicians and their non-physician employers, and be declared unenforceable in physicians' previously-executed employment agreements between physicians and their non-physician employers that currently exist (Directive to Take Action); and be it further

RESOLVED, that our AMA will engage in advocacy for adoption of such legislation at the federal level. (Directive to Take Action)

Your Reference Committee heard predominantly supportive testimony on Resolution 228. Testimony noted that most physicians are employed, and because they have little bargaining power with employers, cannot walk away from bad employment deals or negotiate due process clauses in employment or other contracts. Testimony also indicated that many states do not recognize medical staff bylaws as a contract so many physicians have no protections under hospital bylaws against due process waivers. Further testimony revealed that due process waivers harm patients because they discourage physicians from speaking out about patient care concerns and effectively make physicians at-will employees whose employment can be terminated at any time. Your Reference Committee notes that our AMA is already on the record supporting the 2024 "Physician and Patient Safety Act" as requested by the resolution. Therefore, your Reference Committee recommends that Resolution 228 be adopted.

(10) RESOLUTION 230 — PROTECTING PATIENTS FROM INAPPROPRIATE DENTIST AND DENTAL HYGIENIST SCOPE OF PRACTICE EXPANSION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 230 be adopted.

HOD ACTION: Resolution 230 adopted.

RESOLVED, that our American Medical Association advocacy efforts recognize the threat posed to patient safety when dentists and dental hygienists are authorized to practice medicine and administer procedures outside their level of education and training (New HOD Policy); and be it further

RESOLVED, that our AMA actively oppose regulatory and legislative efforts authorizing dentists and dental hygienists to practice outside their level of education and training. (Directive to Take Action)

Your Reference Committee heard testimony in support of Resolution 230. Testimony emphasized that patient safety is threatened when health care professionals, including dentists and dental hygienists, practice outside the scope of their education and training. Your Reference Committee heard that Resolution 230 aligns with our AMA's existing campaign supporting physician-led care and opposing inappropriate scope expansions. Therefore, your Reference Committee recommends that Resolution 230 be adopted.

(11) RESOLUTION 231 — SUPPORTING THE ESTABLISHMENT OF RARE DISEASE ADVISORY COUNCILS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 231 be adopted.

HOD ACTION: Resolution 231 referred.

RESOLVED, that our American Medical Association will support state legislation for the establishment of Rare Disease Advisory Councils in each state (New HOD Policy).

Your Reference Committee heard mixed testimony on Resolution 231. Your Reference Committee heard that Rare Disease Advisory Councils give the rare disease community a stronger voice in state government and support patients and their caregivers. Your Reference Committee heard that Rare Disease Advisory Councils are uniquely positioned to add gravitas to the needs of patients with rare diseases and the health care professionals that care for them. Additional testimony noted that Rare Disease Advisory Councils play an important role in filling gaps in knowledge surrounding this patient population and emphasized that it is important that these Councils are given the support they need to expand to all states (27 states already have these Councils), giving rare disease patients across the U.S. a strong and unified voice. However, your Reference Committee also heard testimony in support of referral. Testimony asked for further study on the involvement of specialists and medical specialty associations in Rare Disease Advisory Councils and expressed concern that Rare Disease Advisory Councils can become a mechanism for the pharmaceutical industry – rather than patients and their health care team – to further exert influence on the policymaking process. However, your Reference Committee heard mostly supportive testimony and also notes that adoption of Resolution 231 would not prevent our AMA from working with state and specialty associations to ensure the appropriate design of Rare Disease Advisory Councils. Therefore, your Reference Committee recommends that Resolution 231 be adopted.

(12) RESOLUTION 232 — MEDICARE ADVANTAGE PART B DRUG COVERAGE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 232 be adopted.

HOD ACTION: Resolution 232 adopted.

RESOLVED, that our American Medical Association will advocate with Congress, through the appropriate oversight committees, and with the Centers for Medicare & Medicaid Services (CMS) to require that Medicare Advantage (MA) plans cover physician-administered drugs and biologicals in such a way that the patient out of pocket cost is the same or less than the amount that a patient with traditional Medicare plus a Medigap plan would pay. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 232. Your Reference Committee heard that Resolution 232 addresses significant concerns regarding the equity of drug coverage in Medicare Advantage plans. Your Reference Committee heard that by supporting this resolution, our AMA would enhance its ability to advocate for more equitable drug coverage policies within these plans. Testimony noted that the disparities in out-of-pocket costs for drugs under Medicare Advantage plans lead to inequitable health outcomes, particularly for less affluent patients. Testimony highlighted that by advocating for changes to these plans, our AMA is effectively positioned to influence future Centers for Medicare & Medicaid Services rules. Though one individual testified that this increased coverage could lead to the erosion of Traditional Medicare plans, most of the testimony supported this resolution. Therefore, your Reference Committee recommends that Resolution 232 be adopted.

(13) RESOLUTION 235 — ESTABLISH A CYBER-SECURITY RELIEF FUND

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 235 be adopted.

HOD ACTION: Resolution 235 adopted.

RESOLVED, that our American Medical Association, through appropriate channels, advocate for a 'Cyber Security Relief Fund" to be established by Congress (Directive to Take Action); and be it further

RESOLVED, that the "Cyber Security Relief Fund" be funded through contributions from health insurance companies and all payers - as a mandated requirement by each of the payer (Directive to Take Action); and be it further

RESOLVED, that the "Cyber Security Relief Fund" only be utilized for 'uninterrupted' payments to all providers- in a structured way, in the event of future cyber-attacks affecting payments. (Directive to Take Action)

Your Reference Committee heard mixed but mostly supportive testimony on Resolution 235. Your Reference Committee heard about the importance of having a safety net to ensure that providers are paid by major insurers even if a cyber-attack should occur. Testimony also highlighted that cyber-attacks have continued to escalate and become more complex. Your Reference Committee heard that the recent ransomware attack on Change Healthcare caused thousands of physician payments to be withheld for weeks or months, resulting in devastating consequences to thousands of families because of inability to fulfill the payroll needs of the physicians and their employees. However, your Reference Committee also heard that this resolution should be referred for study so that this complex issue can be more thoroughly researched. Nevertheless, your Reference Committee heard significantly more positive testimony for this resolution than testimony in support of referral. Therefore, your Reference Committee recommends that Resolution 235 be adopted.

(14) RESOLUTION 238 — AMA SUPPORTS EFFORTS TO FUND OVERDOSE PREVENTION SITES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 238 be adopted.

HOD ACTION: Resolution 238 adopted.

RESOLVED, that our American Medical Association support legislation or regulation that would fund overdose prevention sites. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 238. Your Reference Committee heard about the benefits of overdose prevention sites (also known as safe injection sites or harm reduction centers) which include providing sterile supplies and administering naloxone in the event of an opioid-related overdose. Your Reference Committee heard testimony that overdose prevention sites have prevented thousands of deaths and have been successful in helping individuals access treatment for their substance use disorder. Your Reference Committee heard clear support for removing barriers to funding for these centers. Therefore, your Reference Committee recommends that Resolution 238 be adopted.

(15) RESOLUTION 248 — SUSTAIN FUNDING FOR HRSA (HEALTH RESOURCES SERVICES AND ADMINISTRATION) 340B GRANT-FUNDED PROGRAMS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 248 be adopted.

HOD ACTION: Resolution 248 referred for decision.

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

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.; and (6) supports 340B programs funded by HRSA grants in their utilization of the program as legislatively intended. (Modify Current HOD Policy)

Your Reference Committee heard minimal testimony on Resolution 248. Your Reference Committee heard supportive testimony from the authors of the resolution for the overall need for support of 340B programs. Your Reference Committee also heard testimony reflecting concerns about abuses of 340B programs and expressed that our AMA should not categorically support 340B programs because there are bad actors in this space. Therefore, your Reference Committee recommends that Resolution 248 be adopted.

(16) RESOLUTION 250 — ENDORSEMENT OF THE UNIFORM HEALTH-CARE DECISIONS ACT

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 250 be adopted.

HOD ACTION: Resolution 250 referred.

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)

Your Reference Committee heard mixed testimony on Resolution 250. Your Reference Committee heard that our AMA policy supported the 1993 Uniform Health-Care Decisions Act and that a new, updated Uniform Health Care Decisions Act was adopted in 2023 by the Uniform Laws Commission. Your Reference Committee heard that the new Act modernizes and expands the Act to reflect changes in how health care is delivered. Your Reference Committee also heard that this updated model legislation tackles complex issues that will impact medical practice, and that further study is needed as well as concerns around the separate advance directives specifically for mental health. However, your Reference Committee heard significantly more supportive testimony that highlighted all the work that our AMA has already done in this space. Therefore, your Reference Committee recommends that Resolution 250 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(17) BOARD OF TRUSTEES REPORT 09 — COUNCIL ON LEGISLATION SUNSET REVIEW OF 2014 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 9 be amended by addition to read as follows:

The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to this report be acted upon in the manner indicated, except for Policy 45.975, which should be retained, and the remainder of this report be filed.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the Recommendation of Board of Trustees Report 9 be adopted as amended and that the remainder of the report be filed.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Clause 3 of Policy H-185.951 be amended by addition and deletion to read as follows:

3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on ~~his/her~~ their own to obtain and perform a protime/INR without restrictions.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Clause 1 of Policy H-355.975 be amended by addition and deletion to read as follows:

1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by ~~his/her~~ their state licensing agency should ~~his/her~~ their name appear on the National Practitioner Data Bank.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Clause 1 of Policy H-40.967 be amended by addition and deletion to read as follows:

1. Our AMA endorses voluntary physician participation in the military reserve components' medical programs as a means of actively aiding national defense while preserving the right of the individual physician to practice ~~his/her~~ their profession without interruption in peace time.

HOD ACTION: Recommendations in Board of Trustees Report 9 adopted as amended and the remainder of the Report filed.

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

Your Reference Committee heard testimony that Board of Trustees Report 9 should be adopted with two noted amendments. Your Reference Committee heard that some policies recommended to be retained were not updated to comply with AMA Policy H-65.942, which calls for gender-neutral language in AMA policy. Your Reference Committee agrees and therefore recommends that AMA Policies H-185.951, H-355.975, and H-40.967, which include the reference to “his” and “her,” be amended accordingly. Your Reference Committee heard additional testimony that H-45.975 includes policy that remains relevant regarding the substitution of third-class medical certificate with a driver's license. Your Reference Committee agrees and therefore recommends that H-45.975 should be retained.

(18) BOARD OF TRUSTEES REPORT 12 – AMA EFFORTS ON MEDICARE PAYMENT REFORM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 12 be amended by addition of the following Recommendations to read as follows:

1) Our AMA increase media awareness around the 2024 AMA Annual meeting about the need for Medicare Payment Reform, eliminating budget neutrality reductions, and instituting annual cost of living increases.
2) Our AMA step up its public relations campaign to get more buy-in from the general public about the need for Medicare payment reform.
3) Our AMA increase awareness to all physicians about the efforts of our AMA on Medicare Payment Reform.
4) Our AMA advocate for abolition of all MIPS penalties in light of the current inadequacies of Medicare payments.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 12 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 12 adopted as amended and the remainder of the Report filed.

Your Reference Committee heard testimony acknowledging and expressing appreciation for our AMA's strong advocacy activities outlined in BOT Report 12 to fix the broken Medicare physician payment system. Testimony emphasized, however, the need for increased dialogue and public communication about our AMA's ongoing advocacy for Medicare payment reform, a more effective use of social media platforms, and other public engagement strategies to mobilize broad public support and understanding of this pressing issue. Those testifying addressed the challenges physicians face due to inadequate reimbursement rates, a broken Medicare payment system, and highlighted the need for immediate reform to ensure the sustainability of medical practices across the nation. Your Reference Committee heard unanimous and passionate support for adding a recommendation to BOT Report 12 that would call for greater public attention to be generated that clearly articulates and bolsters the urgency of enacting Medicare payment reform. The recommendation calls on our AMA to increase media awareness, step up our AMA's public relations campaign, increase awareness to all physicians about the efforts of our AMA on Medicare payment reform, and advocate for abolition of all MIPS penalties. Your Reference Committees agrees with the unanimous sentiments of those testifying and recommends adding the proffered recommendation to BOT Report 12.

(19) BOARD OF TRUSTEES REPORT 14 — PHYSICIAN ASSISTANT AND NURSE PRACTITIONER MOVEMENT BETWEEN SPECIALTIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Recommendation of Board of Trustees Report 14 be amended by addition and deletion to read as follows:

3. That the AMA encourage hospitals and other health care entities employing nurse practitioners and physician assistants to ensure that the ~~nurse~~ practitioner's certification aligns with the specialty in which they will practice. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 14 be amended by addition of a fifth Recommendation to read as follows:

5. Our AMA continue to support research into the cost and quality of primary care delivered by nurse practitioners and physician assistants. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 14 be amended by addition of a sixth Recommendation to read as follows:

6. That our AMA continue to support research into the distribution and impact of nurse practitioners and physician assistants on primary care in underserved areas. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 14 be amended by addition of a seventh Recommendation to read as follows:

7. That our AMA continue to support expansion of access to physicians in under resourced areas. (New HOD Policy)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations one and two of Board of Trustees Report 14 referred.

HOD ACTION: Recommendations in Board of Trustees Report 14 adopted as amended and the remainder of the Report filed.

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

1. That the American Medical Association (AMA) support workforce research, including surveys by state medical and nursing boards, that specifically focus on gathering information on nurse practitioners and physician assistants practicing in specialty care, their certification(s), alignment of their certification to their specialty, and whether they have switched specialties during their career. (New HOD Policy)
2. That the AMA support research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. (New HOD Policy)
3. That the AMA encourage hospitals and other health care entities employing nurse practitioners to ensure that the nurse practitioner's certification aligns with the specialty in which they will practice. (New HOD Policy)
4. That the AMA continue educating policymakers and lawmakers on the education, training, and certification of nurse practitioners and physician assistants, including the concept of specialty switching. (New HOD Policy)

Your Reference Committee heard supportive testimony for Board of Trustees Report 14. Your Reference Committee heard that while the concept of specialty switching by nurse practitioners and physician assistants is well known, there are little publicly available data on this issue. The Board Report, therefore, calls on our AMA to support research in this area to fill this knowledge gap, including through workforce surveys and studies, as well as research that evaluates the impact of specialty switching by nurse practitioners and physician assistants on the cost and quality of patient care. Your Reference Committee heard some testimony urging referral of Recommendations 1 and 2 of the Board of Trustees Report which call on our AMA to support such studies. However, your Reference Committee heard, on balance, testimony that favored adoption of all the Recommendations found in the Report instead of referral. Your Reference Committee also received an amendment, supported by others, that calls on our AMA to continue supporting research related to nurse practitioners practicing in primary care. This amendment is consistent with existing AMA policy and AMA's ongoing advocacy related to scope of practice. Therefore, Your Reference Committee recommends that Board of Trustees Report 14 be adopted as amended, and the remainder of the report be filed.

(20) BOARD OF TRUSTEES REPORT 16 — SUPPORT FOR MENTAL HEALTH COURTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third Recommendation of Board of Trustees Report 16 be amended by addition and deletion to read as follows:

(3) encourages diversion and treatment programs ~~drug courts to~~ that rely upon evidence-based models of care, including all medications used for ~~opioid~~ treatment of substance use disorder, for those who the judge or court determine would benefit from intervention, including treatment, rather than incarceration; and

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 16 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 16 adopted as amended and the remainder of the Report filed.

The Board of Trustees recommends that existing policy – Policy H-100.955, entitled, "Support for Drug Courts" – be amended by addition and deletion in lieu of Resolution 202 as follows:

Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans Courts, Sobriety Courts, and Similar Programs

Our AMA:

1. supports the establishment and use of diversion and treatment programs ~~drug courts~~, including drug courts, mental health courts, veterans courts, sobriety courts, and other types of similar programs, as an effective method of intervention within a comprehensive system of community-based supports and services for individuals with a mental illness or substance use disorder involved in the justice system ~~addictive disease who are convicted of nonviolent crimes~~;
2. encourages legislators and court systems to establish diversion and treatment programs ~~drug courts~~ at the state and local level in the United States; ~~and~~
3. encourages diversion and treatment programs ~~drug courts~~ to rely upon evidence-based models of care, including medications for opioid use disorder, for those who the judge or court determine would benefit from intervention, including treatment, rather than incarceration; and
4. supports individuals enrolled in diversion or treatment programs not be removed from a program solely because of evidence showing that an individual used illegal drugs while enrolled. (Modify HOD Policy)

Your Reference Committee heard supportive testimony for the recommendations of Board of Trustees Report 16. Your Reference Committee heard testimony that our current AMA policy and ongoing advocacy initiatives support increased access to evidence-based treatment for mental illness and substance use disorders. Testimony also encouraged support for access to medication for opioid use disorder and other substance use disorders. Your Reference Committee heard that if there are evidence-based programs for mental health and substance use disorders that can benefit individuals who would otherwise be incarcerated, those diversion programs should be strongly considered. Your Reference Committee received a minor technical amendment to this effect that was widely supported. Therefore, your Reference Committee recommends that the recommendations in Board of Trustees Report 16 be adopted as amended, and the remainder of the report be filed.

(21) BOARD OF TRUSTEES REPORT 17 — DRUG POLICY REFORM

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Recommendation of Board of Trustees Report 17 amended by addition and deletion to read as follows:

~~1. That the American Medical Association (AMA) will continue to monitor the legal and public health effects of state and federal policies to reclassify criminal offenses for drug possession for personal use; (New HOD Policy)~~

1. That our American Medical Association (AMA) support elimination of criminal penalties for drug possession for personal use as part of a larger set of related public health and legal reforms designed to improve carefully selected outcomes.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Recommendation of Board of Trustees Report 17 be amended by addition to read as follows:

2. That the AMA will support federal and state efforts to automatically expunge, at no cost to the individual, criminal records for drug possession for personal use upon completion of a sentence or penalty; (New HOD Policy) and

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Recommendation in Boart of Trustees Report 17 be amended by addition to read as follows:

3. That the AMA support programs that provide comprehensive substance use disorder treatment and social support to people who use or possess illicit drugs for personal use as an alternative to incarceration-based penalties, including for persons under parole, probation, pre-trial, or other civic, criminal, or judicial supervision. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Board of Trustee Report 14 be amended by addition of a fourth Recommendation to read as follows:

4. Concurrently, that our AMA support robust policies and funding that facilitate people's access to evidence-based prevention, early intervention, treatment, harm reduction, and other supportive services – with an emphasis on youth and racially and ethnically minoritized people – based on individualized needs and with availability in all communities.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 17 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 17 adopted as amended and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 203 and the remainder of the report be filed:

1. That the American Medical Association (AMA) will continue to monitor the legal and public health effects of state and federal policies to reclassify criminal offenses for drug possession for personal use; (New HOD Policy)
2. That the AMA will support federal and state efforts to expunge, at no cost to the individual, criminal records for drug possession for personal use upon completion of a sentence or penalty; (New HOD Policy) and
3. That the AMA support programs that provide comprehensive substance use disorder treatment and social support to people who use or possess illicit drugs for personal use as an alternative to incarceration-based penalties for persons under parole, probation, pre-trial, or other civic, criminal, or judicial supervision. (New HOD Policy)

Your Reference Committee heard supportive testimony on the spirit of Board of Trustees Report 17. However, your Reference Committee heard limited testimony in support of continuing to monitor the effects of state and federal policies to decriminalize drug possession for personal use. Instead, most of the testimony heard by your Reference Committee called on our AMA to directly support decriminalization of drug possession for personal use as part of a larger set of public health and legal reforms. Your Reference Committee also heard wide-ranging concerns about racial and other inequities regarding Black and Brown individuals who are disproportionately incarcerated in the nation's jails and prisons for drug possession offenses. Testimony also highlighted that individuals who served a sentence or experienced other penalties for drug possession for personal use should have those penalties automatically expunged at the completion of their sentence. Your Reference Committee received amendments reflecting both concerns. Therefore, your Reference Committee recommends that Board of Trustees Report 17 be adopted as amended, and the remainder of the report be filed.

(22) BOARD OF TRUSTEES REPORT 18 — SUPPORTING HARM REDUCTION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation two of Board of Trustees Report 18be amended by addition and deletion to read as follows:

~~2.That the AMA oppose the concept, promotion, or practice of "safe smoking" with respect to inhalation of tobacco, cannabis or any illicit substance; (New HOD Policy)~~

2. That the AMA support decriminalization of harm reduction supplies that reduce the likelihood of injection drug use and mitigate health risks of all types of drug use, including injection drug use and smoking.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 18 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 18 adopted as amended and the remainder of the Report filed.

The Board of Trustees recommends that the following new policy be adopted in lieu of Resolution 204, and that the remainder of the report be filed.

1. That the American Medical Association (AMA) support efforts to decriminalize the possession of non-prescribed buprenorphine for personal use by individuals who lack access to a physician for the treatment of opioid use disorder; (New HOD Policy)

2. That the AMA oppose the concept, promotion, or practice of "safe smoking" with respect to inhalation of tobacco, cannabis or any illicit substance; (New HOD Policy)
3. That the AMA encourage additional study whether "safer smoking supplies" may be a potential harm reduction measure to reduce harms from the nation's overdose and death epidemic; and (New HOD Policy)
4. That the AMA reaffirm Policy D-95.987, "Prevention of Drug-Related Overdose." (Reaffirm AMA Policy)

Your Reference Committee heard supportive testimony on Board of Trustees Report 18. Your Reference Committee heard supportive testimony on the benefits of increasing access to buprenorphine for the treatment of opioid use disorder (OUD) through multiple means, including support for decriminalizing non-prescribed buprenorphine for personal use. Your Reference Committee also heard significant testimony noting that there is no such thing as safe smoking. However, your Reference Committee also heard testimony noting support for access to harm reduction supplies that reduce the likelihood of injection drug use and mitigate the health risks of all types of drug use and received an amendment to this effect. Therefore, your Reference Committee recommends that Board of Trustees Report 18 be adopted as amended, and the remainder of the report be filed.

(23) RESOLUTION 201 — RESEARCH CORRECTING POLITICAL MISINFORMATION AND DISINFORMATION ON SCOPE OF PRACTICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 201 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA Board of Trustees report its findings and recommendations by the ~~I-24~~ A-25 meeting to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 201 be adopted as amended.

HOD ACTION: Resolution 201 adopted as amended.

RESOLVED, that our American Medical Association perform a comprehensive literature review on current research on correcting political misinformation and disinformation and conduct field research on ways to correct political misinformation and disinformation amongst policymakers as it pertains to scope of practice (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees report its findings and recommendations by the I-24 meeting to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice. (Directive to Take Action)

Your Reference Committee heard overwhelmingly supportive testimony on Resolution 201. There was consensus that our AMA's existing scope of practice campaign would benefit from targeted research on political misinformation and effective messaging in scope of practice advocacy. Your Reference Committee also heard that, to ensure there is enough time to pursue the research sought by this Resolution and prepare a report, the Board of Trustees report on the findings of this research should be due at the 2025 AMA Annual Meeting rather than the 2024 AMA Interim Meeting. Therefore, your Reference Committee recommends that Resolution 201 be adopted as amended.

(24) RESOLUTION 204 — STAFFING RATIOS IN THE EMERGENCY DEPARTMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper physician supervision of non-physician practitioners ~~NPPs~~ in the Emergency Department (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 204 be amended by addition and deletion to read as follows:

~~RESOLVED, that our AMA seek federal legislation or regulation that would require all Emergency Departments to be staffed 24-7 by a qualified physician. (Directive to Take Action)~~

RESOLVED, that our AMA support that all Emergency Departments be staffed 24-7 by a qualified physician. (New HOD policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 204 be adopted as amended.

HOD ACTION: Resolution 204 adopted as amended.

RESOLVED, that our American Medical Association seek federal legislation or regulation prohibiting staffing ratios that do not allow for proper supervision of NPPs in the Emergency Department (Directive to Take Action); and be it further

RESOLVED, that our AMA seek federal legislation or regulation that would require all Emergency Departments to be staffed 24-7 by a qualified physician. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 204. Your Reference Committee heard significant testimony in support of federal law prohibiting staffing ratios that do not allow for proper supervision of non-physicians in the emergency department; this included an amendment to clarify that such supervision must be done by a physician. Regarding the second Resolved clause, your Reference Committee heard testimony opposing the independent practice of non-physicians and promoting physician-led, team-based, care in the emergency department. While some testimony indicated that there is no shortage of emergency medicine physicians and that it would not be a hardship on the profession to ensure that a physician was onsite to ensure proper supervision of emergency care services, other testimony indicated that a 24/7 physician supervision requirement would be impossible for some rural and underserved hospitals and could lead to hospital closures. Your Reference Committee also heard significant testimony noting that a Board of Trustees report is currently being drafted for the AMA 2024 Interim Meeting and that this report will directly address the issue of possible rural exceptions to requirements for 24/7 physician supervision in emergency departments. Your Reference Committee understands that this pending Board report will be influential in the development of AMA policy when it comes to physician supervision in emergency departments. Therefore, your Reference Committee recommends that the first Resolved clause be adopted as amended and the second Resolved clause be referred.

(25) RESOLUTION 206 — INDIAN HEALTH SERVICE YOUTH REGIONAL TREATMENT CENTERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support the expansion of Indian Health Service Youth Regional Treatment Centers, recognizing them as ~~a model for~~ culturally-rooted, ~~evidence-based~~ behavioral health and substance use disorder treatment centers for~~, and prompt referral of eligible~~ American Indian/Alaskan Native (AI/AN) youth t~~o Youth Regional Treatment Centers (YRTCs) for community-directed care~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 206 be adopted as amended.

HOD ACTION: Resolution 206 adopted as amended.

RESOLVED, that our American Medical Association support the expansion of Indian Health Service Youth Regional Treatment Centers, recognizing them as a model for culturally-rooted, evidence-based behavioral health treatment, and prompt referral of eligible AI/AN youth to Youth Regional Treatment Centers (YRTCs) for community-directed care. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 206. Your Reference Committee heard that American Indian/Alaskan Native (AI/AN) populations benefit from culturally rooted care for mental illness and substance use disorders. Testimony also stated that the AI/AN population would benefit from greater access to evidence-based care for mental illness and substance use disorders. Your Reference Committee also heard testimony concerning whether the programs supported by the Indian Health Service all are "models," and received multiple amendments suggesting the removal of this language in the resolution, but heard nothing to suggest any hesitation surrounding supporting the treatment programs in general. Therefore, your Reference Committee recommends that Resolution 206 be adopted as amended.

(26) RESOLUTION 207 — BIOSIMILAR USE RATES AND PREVENTION OF PHARMACY BENEFIT MANAGER ABUSE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 207 be deleted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 207 be adopted as amended.

HOD ACTION: A new Resolve added to Resolution 207 to read as follows:

RESOLVED, that our AMA supports coverage structures that: increase use of lower cost biosimilars when clinically appropriate, share savings between payers and patients ~~physicians~~, and reduce patient costs.

HOD ACTION: The new Resolve of Resolution 207 referred.

HOD ACTION: Resolution 207 adopted as amended.

RESOLVED, that our American Medical Association support economic incentives to increase physician use of less expensive biosimilars instead of their reference biologics (New HOD Policy); and be it further

RESOLVED, that our AMA encourage the Federal Trade Commission (FTC) and Department of Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed between biologics originators and PBMs to ensure they do not impede biosimilar development and uptake. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 207. Your Reference Committee heard support for the concept of decreasing patient cost by prescribing less expensive medication and ensuring fair competition for biosimilars. However, your Reference Committee also heard that financial compensation for physicians should not be a factor in what physicians ultimately prescribe, rather the patient's health should be the only determining factor. Further testimony suggested that removing the reference to economic incentives would strengthen the resolution. Therefore, your Reference Committee recommends that Resolution 207 be adopted as amended.

(27) RESOLUTION 208 — IMPROVING SUPPLEMENTAL NUTRITION PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 208 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association supports ~~regulatory and legal reforms to~~ extending ~~multie~~eligibility for USDA Food Assistance to enrolled members of federally-recognized American Indian and Alaska Native Tribes and Villages to ~~all~~ federal feeding programs~~, such as, but not limited to, Supplemental Nutrition Assistance Program (SNAP) and Food Distribution Program on Indian Reservations (FDPIR)~~. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 208 be adopted as amended.

HOD ACTION: Resolution 208 adopted as amended.

RESOLVED, that our American Medical Association support regulatory and legal reforms to extend multieligibility for USDA Food Assistance to enrolled members of federally-

recognized American Indian and Alaska Native Tribes and Villages to all federal feeding programs, such as, but not limited to, Supplemental Nutrition Assistance Program (SNAP) and Food Distribution Program on Indian Reservations (FDPIR). (New HOD Policy)

Your Reference Committee heard testimony in favor of Resolution 208. Your Reference Committee heard that food insecurity is a public health crisis, especially among American Indian and Alaska Native (AI/AN) persons, and that such individuals experience food insecurity at twice the rate of their white counterparts. Your Reference Committee further heard that US nutrition programs for AI/AN persons, including the Food Distribution Program on Indian Reservations (FDPIR) and the recently launched Indian Health Service (IHS) Produce Prescription Pilot Program, differ from other nutrition programs because they include staple foods and ingredients commonly used in pre-contact AI/AN societies and food systems. Moreover, your Reference Committee heard that federally recognized AI/AN Tribes and Villages without a reservation or land base, and the 2.8 million AI/AN persons in urban areas (greater than the population on Tribal lands), are all ineligible for federal nutrition assistance programs for AI/AN persons. However, your Reference Committee heard that amendments to the resolution would help clarify its intent and implementation. Specifically, your Reference Committee heard that the language in the resolution, referring to “multieligibility” for all United States Department of Agriculture food programs, is not clear and that amended language is needed to make the resolution’s intent and its implementation stronger. Therefore, your Reference Committee recommends that Resolution 208 be adopted as amended.

(28) RESOLUTION 214 — SUPPORT FOR PAID SICK LEAVE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 214 be amended by addition to read as follows:

RESOLVED, that our American Medical Association amend Policy H-440.823, "Paid Sick Leave," as follows:

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; ~~and~~ (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome; and (4) advocates for federal and state policies that guarantee employee access to protected paid sick leave without unduly burdening small businesses. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 214 be adopted as amended.

HOD ACTION: Resolution 214 adopted as amended.

RESOLVED, that our American Medical Association amend Policy H-440.823, "Paid Sick Leave," as follows:

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; ~~and~~ (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome; and (4) advocates for federal and state policies that guarantee employee access to protected paid sick leave. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 214. Your Reference Committee heard that paid leave is a matter of public health and that it is necessary for patients to have reasonable periods of leave to care for themselves and immediate family members. Testimony also noted that that more than half of the lowest-paid workers cannot get time off for an illness. However, your Reference Committee also heard that it can be

extremely difficult for small physician practices, and small businesses in general, to provide paid sick leave for their employees. Therefore, your Reference Committee recommends that Resolution 214 be adopted as amended.

(29) RESOLUTION 215 — AMERICAN INDIAN AND ALASKA NATIVE LANGUAGE REVITALIZATION AND ELDER CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 215 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association recognize that access to language concordant services for American Indian and Alaka Native (AI/AN) patients will require ~~targeted~~ investment ~~as~~in Indigenous languages in North America ~~are threatened due to a complex history of removal and assimilation by state and federal actors~~ (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 215 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~collaborate with stakeholders, including but not limited to the National Indian Council on Aging and Association of American Indian Physicians, to identify~~ support the development of best practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare outside of the umbrella of the Indian Health Service. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 215 be adopted as amended.

HOD ACTION: Resolution 215 adopted as amended.

RESOLVED, that our American Medical Association recognize that access to language concordant services for AI/AN patients will require targeted investment as Indigenous languages in North America are threatened due to a complex history of removal and assimilation by state and federal actors (New HOD Policy); and be it further

RESOLVED, that our AMA support federal-tribal funding opportunities for American Indian and Alaska Native language revitalization efforts, especially those that increase health

information resources and access to language-concordant health care services for American Indian and Alaska Native elders living on or near tribal lands (New HOD Policy); and be it further

RESOLVED, that our AMA collaborate with stakeholders, including but not limited to the National Indian Council on Aging and Association of American Indian Physicians, to identify best practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare outside of the umbrella of the Indian Health Service. (Directive to Take Action)

Your Reference Committee heard mostly supportive testimony on Resolution 215. Your Reference Committee heard that the population of American Indian/Alaska Native (AI/AN) elders are the stewards of hundreds of Indigenous cultures, languages, and traditional knowledge systems. Your Reference Committee further heard that AI/AN elders experience significant health and socioeconomic inequities including the lowest life expectancy of all racial/ethnic groups in the U.S. and a high uninsurance rate. Moreover, your Reference Committee heard that while AI/AN elders receive primary care through the Indian Health Service (IHS), underfunding and understaffing has forced IHS to rely on non-IHS facilities for more specialized elder care, including hospice and respite care, which necessitates AI/AN elders having to navigate unknown health systems not respectful of their cultural values and traditions. Your Reference Committee further heard that culturally competent care is vital for health outcomes and is even more critical for older adults with changes in cognition due to delirium and dementia. Furthermore, your Reference Committee heard that our AMA has long-standing policy that supports improving health care for American Indians, both those living on reservations and outside reservation lands, in order to decrease health inequities for these individuals. Additional testimony in support noted that amendments would help clean up some language in the resolution to make it less controversial and allow for more flexibility in implementing its intent. Your Reference Committee appreciates the importance of the issues identified in this resolution and agrees that amendments would be helpful. Therefore, your Reference Committee recommends that Resolution 215 be adopted as amended.

(30) RESOLUTION 216 — THE AMA SUPPORTS H.R. 7225, THE BIPARTISAN "ADMINISTRATIVE LAW JUDGES COMPETITIVE SERVICE RESTORATION ACT"

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~support H.R. 7225, the bipartisan "Administrative Law Judges Competitive Service Restoration Act" that~~ supports ~~the~~ merit-based processes for the selection of all Medicare/Medicaid Administrative Law Judges. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 216 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 216 be changed to read as follows:

MERIT-BASED SELECTION OF ADMINISTRATIVE LAW JUDGES

HOD ACTION: Resolution 216 adopted as amended with a change of title.

MERIT-BASED SELECTION OF ADMINISTRATIVE LAW JUDGES

RESOLVED, that our American Medical Association support H.R. 7225, the bipartisan "Administrative Law Judges Competitive Service Restoration Act" that supports the merit-based process for the selection of all Medicare/Medicaid Administrative Law Judges. (New HOD Policy)

Your Reference Committee heard supportive testimony on Resolution 216. Your Reference Committee heard that the selection process for Administrative Law Judges (ALJs) is important for ensuring impartial and competent adjudication in Medicare and Medicaid disputes. Your Reference Committee also heard that current regulations significantly impact the quality of decisions made by ALJs and that a merit-based selection process is important to maintain high standards. However, your Reference Committee heard that referencing a specific bill in our policy is not consistent with our AMA's standard practice. Testimony noted that our AMA avoids using specific bill numbers in policy to maintain flexibility and avoid endorsing particular legislative texts that may change over

time. An amendment was provided that removed the specific legislation included in the Resolution. Therefore, your Reference Committee recommends that Resolution 216 should be adopted as amended with a change in title.

(31) RESOLUTION 219 — BUNDLING FOR MATERNITY CARE SERVICES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~advocates for~~ supports the separate payment of services not accounted for in the valuation of the maternity global codes and opposes the inappropriate bundling of related services. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 219 be adopted as amended.

HOD ACTION: Resolution 219 adopted as amended.

RESOLVED, that our American Medical Association advocates for the separate payment of services not accounted for in the valuation of the maternity global codes and opposes the inappropriate bundling of related services. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 219. Your Reference Committee heard that better recognition and reimbursement for comprehensive maternity care that extends beyond what is covered by the global obstetric codes is needed. Testimony highlighted that many critical services provided during pregnancy, such as increased screenings, intensive counseling for genetic tests, group prenatal care, social assessment and management of social determinants of health, and the management of labor to avoid cesarean sections are not adequately accounted for in the current coding system. Your Reference Committee also heard that our AMA is actively engaging in a comprehensive review of maternity care practices through a Current Procedural Terminology (CPT) workgroup, which is expected to propose significant changes to the existing coding system to better reflect current medical practices and address stakeholder needs. A minor amendment was also offered on this resolution. Testimony noted that this minor amendment was needed to align with how the CPT process works. Therefore, your Reference Committee recommends that Resolution 219 be adopted as amended.

(32) RESOLUTION 220 — RESTORATIVE JUSTICE FOR THE TREATMENT OF SUBSTANCE USE DISORDERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 220 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association (1) continues to support the right of incarcerated individuals to receive appropriate care for substance use disorders, (2) supports efforts ~~providing incentives~~ for incarcerated individuals to participate ~~overcome substance use disorders, such as participation~~ in a treatment or diversion program ~~as a condition for early release~~, and (3) supports providing access to social services and family therapy during and after incarceration (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 220 be amended by addition to read as follows:

RESOLVED, that our AMA (1) recognizes that criminalization of substance use disproportionately impacts minoritized and disadvantaged communities due to structural racism and implicit bias, (2) acknowledges inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments, and (3) supports stigma reduction, implicit bias and antiracism training for medical professionals working in correctional facilities. (New HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 220 be adopted as amended.

HOD ACTION: Resolution 220 adopted as amended.

RESOLVED, that our American Medical Association (1) continues to support the right of incarcerated individuals to receive appropriate care for substance use disorders, (2) supports providing incentives for incarcerated individuals to overcome substance use disorders, such as participation in treatment as a condition for early release, and (3) supports providing access to social services and family therapy during and after incarceration (New HOD Policy); and be it further

RESOLVED, that our AMA (1) recognizes that criminalization of substance use disproportionately impacts minoritized and disadvantaged communities due to structural racism and implicit bias, (2) acknowledges inequitable sentencing structures, such as towards crack cocaine versus opioids, have contributed to unjust imprisonments, and (3) supports implicit bias and antiracism training for medical professionals working in correctional facilities. (New HOD Policy)

Your Reference Committee heard mostly supportive testimony on Resolution 220. Your Reference Committee heard about the benefits of evidence-based treatment for substance use disorders while in jail or prison. Testimony also highlighted inequitable treatment for racially and ethnically diverse populations while incarcerated. However, your Reference Committee heard concerns about coercing individuals into treatment while also hearing testimony that jails and prisons are sub-optimal places to receive treatment for a substance use disorder. Your Reference Committee appreciates the input from our colleagues in the U.S. Public Health Service in supporting access to evidence-based care for substance use disorders. Your Reference Committee agrees with both points. Therefore, your Reference Committee recommends that Resolution 220 be adopted as amended.

(33) RESOLUTION 222 — STUDYING AVENUES FOR PARITY IN MENTAL HEALTH & SUBSTANCE USE COVERAGE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 222 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association increase advocacy efforts towards the National Association of Insurance Commissioners (NAIC) and state and federal policymakers~~continue to advocate~~ for meaningful financial and other ~~study potential~~ penalties ~~to~~for insurers that do ~~for~~ not comply~~ing~~ with mental health and substance use parity laws~~.~~;and be it further (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 222 be adopted as amended.

HOD ACTION: A second Resolve added to Resolution 222 to read as follows:

RESOLVED, that our American Medical Association work with state medical societies to advocate to state departments of insurance for meaningful enforcement of penalties for insurers that do not comply with mental health and substance use parity laws.

HOD ACTION: Resolution 222 adopted as amended.

RESOLVED, that our American Medical Association study potential penalties to insurers for not complying with mental health and substance use parity laws. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 222. Your Reference Committee heard testimony expressing deep frustration that mental health and substance use disorder parity laws are not meaningfully enforced despite more than a decade of parity violations by health insurance companies. Your Reference Committee also heard testimony that even when parity laws are enforced, the penalties are too small and ineffectual to prevent future violations. Your Reference Committee heard testimony that our AMA's state and federal advocacy has called for meaningful penalties to be imposed against health insurers and other payers that violate mental health substance use disorder parity laws. Testimony noted that while there could be benefits from an additional study of gaps in enforcement and potential penalties, there is greater benefit to our AMA focusing its resources on continued advocacy, and received an amendment expressing this. Therefore, your Reference Committee recommends that Resolution 222 be adopted as amended.

(34) RESOLUTION 224 — ANTIDISCRIMINATION PROTECTIONS FOR LGBTQ+ YOUTH IN FOSTER CARE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 224 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~collaborate with state medical societies and other appropriate stakeholders to~~ supports policies on the federal and state levels that establish nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 224 be deleted.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 224 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA ~~encourage~~ supports child welfare agency~~ies~~ ~~to implement~~ practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b) ~~adopt programs to~~ prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve recruitment of foster families that are affirming of LGBTQ+ youth; and (d) allow gender diverse youth to be placed in residential foster homes that are willing to accept their gender identity. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 224 be adopted as amended.

HOD ACTION: The second Resolve of Resolution 224 referred.

HOD ACTION: Resolution 224 adopted as amended.

RESOLVED, that our American Medical Association collaborate with state medical societies and other appropriate stakeholders to support policies on the federal and state levels that establish nondiscrimination protections within the foster care system on the basis of sexual orientation and gender identity (New HOD Policy); and be it further

RESOLVED, that our AMA support efforts by the Department of Health and Human Services and other appropriate stakeholders to establish a reporting mechanism for the collection of anonymized and aggregated sexual orientation and gender identity data in the Foster Care Analysis and Reporting System only when strong privacy protections exist (New HOD Policy); and be it further

RESOLVED, that our AMA encourage child welfare agencies to implement practices, policies, and regulations that: (a) provide training to child welfare professionals, social workers, and foster caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b) adopt programs to prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve recruitment of foster families that are affirming

of LGBTQ+ youth; and (d) allow gender diverse youth to be placed in residential foster homes that are willing to accept their gender identity. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 224. Your Reference Committee heard that this was a timely issue and emphasized the unique vulnerability of LGBTQ+ youth in foster care. However, your Reference Committee also heard that this resolution would support the collection of sexual orientation data by the Adoption and Foster Care Analysis and Reporting System (AFCARS). Testimony highlighted that the collection of sexual orientation data by AFCARS was proposed by the federal government back in 2016, however, this portion of the proposed rule was never implemented and in 2020 was ultimately rejected. Your Reference Committee heard that since then, there has been a divide in the community concerning whether these data should be collected. Testimony noted that most LGBTQ+ groups believe that this information should be collected by the federal government to enhance recruitment of foster homes, promote visibility for marginalized groups, help to analyze youth outcomes, and address disparities. However, your Reference Committee also heard that many state and local child welfare agencies believe that AFCARS is not the appropriate vehicle to collect this information, that it was unclear how this information in a Federal Government database would result in support services for children, and that this information should be tracked separately from AFCARS. Further, testimony noted that state and local child welfare agencies track information about a youth's or provider's sexual orientation and noted that this information can be collected as part of the title IV-E agency's casework and should be documented in the case file. Additional testimony, though supportive of the concepts in the resolution, noted concern that the resolution could out a child’s gender identity/sexual orientation in the foster process before the child is ready, causing harm to the child. Your Reference Committee heard that due to this divide in the community, our AMA should not adopt the second resolved since our AMA does not have a fully informed position on this topic. Your Reference Committee also heard that the first and third resolves should be slightly amended to broaden them so that they are more applicable across all the work that our AMA does. Your Reference Committee also notes a grammatical error in the third resolved. Therefore, your Reference Committee recommends that Resolution 224 be adopted as amended.

(35) RESOLUTION 229 — OPPOSITION TO LEGALIZATION OF PSILOCYBIN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 229 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association oppose any legislative efforts ~~relatable~~ related to legalization of Psilocybin/Psilocin or its related substances use, except those which have received FDA approval or those prescribed in the context of approved investigational studies. (New HOD Policy) and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 229 be amended by addition of a second Resolve clause to read as follows:

RESOLVED, that our AMA support decriminalization of possession of psychedelics, entactogens, or related substances for personal use.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 229 be adopted as amended.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that that the title of Resolution 229 be changed to read as follows:

PSILOCYBIN AND PSYCHEDELICS

HOD ACTION: Resolution 229 adopted as amended with a change of title.

PSILOCYBIN AND PSYCHEDELICS

RESOLVED, that our American Medical Association oppose any legislative efforts relatable to legalization of Psilocybin/Psilocin or its related substances use. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 229. Your Reference Committee heard clear support for the Food and Drug Administration (FDA) approval process and investigational clinical trials to identify whether new treatments would be efficacious for patients. Your Reference Committee heard concerns that some drugs have been legalized or otherwise supported through the state legislative process rather than evidence-based approaches. Your Reference Committee also heard opposition to the original resolution from multiple delegations noting that comprehensive opposition to the legalization of psylocibin was too broad of a stance for our AMA—particularly given that there is some evidence of potential positive benefits of some uses of psilocybin to treat certain conditions. Testimony supporting referral was limited. Your Reference Committee heard no opposition to the amendment calling for decriminalization of possession of psychedelics, entactogens, or related substances for personal use. Therefore, your Reference Committee recommends that Resolution 229 be adopted as amended.

(36) RESOLUTION 233 — PROHIBITING MANDATORY WHITE BAGGING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 233 be amended by addition to read as follows:

RESOLVED, that our American Medical Association urge state and federal policymakers to enact legislation to prohibit the mandatory use of white bagging policies that condition coverage of a clinician-administered drug, such as an IV infusion, on the drug being dispensed from a pharmacy benefit manager-affiliated mail order pharmacy. (Directive to Take Action).

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 233 be adopted as amended.

HOD ACTION: Resolution 233 adopted as amended.

RESOLVED, that our American Medical Association urge state and federal policymakers to enact legislation to prohibit the mandatory use of white bagging (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 233. Your Reference Committee heard that the practice of “white bagging” when mandatory, excludes payment for medically necessary drugs from any physician that is not under common ownership with the insurer or Pharmacy Benefits Managers (PBMs). Your Reference Committee also heard testimony that emphasized the potential negative outcomes from this practice including the severe risk of limiting access, disruptions of care, and drug waste. Your Reference Committee also heard testimony that noted the importance of defining white bagging more definitively and received amendments to this

effect which received support. Therefore, Your Reference Committee recommends that Resolution 233 be adopted as amended.

(37) RESOLUTION 234 — STATE PRESCRIPTION DRUG AFFORDABILITY BOARDS - STUDY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 234 be deleted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 234 be adopted as amended.

HOD ACTION: Resolution 234 adopted as amended.

RESOLVED, that our American Medical Association conduct a study to determine how upper payment limits (UPLs) established by state prescription drug affordability boards (PDABs) will impact reimbursement for physician-administered drugs and what impact state UPLs will have on patient access to care (Directive to Take Action); and be it further

RESOLVED, that our AMA report the results of the study on UPLs to the House of Delegates at A-25. (Directive to Take Action)

Your Reference Committee heard limited but supportive testimony on Resolution 234. Your Reference Committee heard support for our AMA to conduct an economic impact study of state prescription drug affordability boards on physician practices and patients' access to treatment. Your Reference Committee appreciates the offer from the resolution's author to contribute to that study. Your Reference Committee also heard that the proposed requirement in this resolution to report the study's results to the House of Delegates at A-25, is redundant because our AMA already has established mechanisms for reporting such studies. Therefore, your Reference Committee recommends that Resolution 234 be adopted as amended.

(38) RESOLUTION 239 — REQUIRING STORES THAT SELL TOBACCO PRODUCTS TO DISPLAY NYS QUITLINE INFORMATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 239 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association seek federal legislation and/or regulation requiring all stores licensed to sell tobacco or nicotine products to display easily visible information about the ~~CDC hotline~~ national tobacco cessation quitline portals and telephone hotlines ~~1-800-QUIT-NOW~~, in multiple languages and/or the corresponding information for a given ~~the corresponding~~ state or territory. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 239 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 239 be changed to read as follows:

REQUIRING STORES THAT SELL TOBACCO PRODUCTS TO DISPLAY THE NATIONAL TOLLFREE QUIT NOW HOTLINE.

HOD ACTION: Resolution 239 adopted as amended with a change of title.

REQUIRING STORES THAT SELL TOBACCO PRODUCTS TO DISPLAY THE NATIONAL TOLLFREE QUIT NOW HOTLINE.

RESVOLVED, that our American Medical Association seek federal legislation and/or regulation requiring all stores licensed to sell tobacco or nicotine products to display easily visible information about the CDC hotline 1-800-QUIT-NOW in multiple languages and/or the information for the corresponding state or territory. (Directive to Take Action)

Your Reference Committee heard limited testimony in support of Resolution 239. Your Reference Committee heard that some states' Tobacco Control Programs allow tobacco products to contain a Quitline phone number and website on them. Your Reference

Committee also heard that our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Moreover, your Reference Committee heard that, in light of the continuing and urgent need to assist individuals in smoking cessation, our AMA policy states that physicians should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Your Reference Committee further heard that our AMA also strongly supports federal and state efforts related to tobacco cessation and has policy supporting the use of the federally funded CDC National Tobacco Quitline network and ongoing media campaigns to help Americans quit using tobacco. Your Reference Committee also heard that adopting Resolution 239 would be consistent with existing AMA policy but that amendments were needed to change the title to remove the reference to New York State's Quitline, to add a reference to national portals and hotlines, and to make implementation of the resolution less costly and easier to implement. Therefore, your Reference Committee recommends that Resolution 239 be adopted as amended with a change in title.

(39) RESOLUTION 242 — CANCER CARE IN INDIAN HEALTH SERVICES FACILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 242 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~actively advocate~~ support ~~for~~ the federal government continuing to ~~continue~~ enhanc~~e~~ing and develop~~ing~~ alternative pathways for American Indian and Alaska Native patients to access the full spectrum of health ~~cancer~~ care, including ~~and cancer-directed therapies~~ within and outside of the established Indian Health Service (IHS) system (New HOD Policy)~~(Directive to Take Action)~~; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 242 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA (a) support collaborative research efforts to better understand the limitations of IHS health ~~cancer~~ care, including barriers to access, disparities in treatment outcomes, and areas for improvement and (b) encourage ~~cancer linkage~~ studies between the IHS and the CDC to better evaluate regional ~~cancer rates,~~ health outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations, including with respect to cancer care. (New HOD Policy)~~(Directive to Take Action)~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 242 be amended by addition of a third Resolve clause to read as follows:

RESOLVED, That our AMA support federal and other efforts to increase funding for and provide technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities, including by contracting with other physician practices. (New HOD Policy)

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 242 be adopted as amended.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that the title of Resolution 242 be changed to read as follows:

HEALTH CARE ACCESS FOR AMERICAN INDIANS AND ALASKA NATIVES

HOD ACTION: Resolution 242 adopted as amended with a change of title.

HEALTH CARE ACCESS FOR AMERICAN INDIANS AND ALASKA NATIVES

RESOLVED, that our American Medical Association actively advocate for the federal government to continue enhancing and developing alternative pathways for American Indian and Alaska Native patients to access the full spectrum of cancer care and cancer-directed therapies outside of the established Indian Health Service system (Directive to Take Action); and be it further

RESOLVED, that our AMA (a) support collaborative research efforts to better understand the limitations of IHS cancer care, including barriers to access, disparities in treatment outcomes, and areas for improvement and (b) encourage cancer linkage studies between the IHS and the CDC to better evaluate regional cancer rates, outcomes, and potential treatment deficiencies among American Indian and Alaska Native populations. (Directive to Take Action)

Your Reference Committee heard supportive testimony on Resolution 242. Your Reference Committee heard that it is imperative for our AMA to support increasing access to cancer care in Indian Health Service facilities because cancer is the leading cause of death among American Indian and Alaska Native (AI/AN) persons in the United States. Testimony also noted that AI/AN individuals have very limited access to comprehensive cancer care centers and often face prohibitively expensive care requirements which leads to worse health outcomes for this population. Your Reference Committee also heard that federal Indian Health Service (IHS) facilities do not offer on-site cancer care or provide payment for cancer treatment, unlike other federal health programs like the Department of Veterans Affairs (VA), unless funds are available for referral. Moreover, your Reference Committee heard that for the ten most populated AI/AN reservations, the median travel distance to a National Cancer Institute (NCI) cancer center is 186.5 miles, and the median travel time is 3.37 hours, and that such barriers to cancer screening and treatment can often result in worse health outcomes. However, your Reference Committee also heard concerns about adopting disease-specific cancer care policies for AI/AN populations rather than broader language that continues to support access to all care and access to all specialty-specific care. Your Reference Committee heard that adopting more general policy would provide more flexibility to our AMA to advocate for improvements to AI/AN health outcomes and access to health care, including cancer care. Your Reference Committee also heard that a new resolve clause on increasing funding and technical assistance to develop and expand accessible specialty care services at IHS, Tribal, and Urban Indian Health Programs and associated facilities would be a worthwhile addition and received a proposed amendment regarding this issue. Therefore, your Reference Committee recommends that Resolution 242 be adopted as amended.

(40) RESOLUTION 247 — PROHIBIT HEALTH BENEFIT PLANS FROM CHARGING COST SHARING FOR COVERED PROSTATE CANCER SCREENING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 247 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support ~~advocate for~~ federal legislation requiring that health benefit plans may not charge any form of cost sharing for covered prostate cancer screening.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 247 be adopted as amended.

HOD ACTION: Resolution 247 adopted as amended.

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)

Your Reference Committee heard mixed testimony on Resolution 247. Your Reference Committee heard that this resolution aims to address disparities in cancer screening coverage, specifically for prostate cancer, which lacks a federal mandate for no-cost screening unlike breast, cervical, and colorectal cancers. Your Reference Committee heard that prostate cancer screening using Prostate-Specific Antigen (PSA) tests is vital for early detection and significantly improves survival rates, yet cost-sharing remains a barrier for many patients. Testimony highlighted that several states have already implemented policies to remove cost-sharing for prostate cancer screening, reflecting a growing recognition of the need for equitable screening practices. However, some minor amendments were offered to broaden the resolution. Therefore, your Reference Committee recommends that Resolution 247 be adopted as amended.

(41) RESOLUTION 249 — PEDIATRIC SPECIALTY MEDICAID REIMBURSEMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve be amended by addition and deletion to read as follows:

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

RESOLVED, That our AMA advocate for payment parity with Medicare for the same or similar services provided to pediatric patients under Medicaid; and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve be amended by deletion to read as follows:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve be amended by addition and deletion to read as follows:

RESOLVED, that our AMA work with interested state parties ~~stakeholders~~ to support the implementation of the value-based payment model for pediatric specialists in state Medicaid programs~~.~~, (Directive to Take Action) and be it further

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 249 be amended by addition of a fifth Resolve to read as follows:

RESOLVED, That our AMA advocate for any demonstration projects undertaken to modernize Medicaid payment using value based payment models developed by the AMA and pediatric specialty societies be exempt from Medicaid demonstration project budget neutrality requirements.

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 249 be adopted as amended.

HOD ACTION: Resolution 249 adopted as amended.

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

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

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

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

Your Reference Committee heard testimony in support of Resolution 249. Testimony addressed issues with Medicaid reimbursement rates for pediatric subspecialists and its implications on health equity. Your Reference Committee heard that there are disparities in reimbursement that currently disincentivize specialists from entering pediatric fields. Your Reference Committee was offered an amendment that requested that our AMA advocate for payment parity with Medicare to incentivize more specialists to enter this field, which received support. Additionally, testimony emphasized the need to develop and implement value-based payment models designed to make pediatric specialist practices sustainable and promote broader access to care, ultimately supporting health equity among pediatric patients. Therefore, your Reference Committee recommends that Resolution 249 be adopted as amended.

(42) RESOLUTION 252 — MODEL LEGISLATION TO PROTECT THE FUTURE OF MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 252 be amended by addition and deletion to read as follows:

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 to ensure the education and implementation of optimized healthcare.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 252 be adopted as amended.

HOD ACTION: Resolution 252 adopted as amended.

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.

Your Reference Committee heard mixed but mostly supportive testimony on Resolution 252. Your Reference Committee heard about the importance of diversity, equity, and inclusion (DEI) in medical school. Testimony noted the value of having DEI in medical school settings and highlighted that in certain states, DEI is not supported. Testimony also noted bills in Congress and at the state level that would restrict GME funding if schools mandate DEI initiatives. Your Reference Committee also heard that our AMA has strong policy that supports diversity in medical education including through scholarship programs, loan repayment programs, pipeline programs, early and diverse recruiting methods and more. Testimony also highlighted that our AMA has policy calling on our AMA to advocate for resources to establish and maintain DEI offices at medical schools that are staff-managed with student and physician guidance as well as committed to community engagement. However, your Reference Committee also heard that our AMA does not create federal model legislation and was offered an amendment to that effect. An additional amendment was received that tied this resolution to the implementation of optimized healthcare and was not opposed. Therefore, your Reference Committee recommends that Resolution 252 be adopted as amended.

(43) 253 — ADDRESSING THE FAILED IMPLEMENTATION OF THE NO SURPRISES ACT IDR PROCESS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 253 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the title of Resolution 253 be changed to read as follows:

ADDRESSING THE FAILED IMPLEMENTATION OF THE NO SURPRISES ACT INDEPENDENT DISPUTE RESOLUTION PROCESS

HOD ACTION: Resolution 253 adopted with a change of title.

ADDRESSING THE FAILED IMPLEMENTATION OF THE NO SURPRISES ACT INDEPENDENT DISPUTE RESOLUTION PROCESS

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

1. Specific requirements for insurers: Insurers must be required to make IDR loss payments directly to physicians, clarify IDR eligibility on explanation of benefit forms, and be prohibited from falsely claiming ineligibility due to network status or incorrect venue claims;

2. Operational improvements in the IDR process: IDR entities must not close claims based on unverified insurer claims, an adequate number of IDR entities must be certified, and a structured timeline must be set for IDR entity selection and payment process (Directive to Take Action).

Your Reference Committee heard supportive testimony on Resolution 253. Your Reference Committee heard testimony recognizing that passage of this resolution would complement continued advocacy by our AMA in this space to promote enforcement of the No Surprises Act and specifically enforcement of the Independent Dispute Resolution provisions. Therefore, your Reference Committee recommends that Resolution 253 be adopted.

RECOMMENDED FOR ADOPTION IN LIEU OF

(44) BOARD OF TRUSTEES REPORT 13 — PROHIBITING COVENANTS NOT-TO-COMPETE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Recommendations for Board of Trustees Report 13 be adopted in lieu of the Recommendations in Board of Trustees Report 13 and the remainder of the Report be filed.

1. That the AMA oppose all restrictive covenants between employers and physician employees and regularly update its state restrictive covenant legislative template. (New HOD Policy)

2. That our AMA continue to assist interested state medical associations and specialty societies in developing strategies for physician employee retention. (New HOD Policy)

HOD ACTION: Alternate Recommendations for Board of Trustees Report 13 adopted in lieu of the Recommendations in Board of Trustees Report 13 and the remainder of the Report filed.

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

1. That the American Medical Association (AMA) continue to assist interested state medical associations in developing fair and reasonable strategies regarding restrictive covenants between physician employers and physician employees including regularly updating the AMA's state restrictive covenant legislative template. (New HOD Policy)

Your Reference Committee heard mixed testimony on the recommendations of Board of Trustees Report 13. Your Reference Committee heard supportive testimony that noted the numerous recommendations concerning how non-competes might be modified in ways that promote physician mobility and access to patient care while continuing to protect the legitimate business interests of physician practice owners. However, your Reference Committee also heard a wealth of testimony against adoption and instead urged our AMA to ban all physician non-competes between employers and physician employees. This testimony emphasized many reasons to support a ban on all physician non-competes, including harm to patient care and trapping physicians in detrimental working conditions. Testimony also noted that non-competes are not effective in achieving the desired goals of physician employers.

Your Reference Committee believes that the weight of testimony supported a ban on all physician non-competes. Your Reference Committee also heard that our AMA must do

everything in its power to support and protect independent physician practices including continuing to assist interested state medical associations and national medical specialty societies develop strategies for physician employee retention. Therefore, your Reference Committee recommends that Alternate Recommendations be adopted in lieu of Board of Trustees Report 13.

(45) RESOLUTION 210 — SUPPORT FOR PHYSICIANS PURSUING COLLECTIVE BARGAINING AND UNIONIZATION
RESOLUTION 236 — SUPPORT OF PHYSICIANS PURSUING COLLECTIVE BARGAINING AND UNIONIZATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 210 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association ~~convenes an updated~~ study ~~of~~ opportunities for the AMA or physician associations to support physicians initiating and navigating a collective bargaining process, including but not limited to unionization. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that amended Resolution 210 be adopted in lieu of Resolution 236.

HOD ACTION: Resolution 210 adopted in lieu of Resolution 236.

RESOLUTION 210

RESOLVED, that our American Medical Association convenes an updated study of opportunities for the AMA or physician associations to support physicians initiating a collective bargaining process, including but not limited to unionization. (Directive to Take Action)

RESOLUTION 236

RESOLVED, that our American Medical Association investigate avenues for the AMA and other physician associations to aid physicians in initiating and navigating collective bargaining efforts, encompassing but not limited to unionization. (Directive to Take Action)

Your Reference Committee heard testimony largely in support of Resolutions 210 and 236, both of which call on our AMA to research ways that physician associations might support physicians in the collective bargaining process, including but not limited to

unionization. Your Reference Committee also heard significant testimony indicating that collective bargaining is an important and timely issue given that physicians are increasingly becoming employed by large hospitals and health systems. While your Reference Committee heard some testimony that opposed the formation of unions, significant testimony stressed that collective bargaining or unionization can help employed physicians overcome a lack of individual bargaining power and negotiate with employers for improved working conditions and to safeguard quality patient care. Testimony emphasized that, considering the shifting landscape in this space, a study on AMA's role in supporting physicians navigating the collective bargaining process would be useful for AMA members. Your Reference Committee also heard some concerns that these Resolutions are not ripe for adoption given that there is a pending Council on Ethics and Judicial Affairs (CEJA) report on collective bargaining due at the 2024 AMA Interim Meeting. Your Reference Committee understands that this CEJA report can and will be considered in the study sought by Resolution 210 and 236 and will complement it. As such, your Reference Committee recommends that Resolution 210 be adopted as amended in lieu of Resolution 236.

(46) RESOLUTION 213 — ACCESS TO COVERED BENEFITS WITH AN OUT OF NETWORK ORDERING PHYSICIAN
RESOLUTION 245 — PATIENT ACCESS TO COVERED BENEFITS ORDERED BY OUT-OF-NETWORK PHYSICIANS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 245 be amended by addition and deletion to read as follows:

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, including imaging, laboratory testing, referrals, medications, and other medically-necessary services for patients under their commercial insurance, ~~even if it is an HMO or point of service plan~~ based solely on the network participation of the ordering physician while preserving evidence based high quality care and healthcare affordability (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 245 be amended by addition to read as follows:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that amended Resolution 245 be adopted in lieu of Resolution 213.

HOD ACTION: Amended Resolution 245 adopted in lieu of Resolution 213.

RESOLUTION 213

RESOLVED, that our American Medical Association develop model legislation to protect patients in direct primary care plans and non-network plans thus furthering the ability of direct primary care physicians and other out-of-network physicians to provide covered services, including imaging, laboratory testing, referrals, medications, and other medically-

necessary services for patients under their commercial insurance, even if it is an HMO or point of service plan (Directive to Take Action); and be it further

RESOLVED, that our AMA develop resources, tool kits, education, and internal experts to support direct primary care and other out-of-network models. (Directive to Take Action)

RESOLUTION 245

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)

Your Reference Committee heard testimony largely in support of Resolutions 245 and 213, both which have the goal of ensuring that patients being cared for by out-of-network physicians, including those in direct primary care practices, can access insurance coverage for care ordered by their out-of-network physicians. Testimony noted that such services could include imaging, laboratory testing, referrals, medications, and other medically necessary services. Your Reference Committee heard that such coverage would provide needed autonomy to physicians and patients from insurance companies in determining the best care and treatment for their patients. Your Reference Committee also heard some concerns about risks and nuances in value-based care models that the Committee believes should be considered in the development of model legislation. Your Reference Committee was offered an amendment, which was supported by the Resolution's authors, that would clarify that the goal of the resolution is the development of state model legislation and provide the opportunity for our AMA to support federal efforts. Therefore, your Reference Committee recommends that Resolution 245 be adopted as amended in lieu of Resolution 213.

(47) RESOLUTION 217 — PROTECTING ACCESS TO IVF TREATMENT
RESOLUTION 226 — PROTECTING ACCESS TO IVF TREATMENT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 217 be amended by addition to read as follows:

RESOLVED, that our AMA work with other interested organizations to oppose any civil or criminal legislation or ballot measures or court rulings that (a) would equate gametes (oocytes and sperm) or embryos with children, and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART) (New HOD Policy); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 217 be amended by addition and deletion to read as follows:

RESOLVED, that our AMA, through the AMA Task Force to Preserve the Patient-Physician Relationship, report back at I-24 ~~A-25~~, on the status of, and AMA's activities surrounding, proposed ballot measures or legislation~~,~~ and pending court rulings, ~~and legislation~~ that (a) would equate gametes or embryos with children and/or (b) would otherwise restrict or interfere with evidence-based care for Assisted Reproductive Technology (ART). (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that amended Resolution 217 be adopted in lieu of Resolution 226.

HOD ACTION: Amended Resolution 217 adopted in lieu of Resolution 226.

RESOLUTION 217

RESOLVED, that our American Medical Association oppose any legislation or ballot measures that could criminalize in-vitro fertilization (New HOD Policy); and be it further

RESOLVED, that our AMA work with other interested organizations to oppose any legislation or ballot measures or court rulings that equate gametes (oocytes and sperm) or embryos with children (New HOD Policy); and be it further

RESOLVED, that our AMA report back at A-25, on the status of, and AMA's activities surrounding, ballot measures, court rulings, and legislation that equate embryos with children. (Directive to Take Action)

RESOLUTION 226

RESOLVED, that our American Medical Association oppose any legislation that could criminalize in-vitro fertilization (New HOD Policy); and be it further

RESOLVED, that our AMA work with other interested organizations to oppose Court rulings that equate gametes (oocytes and sperm) or embryos with children. (Directive to Take Action)

Your Reference Committee heard strong and unanimous testimony supporting the first and second resolved clauses of Resolution 217 and in support of an amendment to broaden the scope of the Resolution. Your Reference Committee heard about the importance of our AMA opposing legislation, ballot measures, and court rulings that could criminalize in-vitro fertilization (IVF) or equate gametes or embryos with children. Your Reference Committee also heard that a recent state Supreme Court decision that recognized embryos as children sets a dangerous precedent and threatens access to evidence-based reproductive care. Your Reference Committee also heard limited testimony suggesting that the resolution should be expanded to include opposing the "personhood" of fetuses as well as embryos and gametes, but alternative testimony noted that this was beyond the scope of the evidence presented in the resolution. Your Reference Committee notes that our AMA has strong and extensive policy opposing limitations and bans on access to evidence-based reproductive health services, including abortion, that already enables our AMA to oppose governmental interference in the practice of medicine due to legal recognition of fetal "personhood." Your Reference Committee also heard testimony that the third resolved clause requiring a report back is duplicative of existing policy and activities. Your Reference Committee heard that monitoring governmental interference in IVF is being already being undertaken by the AMA Task Force to Preserve the Patient-Physician Relationship, which was formed by the House of Delegates in 2022 and has 20 representatives from state and specialty medical associations and ten representatives from AMA Councils. Testimony in support of the third resolved emphasized the need for a report on Task Force's activities. Your Reference Committee notes that existing AMA policy already directs the Task Force to report back on its activities on an annual basis. Testimony also noted that Resolutions 217 and 226 were very similar and as such, only one of the resolutions was needed. Therefore, your Reference Committee recommends that Resolution 217 be adopted as amended in lieu of Resolution 226.

(48) RESOLUTION 251 — STREAMLINE PAYER QUALITY METRICS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Alternate Resolution 251 be adopted in lieu of Resolution 251.

RESOLVED, that our American Medical Association will continue to advocate for improvements in private payers' quality programs.

HOD ACTION: Alternate Resolution 251 adopted in lieu of Resolution 251.

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)

Your Reference Committee heard mixed testimony on Resolution 251. Your Reference Committee heard that this resolution seeks to address the inconsistencies in quality benchmarks set by Medicare and various third-party insurance carriers, which create challenges for primary care physicians in tracking, analyzing, and meeting these measures. Your Reference Committee heard that while the Centers for Medicare and Medicaid Services (CMS) does not control the quality metrics set by private payers, it is crucial for our AMA to advocate for alignment in these quality programs to reduce administrative burdens and ensure fair evaluation of physician performance. However, your Reference Committee heard that alternatives needed to be made to this resolution so that the spirit of the resolution is maintained while at same time appropriately shifting the focus towards advocating for improvements in private payers' quality programs without placing the onus on CMS. Testimony noted that these alternatives would allow our AMA to effectively work towards consistency, compliance, communication, and access in quality measurement standards, enhancing both physician practice sustainability and patient care outcomes. Therefore, your Reference Committee recommends that Alternate Resolution 251 be adopted in lieu of Resolution 251.

RECOMMENDED FOR REFERRAL

(49) BOARD OF TRUSTEES REPORT 15 — AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE
RESOLUTION 202 — USE OF ARTIFICIAL INTELLIGENCE AND ADVANCED TECHNOLOGY BY THIRD PARTY PAYORS TO DENY HEALTH INSURANCE CLAIMS
RESOLUTION 246 — AUGMENTED INTELLIGENCE IN HEALTH CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Board of Trustees Report 15, Resolution 202, and Resolution 246 be referred for report back at the 2024 Interim Meeting of the House of Delegates.

HOD ACTION: Board of Trustees Report 15, Resolution 202, and Resolution 246 referred for report back at the 2024 Interim Meeting of the House of Delegates.

BOARD OF TRUSTEES REPORT 15

The Board of Trustees recommends that the following be adopted in lieu of Resolution 206-I-23 and that the remainder of the report be filed:

AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN HEALTH CARE

General Governance

- Health care AI must be designed, developed, and deployed in a manner which is ethical, equitable, responsible, and transparent.
- Use of AI in health care delivery requires clear national governance policies to regulate its adoption and utilization, ensuring patient safety, and mitigating inequities. Development of national governance policies should include interdepartmental and interagency collaboration.
- Compliance with national governance policies is necessary to develop AI in an ethical and responsible manner to ensure patient safety, quality, and continued access to care. Voluntary agreements or voluntary compliance is not sufficient.
- Health care AI requires a risk-based approach where the level of scrutiny, validation, and oversight should be proportionate to the potential overall of disparate harm and consequences the AI system might introduce. [See also Augmented Intelligence in Health Care H-480.939 at (1)]
- Clinical decisions influenced by AI must be made with specified human intervention points during the decision-making process. As the potential for patient harm increases, the point in time when a physician should utilize their clinical judgment to interpret or act on an AI recommendation should occur earlier in the care plan.

- Health care practices and institutions should not utilize AI systems or technologies that introduce overall or disparate risk that is beyond their capabilities to mitigate. Implementation and utilization of AI should avoid exacerbating clinician burden and should be designed and deployed in harmony with the clinical workflow.
- Medical specialty 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 standards for AI use in their specific domain. [See Augmented Intelligence in Health Care H-480.940 at (2)]

When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies

- When AI is used in a manner which directly impacts patient care, access to care, or medical decision making, that use of AI should be disclosed and documented to both physicians and/or patients in a culturally and linguistically appropriate manner. The opportunity for a patient or their caregiver to request additional review from a licensed clinician should be made available upon request.
- When AI is used in a manner which directly impacts patient care, access to care, medical decision making, or the medical record, that use of AI should be documented in the medical record.
- AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review.
- When health care content is generated by generative AI, including by large language models, it should be clearly disclosed within the content that was generated by an AI enabled technology.
- When AI or other algorithmic-based systems or programs are utilized in ways that impact patient access to care, such as by payors to make claims determinations or set coverage limitations, use of those systems or programs must be disclosed to impacted parties.
- The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology.

What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies

- When AI-enabled systems and technologies are utilized in health care, the following information should be disclosed by the AI developer to allow the purchaser and/or user (physician) to appropriately evaluate the system or technology prior to purchase or utilization:
    - Regulatory approval status
    - Applicable consensus standards and clinical guidelines utilized in design, development, deployment, and continued use of the technology
    - Clear description of problem formulation and intended use accompanied by clear and detailed instructions for use
    - Intended population and intended practice setting

- Clear description of any limitations or risks for use, including possible disparate impact
- Description of how impacted populations were engaged during the AI lifecycle
- Detailed information regarding data used to train the model:
  - Data provenance
  - Data size and completeness
  - Data timeframes
  - Data diversity
  - Data labeling accuracy
- Validation Data/Information and evidence of:
  - Clinical expert validation in intended population and practice setting and intended clinical outcomes
  - Constraint to evidence-based outcomes and mitigation of "hallucination" or other output error
  - Algorithmic validation
  - External validation processes for ongoing evaluation of the model performance, e.g., accounting for AI model drift and degradation
  - Comprehensiveness of data and steps taken to mitigate biased outcomes
  - Other relevant performance characteristics, including but not limited to performance characteristics at peer institutions/similar practice settings
  - Post-market surveillance activities aimed at ensuring continued safety, performance, and equity
- Data Use Policy
  - Privacy
  - Security
  - Special considerations for protected populations or groups put at increased risk
- Information regarding maintenance of the algorithm, including any use of active patient data for ongoing training
- Disclosures regarding the composition of design and development team, including diversity and conflicts of interest, and points of physician involvement and review

- Purchasers and/or users (physicians) should carefully consider whether or not to engage with AI-enabled health care technologies if this information is not disclosed by the developer. As the risk of AI being incorrect increases risks to patients (such as with clinical applications of AI that impact medical decision making), disclosure of this information becomes increasingly important. [See also Augmented Intelligence in Health Care H-480.939]

Generative Augmented Intelligence

- Generative AI should: (a) only be used where appropriate policies are in place within the practice or other health care organization to govern its use and help mitigate associated risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA41 compliant Business Associate Agreement).

- Appropriate governance policies should be developed by health care organizations and account for and mitigate risks of:
  - Incorrect or falsified responses; lack of ability to readily verify the accuracy of responses or the sources used to generate the response
  - Training data set limitations that could result in responses that are out of date or otherwise incomplete or inaccurate for all patients or specific populations
  - Lack of regulatory or clinical oversight to ensure performance of the tool
  - Bias, discrimination, promotion of stereotypes, and disparate impacts on access or outcomes
  - Data privacy
  - Cybersecurity
  - Physician liability associated with the use of generative AI tools
- Health care organizations should work with their AI and other health information technology (health IT) system developers to implement rigorous data validation and verification protocols to ensure that only accurate, comprehensive, and bias managed datasets inform generative AI models, thereby safeguarding equitable patient care and medical outcomes. [See Augmented Intelligence in Health Care H-480.940 at (3)(d)]
- Use of generative AI should incorporate physician and staff education about the appropriate use, risks, and benefits of engaging with generative AI. Additionally, physicians should engage with generative AI tools only when adequate information regarding the product is provided to physicians and other users by the developers of those tools.
- Clinicians should be aware of the risks of patients engaging with generative AI products that produce inaccurate or harmful medical information (e.g., patients asking chatbots about symptoms) and should be prepared to counsel patients on the limitations of AI driven medical advice.
- Governance policies should prohibit the use of confidential, regulated, or proprietary information as prompts for generative AI to generate content.
- Data and prompts contributed by users should primarily be used by developers to improve the user experience and AI tool quality and not simply increase the AI tool's market value or revenue generating potential.

Physician Liability for Use of Augmented Intelligence-Enabled Technologies

- Current AMA policy states that 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. [See Augmented Intelligence in Health Care H-480.939]
  - 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.
  - 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.

- 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.
- When physicians do not know or have reason to know that there are concerns about the quality and safety of an AI-enabled technology, they should not be held liable for the performance of the technology in question.

Data Privacy and Augmented Intelligence

- Entity Responsibility:
  - Entities should make information available about the intended use of generative AI in health care and identify the purpose of its use. Individuals should know how their data will be used or reused, and the potential risks and benefits.
  - Individuals should have the right to opt-out, update, or forget use of their data in generative AI tools. These rights should encompass AI training data and disclosure to other users of the tool.
  - Generative AI tools should not reverse engineer, reconstruct, or reidentify an individual's originally identifiable data or use identifiable data for nonpermitted uses, e.g., when data are permitted to conduct quality and safety evaluations. Preventive measures should include both legal frameworks and data model protections, e.g., secure enclaves, federated learning, and differential privacy.

- User Education:
  - Users should be provided with training specifically on generative AI. Education should address:
    - legal, ethical, and equity considerations;
    - risks such as data breaches and re-identification;
    - potential pitfalls of inputting sensitive and personal data; and
    - the importance of transparency with patients regarding the use of generative AI and their data.

[See H-480.940, Augmented Intelligence in Health Care, at (4) and (5)]

Augmented Intelligence Cybersecurity

- AI systems must have strong protections against input manipulation and malicious attacks.
- Entities developing or deploying health care AI should regularly monitor for anomalies or performance deviations, comparing AI outputs against known and normal behavior.
- Independent of an entity's legal responsibility to notify a health care provider or organization of a data breach, that entity should also act diligently in identifying and notifying the individuals themselves of breaches that impact their personal information.
- Users should be provided education on AI cybersecurity fundamentals, including specific cybersecurity risks that AI systems can face, evolving tactics of AI cyber

attackers, and the user's role in mitigating threats and reporting suspicious AI behavior or outputs.

Payor Use of Augmented Intelligence and Automated Decision-Making Systems

- Use of automated decision-making systems that determine coverage limits, make claim determinations, and engage in benefit design should be publicly reported, based on easily accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria), and disclosed to both patients and their physician in a way that is easy to understand.
- Payors should only use automated decision-making systems to improve or enhance efficiencies in coverage and payment automation, facilitate administrative simplification, and reduce workflow burdens. Automated decision-making systems should never create or exacerbate overall or disparate access barriers to needed benefits by increasing denials, coverage limitations, or limiting benefit offerings. Use of automated decision-making systems should not replace the individualized assessment of a patient's specific medical and social circumstances and payors' use of such systems should allow for flexibility to override automated decisions. Payors should always make determinations based on particular patient care needs and not base decisions on algorithms developed on "similar" or "like" patients.
- Payors using automated decision-making systems should disclose information about any algorithm training and reference data, including where data were sourced and attributes about individuals contained within the training data set (e.g., age, race, gender). Payors should provide clear evidence that their systems do not discriminate, increase inequities, and that protections are in place to mitigate bias.
- Payors using automated decision-making systems should identify and cite peer-reviewed studies assessing the system's accuracy measured against the outcomes of patients and the validity of the system's predictions.
- Any automated decision-making system recommendation that indicates limitations or denials of care, at both the initial review and appeal levels, should be automatically referred for review to a physician (a) possessing a current and valid non-restricted license to practice medicine in the state in which the proposed services would be provided if authorized and (b) be of the same specialty as the physician who typically manages the medical condition or disease or provides the health care service involved in the request prior to issuance of any final determination. Prior to issuing an adverse determination, the treating physician must have the opportunity to discuss the medical necessity of the care directly with the physician who will be responsible for determining if the care is authorized.
- Individuals impacted by a payor's automated decision-making system, including patients and their physicians, must have access to all relevant information (including the coverage criteria, results that led to the coverage determination, and clinical guidelines used).
- Payors using automated decision-making systems should be required to engage in regular system audits to ensure use of the system is not increasing overall or disparate claims denials or coverage limitations, or otherwise decreasing access to care. Payors using automated decision-making systems should make statistics regarding systems' approval, denial, and appeal rates available on their website (or another publicly available website) in a readily accessible format with patient population demographics to report and contextualize equity implications of

automated decisions. Insurance regulators should consider requiring reporting of payor use of automated decision-making systems so that they can be monitored for negative and disparate impacts on access to care. Payor use of automated decision-making systems must conform to all relevant state and federal laws.

- (New HOD Policy)

RESOLUTION 202

RESOLVED, that our American Medical Association adopt as policy that Commercial third-party payors, Medicare, Medicaid, Workers Compensation, Medicare Advantage and other health plans ensure they are making medical necessity determinations based on the circumstances of the specific patient rather than by using an algorithm, software, or Artificial Intelligence (AI) that does not account for an individual's circumstances (New HOD Policy); and be it further

RESOLVED, that our AMA adopt as policy that coverage denials based on a medical necessity determination must be reviewed by a physician in the same specialty or by another appropriate health care professional for non-physician health care providers. (New HOD Policy)

RESOLUTION 246

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 role in the development, dissemination, implementation, and use of products used in clinical care.
7. Users should have clear guidelines for how and where to report any identified anomalies. Additionally, as with all technology, there should be a national database for reporting errors that holds developers accountable for correcting identified issues.
8. Before using augmented intelligence, physicians and all users should receive adequate training and have educational materials available for reference, especially in instances where the technology is not intuitive and there are periods of nonuse.
9. Physicians should inquire about whether the AI used is a “continuously learning system” versus a “locked system.” A locked system is more appropriate for clinical care, although a hybrid system may be appropriate as long as the clinical output is based on locked training sets. A locked system gives a predictable output, whereas a continuous learning system will change over time.
10. Algorithms and other information used to derive the information presented as augmented intelligence to physicians and other clinicians should:

    a. Be developed transparently in a way that is accessible, explainable, and understandable to clinicians and patients and details the benefits and limitations of the clinical decision support, and/or augmented intelligence
    b. Have reproducible and explainable outputs
    c. Function in a way that promotes health equities while eliminating potential biases that exacerbate health disparities
    d. Use best practices for user-centered design that allows for efficient and satisfactory use of the technology;
    e. Safeguard patient information by employing privacy and security standards that comply with HIPAA and state privacy regulations
    f. Have a feedback loop that allows users who identify potential safety hazards to easily report problems and malfunctions as well as opportunities to report methods for improvements; and
    g. Contain a level of compatibility to allow use of information between hardware and software made by different manufacturers.

11. Medical students and residents need to learn about the opportunities and limitations of augmented intelligence as they are prepared for future medical practice.
12. The AMA will advocate, through legislation or regulation, for payment to physicians for utilization of artificial intelligence tools that have additional cost or require additional time.

13. Recognizing the rapid pace of change in augmented intelligence, it is important to continually assess and update the AMA's principles at regular intervals. (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on the recommendations in BOT Report 15. Your Reference Committee heard testimony acknowledging the extensive vetting process the recommendations in BOT Report 15 underwent by the Board, Council on Legislation, various AMA business units, multiple specialty societies with expertise in AI, and external AI experts. Testimony also acknowledged that the recommendations were carefully drafted to supplement and build upon existing AMA AI policy, notably H-480.940 and H-480.939 on Augmented Intelligence in Health Care, and D-480.956 on the Use of Augmented Intelligence for Prior Authorization, along with our AMA's Privacy Principles. Testimony further commended the Board for its thoughtful analysis but expressed concerns over omissions in the report regarding the use of AI in the development of scientific literature and the feasibility of some of the transparency and disclosures recommendations. Testimony expressed concerns that the disclosure and transparency recommendations would pose additional burdens on physicians. Your Reference Committee heard testimony regarding Resolutions 202 and 246, as well as considered the substantive on-line comments, which noted that BOT 15 did not address some of the issues raised in these resolutions and comments. Testimony was further heard recommending that BOT 15 should be referred along with Resolutions 202 and 246 for further consideration. Your Reference Committees agrees and recommends referral of BOT 15 and Resolutions 202 and 246 as well as the online forum comments for report back at I-24.

(50) RESOLUTION 218 — DESIGNATION OF DESCENDANTS OF ENSLAVED AFRICANS IN AMERICA

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 218 be referred.

HOD ACTION: Resolution 218 referred.

RESOLVED, that our American Medical Association work with appropriate organizations including, but not limited to, the Association of American Medical Colleges to adopt and define the term Descendants of Enslaved Africans in America and separate if from the generic terms African American and Black in glossaries and on medical school applications. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 218. Your Reference Committee heard that descendants of Enslaved Africans in America are a unique population and that it is important to disaggregate data to make sure everyone is recognized and that the data influencing policies, programs, and solutions are accurate. However, testimony also highlighted that over the last four years our AMA has been working with the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education through the Physician Data Collaborative (PDC) to establish best practices for data sharing and standards for sociodemographic data,

including race, ethnicity, and more. Your Reference Committee heard that these efforts will enable meaningful, collaborative research to better understand the dynamics of the physician workforce continuum. Your Reference Committee also heard that the Office of Management and Budget recently concluded an extensive national consultation process concerning updating race and ethnicity standards, which our AMA provided comments on, and which found that further research is needed to fully understand the implications of a designation for "descendants of enslaved Africans in America" because individuals and civil rights groups disagreed on whether or how to implement this potential revision. Your Reference Committee heard that although the resolution has merit, our AMA needs more time to understand its nuances and implications and to collaborate with our partners through the PDC to discuss and fully consider the short and long-term implications of these changes. Therefore, your Reference Committee recommends that Resolution 218 be referred.

(51) RESOLUTION 243 — DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF FEDERALLY RECOGNIZED TRIBES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 243 be referred.

HOD ACTION: Resolution 243 referred.

RESOLVED, that our American Medical Association add "Enrolled Member of a Federally Recognized Tribe" on all AMA demographic forms (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for the use of "Enrolled Member of a Federally Recognized Tribe" as an additional category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education (Directive to Take Action); and be it further

RESOLVED, that our AMA support the Association of American Medical Colleges (AAMC) inclusion of "Enrolled Member of a Federally Recognized Tribe" on all AAMC demographic forms (New HOD Policy); and be it further

RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical Education (ACGME) to include "Enrolled Member of a Federally Recognized Tribe" on all ACGME demographic forms. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 243. Your Reference Committee heard that over the last four years our AMA has been working with the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education through the Physician Data Collaborative (PDC) to establish best practices for data sharing and standards for sociodemographic data, including race, ethnicity, and more. Your Reference Committee heard that these efforts will enable meaningful, collaborative research to better understand the dynamics of the physician

workforce continuum. Your Reference Committee also heard that the Office of Management and Budget (OMB) recently concluded an extensive national consultation process concerning updating race and ethnicity standards, which our AMA commented on. Testimony highlighted that the OMB ultimately decided to "remove the phrase 'who maintains tribal affiliation or community attachment' in the American Indian/Alaska Native (AI/AN) definition.... to improve estimates of the AI/AN population in Federal statistics." However, your Reference Committee also heard that there may be value in collecting data of members of a federally recognized tribe because it is a legal designation and not a racial category and therefore not subject to the recent U.S. Supreme Court decisions banning the use of race in holistic college admissions processes. Your Reference Committee heard that a potential disadvantage is that there are state recognized tribes and tribes which have lost their federal recognition who would be excluded from this data category. Your Reference Committee also heard that our AMA believed it would be beneficial to study the implications of this designation to ensure that our policy is more comprehensive and does not exclude AI/AN individuals because their tribe is not federally recognized. Testimony also noted that more time is needed to understand the nuances and implications of this resolution and to collaborate with our partners through the PDC to discuss and fully consider the short and long-term implications of these changes. Therefore, your Reference Committee recommends that Resolution 243 be referred.

RECOMMENDED FOR NOT ADOPTION

(52) RESOLUTION 225 — HUMANITARIAN EFFORTS TO RESETTLE REFUGEES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 225 not be adopted.

HOD ACTION: Resolution 225 not adopted.

RESOLVED, that our American Medical Association support increases and oppose decreases to the annual refugee admissions cap in the United States. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 225. Your Reference Committee heard that increasing refugee admission caps is an important social justice issue that will allow more individuals to enter into the United States and begin a new life here. Testimony stated that the United States should be doing more to ensure the wellbeing and safety of refugees all around the world and that this was one small step to help. However, your Reference Committee also heard that the United States is struggling to find adequate funding for necessities for citizens of the United States and that we do not have the ability to provide further monetary assistance to additional asylum seekers at this time. Additionally, testimony stated that our AMA is not an organization that focuses on immigration and does not have the background, expertise, or bandwidth to handle advocacy in this space. Furthermore, your Reference Committee heard that engaging with immigration policy at this time could be politically turbulent and could endanger our AMA's advocacy on other issues. Therefore, your Reference Committee recommends that Resolution 225 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(53) RESOLUTION 237 — ENCOURAGING THE PASSAGE OF THE PREVENTIVE HEALTH SAVINGS ACT (S.114)

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA Policies D-155.994, H-425.988, H-460.894, and H-425.987 be reaffirmed in lieu of Resolution 237.

HOD ACTION: AMA Policies D-155.994, H-425.988, H-460.894, and H-425.987 reaffirmed in lieu of Resolution 237.

RESOLVED, that our American Medical Association encourages continued advocacy to federal and state legislatures of the importance of more accurately and effectively measuring the health and economic impacts of investing in preventive health services to improve health and reduce healthcare spending costs in the long term. (Directive to Take Action); and be it further

RESOLVED, that our AMA reaffirm the following policy: D-155.994, "Value-Based Decision Making in the Health Care System" to encourage legislation and efforts to allow the Congressional Budget Office to more effectively project long-term budget deficit reductions and costs associated with legislation related to preventive health services. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 237. Your Reference Committee heard that the Congressional Budget Office (CBO) was established to provide objective, nonpartisan information to support the U.S. budget process and aid Congress in making effective budget and economic policy and that the CBO is directed to estimate and project the cost of legislation approved by Congressional committees for a specified period of time, usually 10 years. In addition, your Reference Committee heard that 70 percent of U.S. health care expenditures is spent on the management and treatment of chronic disease, and that while much of the political debate around health care in the United States has focused primarily on insurance coverage and access, there has been little discussion around a true transformation of the health system, beginning with measurements of the impacts of preventive health policy. Your Reference Committee also heard an amendment offered to add a reference to "primary care" in the resolution which did not receive much support. Your Reference Committee also heard that the House of Representatives passed legislation, in a bipartisan vote, to direct the CBO to expand the scoring window to estimate the budgetary effects of legislation related to preventive health care services and that our AMA already sent a letter in support of this legislation to House leadership. Your Reference Committee further heard that our AMA already has policy, as noted in the resolution, that recognizes the value and importance of preventive services, and supports legislation and efforts that allow the CBO to more effectively project long-term budget deficit reductions and costs associated with preventive health services. Your Reference Committee heard testimony in favor of reaffirmation of these policies in lieu of adoption. Therefore, your Reference Committee recommends that existing AMA policies D-155.994, H-425.988, H-460.894, and H-425.987 be reaffirmed in lieu of Resolution 237.

Value-Based Decision-Making in the Health Care System D-155.994
1. Our AMA will advocate for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient.
2. Our AMA encourages efforts by the Congressional Budget Office to more comprehensively measure the long-term as well as short-term budget deficit reductions and costs associated with legislation related to the prevention of health conditions and effects as a key step in improving and promoting value-based decision-making by Congress.

The US Preventive Services Task Force Guide to Clinical Preventive Services H-425.988
It is the policy of the AMA: (1) to continue to work with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services; and (2) to continue our efforts to develop and encourage continuing medical education programs in preventive medicine.

Value of Preventive Services H-460.894
Our AMA: (1) encourages committees that make preventive services recommendations to: (a) follow processes that promote transparency and clarity among their methods; (b) develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses; (c) rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available; (d) work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services; and (e) consider the development of recommendations on both primary and secondary prevention; (2) encourages relevant national medical specialty societies to provide input during the preventive services recommendation development process; (3) encourages comparative-effectiveness research on secondary prevention to provide data that could support evidence-based decision making; and (4) encourages public and private payers to cover preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups.

Preventive Medicine Services H-425.987
1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services.
2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review.

(54) RESOLUTION 244 — GRADUATE MEDICAL EDUCATION OPPORTUNITIES FOR AMERICAN INDIAN AND ALASKA NATIVE COMMUNITIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that AMA Policies H-350.977, H-350.976, and D-305.967 be reaffirmed in lieu of Resolution 244.

HOD ACTION: AMA Policies H-350.977, H-350.976, and D-305.967 reaffirmed in lieu of Resolution 244.

RESOLVED, that our American Medical Association supports policy and communication efforts to (1) advance legislative and regulatory policies and actions that establish, authorize, fund, and incentivize the creation of graduate medical education opportunities in IHS, Tribal-administered, and urban Indian health organizations and facilities and (2) establish associated partnerships with accredited medical schools and teaching hospitals (New HOD Policy); and be it further

RESOLVED, that our AMA supports collaboratively working with Tribal nations, Tribal organizations, academic medical centers, policy professionals, medical schools, teaching hospitals, coalition builders, and other stakeholders to advocate to Congress, The White House, the Department of Health and Human Services, and other government entities to establish dedicated graduate medical education funding and programs that benefit Tribal communities, increase physician training sites, and reduce physician shortages, particularly among underserved populations. (New HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 244. Your Reference Committee heard about the importance of graduate medical education (GME) funding and the need for increased support of GME within the Indian Health Service (IHS). Testimony noted the increased health needs of the American Indian and Alaska Native (AI/AN) population and the serious need for more physician providers within these communities. However, your Reference Committee also heard that our AMA already has existing policy that guides our AMA to advance legislative and regulatory policies that bolster and fund graduate medical education opportunities in IHS, Tribal-administered, and urban Indian health organizations and facilities. Furthermore, testimony noted that our current policy also already addresses the importance of the creation and maintenance of partnerships in this space. Your Reference Committee also heard that our AMA is already engaged in this work and has signed onto multiple letters requesting more funding for IHS GME. Testimony also highlighted that our AMA has supported bills like the IHS Workforce Parity Act and asked for additional IHS GME funding and support in Statements for the Record, letters to the Administration, and comment letters. Your Reference Committee also heard that our AMA is consistently advocating for more holistic GME funding, including IHS GME funding. Your Reference Committee also notes that duplicative policy would potentially cause confusion. Therefore, your Reference Committee recommends that existing AMA policies H-350.977, H-350.976, and D-305-967 be reaffirmed in lieu of Resolution 244.

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.

Improving Health Care of American Indians H-350.976
Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.
(2) The federal government provide sufficient funds to support needed health services for American Indians.
(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.
(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.
(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.
(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.
(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.
(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.
(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.
(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.
(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.

3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of “Cap-Flexibility” and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates’ rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation’s health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Landon Combs, MD, Cheryl Gibson Fountain, MD, Tilden Childs III, MD, Matthew Burday, DO, Jennifer Hone, MD, Dayna Isaacs, MD, and all those who testified before the Committee.

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