DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2022 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 (I-22)

Report of Reference Committee B

Hillary Johnson-Jahangir, MD, PhD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 202 – Advocating for State GME Funding
2. Resolution 210 – Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time
3. Resolution 211 – Illicit Drug Use Harm Reduction Strategies
4. Resolution 222 – Allocate Opioid Funds to Train More Addiction Treatment Physicians
5. Resolution 230 – Increased Health Privacy on Mobile Apps in Light of Roe v. Wade

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

6. Resolution 201 – Physician Reimbursement for Interpreter Services
7. Resolution 203 – International Medical Graduate Employment
8. Resolution 205 – Waiver of Due Process Clauses
9. Resolution 206 – The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training
10. Resolution 215 – Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies
11. Resolution 216 – Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare
12. Resolution 219 – Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners
13. Resolution 223 – Criminalization of Pregnancy Loss as the Result of Cancer Treatment
14. Resolution 224 – Fertility Preservation
15. Resolution 227 – Access to Methotrexate Based on Clinical Decisions
16. Resolution 228 – Requirements for Physician Self-reporting of Outpatient Mental Health Services, Treatments or Medications to Credentialing Agencies and Insurers

17. Resolution 233 (Late Resolution 1001) – Urgent AMA Assistance to Puerto Rico and Florida and a Long-Range Project for Puerto Rico

RECOMMENDED FOR REFERRAL

18. Resolution 214 – Universal Good Samaritan Statute
19. Resolution 232 – Obtaining Professional Recognition for Medical Service Professionals

RECOMMENDED FOR ADOPTION IN LIEU OF

20. Resolution 208 – Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals
21. Resolution 229 – Coverage and Reimbursement for Abortion Services
    Resolution 231 – Expanding Support for Access to Abortion Care

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

22. Resolution 213 – Hazard Pay During a Disaster Emergency

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 202 – ADVOCATING FOR STATE GME FUNDING

RECOMMENDATION:

Resolution 202 be adopted.

HOD ACTION: Resolution 202 adopted.

RESOLVED, That our American Medical Association publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate. (Directive to Take Action)

Your Reference Committee heard testimony largely in support of Resolution 202. Your Reference Committee heard that our AMA has extensive policy supporting additional funding for Graduate Medical Education from all sources, including state funding, as well as policy supporting funding of the public health workforce pipeline. Your Reference Committee understands that multiple reports have been written by our AMA on GME funding, including the Compendium of Graduate Medical Education Initiatives that is available on the AMA website and that our AMA's FREIDA resource allows medical students to search for existing residency programs, including state-funded programs. Your Reference Committee recognizes our existing policy and reports and commends our ongoing work; however, given the overwhelming testimony in support of Resolution 202, your Reference Committee recommends that Resolution 202 be adopted.

(2) RESOLUTION 210 – ELIMINATION OF SEASONAL TIME CHANGES AND ESTABLISHMENT OF PERMANENT STANDARD TIME

RECOMMENDATION:

Resolution 210 be adopted.

HOD ACTION: Resolution 210 adopted.

RESOLVED, That our American Medical Association support the elimination of seasonal time changes (New HOD Policy); and be it further

RESOLVED, That our AMA support the adoption of year-round standard time. (New HOD Policy)

Your Reference Committee heard mostly positive testimony in favor of adopting Resolution 210. Your Reference Committee heard that the issue of whether the U.S. should continue to adhere to seasonal time changes or instead switch to permanent Daylight Savings Time (DTS) or Standard Time (ST) had proponents on both sides. Your Reference Committee further heard that the American Academy of Sleep Medicine supports eliminating seasonal time changes and establishing year-round ST due to the health benefits associated with standard time and its relation to the body's natural

circadian rhythm. However, your Reference Committee heard that the U.S. Senate recently passed bipartisan legislation that would make DST permanent across the country and an identical U.S. House of Representatives bill is pending. It is unclear whether the U.S. House of Representatives bill will be considered before the end of the current Congress. Testimony was also heard that establishing policy in favor of permanent Standard Time now would allow our AMA to support Standard Time legislation that may be considered in the future. Therefore, your Reference Committee recommends that Resolution 210 be adopted.

(3) RESOLUTION 211 – ILLICIT DRUG USE HARM REDUCTION STRATEGIES

RECOMMENDATION A:

Resolution 211 be <u>adopted</u>.

RECOMMENDATION B:

AMA Policy H-95.989 be <u>rescinded</u>.

HOD ACTION: Resolution 211 <u>adopted</u> with a change of title and AMA Policy H-95.989 <u>rescinded</u>.

SUBSTANCE USE HARM REDUCTION

RESOLVED, That our American Medical Association amend current policy D-95.987, "Prevention of Drug-Related Overdose," by addition to read as follows:

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

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

<u>6. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.</u> (Modify Current HOD Policy)

Your Reference Committee heard sobering testimony that the nation's overdose epidemic now is killing more than 100,000 people in the United States every year and, tragically, the deaths and harms are ever-increasing. Your Reference Committee agrees with testimony that harm reduction and treatment for substance use disorders are needed to end the epidemic. Testimony highlighted that we are at a point in the nation's overdose epidemic where we truly need to focus on doing everything possible to keep people alive and that harm reduction efforts, whether naloxone, syringe services programs, overdose prevention sites, and fentanyl test strips are among those measures

designed to keep people alive. Your Reference Committee heard testimony that these measures are evidence-based, reasonable public health steps that should be encouraged. Testimony also highlighted that our House of Delegates and our AMA has, for the past several years, advanced many policies in support of harm reduction and decriminalization of public health efforts. Your Reference Committee was not presented with sufficient information to properly evaluate all potential harm reduction initiatives, but notes that, based on testimony received, there is strong evidence and broad support among state and federal policymakers for increasing access to, and decriminalizing possession and use of, fentanyl test strips and other drug checking supplies. Your Reference Committee also heard that our AMA has outdated policy (Policy H-95.989 - Drug Paraphernalia) that conflicts with more recent AMA policy and advocacy activities and agrees with testimony recommending that it be rescinded. Therefore, your Reference Committee recommends that Resolution 211 be adopted, and that Policy H-95.989 be rescinded.

Drug Paraphernalia H-95.989
The AMA opposes the manufacture, sale and use of drug paraphernalia.

(4) RESOLUTION 222 – ALLOCATE OPIOID FUNDS TO TRAIN MORE ADDICTION TREATMENT PHYSICIANS

RECOMMENDATION:

Resolution 222 be <u>adopted</u>.

HOD ACTION: Resolution 222 <u>adopted</u>.

RESOLVED, That our American Medical Association amend Policy H-95.918, "Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs," by addition to read as follows:

Our AMA will advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation against pharmaceutical manufacturers, distributors, or other entities alleged to have engaged in unethical and deceptive misbranding, marketing, and advocacy of opioids, be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain, <u>as well as expanding physician training opportunities to provide clinical experience in the treatment of opioid use disorders.</u> (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony for Resolution 222. Your Reference Committee agrees that current treatment resources are insufficient to effectively address treatment needs for individuals with a substance use disorder. Testimony stated that our AMA has been active in state and national policy initiatives to advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation against pharmaceutical manufacturers, distributors, or other entities alleged to have engaged in unethical and deceptive misbranding, marketing, and advocacy of opioids, be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain. Testimony also highlighted that our AMA advocacy has included

working directly with the Johns Hopkins School of Public Health and more than 50 other patient and medical stakeholders in support of current AMA policy (See Principles for the Use of Opioid Litigation Funds). Your Reference Committee heard that AMA advocacy currently calls for undergraduate and graduate medical education and training programs to hire core faculty in addiction medicine, psychiatry, and pain management to support increasing the physician workforce in these areas. Your Reference Committee agrees that education and training include, but should not be limited to, clinical exposure. Testimony highlighted that medical schools and residency programs would benefit greatly from increasing core curricula in addiction treatment for all specialties. Testimony stated that it is very difficult to build an effective addiction medicine and psychiatry workforce without having a sufficient number of addiction medicine and psychiatry faculty. Therefore, your Reference Committee recommends that Resolution 222 be adopted.

(5) RESOLUTION 230 - INCREASED HEALTH PRIVACY ON MOBILE APPS IN LIGHT OF ROE V. WADE

RECOMMENDATION:

Resolution 230 be adopted.

HOD ACTION: Resolution 230 adopted.

RESOLVED, That AMA policy D-315.968 be amended by addition as follows:

Supporting Improvement to Patient Data Privacy D-315.968
Our AMA will (1) strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data and (2) will work with appropriate stakeholders to oppose using any personally identifiable data to identify patients, potential patients who have yet to seek care, physicians, and any other healthcare providers who are providing or receiving healthcare that may be criminalized in a given jurisdiction.

Your Reference Committee heard testimony mostly in support of Resolution 230. Your Reference Committee heard that Resolution 230 already aligns with current AMA policy and advocacy work including our AMA's Privacy Principles. Testimony highlighted that Policy D.315-968 already directs our AMA to strengthen patient data privacy protections by advocating for legislation that reflects our AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools. Testimony also stated that it is important to ensure that, as the privacy landscape continues to evolve with sensitive overlays, such as reproductive health, it is important that our policy evolves, and part of that evolution is specifically mentioning the importance of covering the privacy rights of all individuals regardless of the modality used to share information, including apps. Therefore, your Reference Committee recommends Resolution 230 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

(6) RESOLUTION 201 – PHYSICIAN REIMBURSEMENT FOR INTERPRETER SERVICES

RECOMMENDATION A:
The first Resolve of Resolution 201 be amended by addition to read as follows:

RESOLVED, That our American Medical Association prioritize physician reimbursement for interpreter services, including American Sign Language, and advocate for legislative and/or regulatory changes to federal health care programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc., for payment for such services (Directive to Take Action); and be it further

RECOMMENDATION B:
The second Resolve of Resolution 201 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~develop model state legislation~~ continue to work with interested state and specialty societies to advocate for physician reimbursement for interpreter services, including American Sign Language, for commercial health plans, workers' compensation plans, Medicaid, Medicaid managed care plans, etc., for payment for such services. (Directive to Take Action).

RECOMMENDATION C:

Resolution 201 be adopted as amended.

HOD ACTION: Resolution 201 adopted as amended.

RESOLVED, That our American Medical Association prioritize physician reimbursement for interpreter services and advocate for legislative and/or regulatory changes to federal health care programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc., for payment for such services (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation for physician reimbursement for interpreter services for commercial health plans, worker compensation plans, Medicaid, Medicaid managed care plans, etc., for payment for such services. (Directive to Take Action)

Your Reference Committee heard robust testimony in support of physician reimbursement for interpreter services. Testimony stated that our AMA already supports access to quality care for all individuals and encourages physicians to make their offices accessible to Limited English Proficiency (LEP) individuals and those who rely on auxiliary aids and services. Testimony also stated that our AMA believes that the financial burden of medical interpretive services and translation should not fall on physician practices. Testimony noted that our AMA already advocates in these areas on many fronts and further stated that this advocacy stems from the extensive policy adopted by our House of Delegates, including Certified Translation and Interpreter Services D-385.957, which would apply to physician reimbursement for interpreter services and advocacy for legislation to support reimbursement for these services. Moreover, your Reference Committee heard extensive testimony on the work our AMA is already doing at the state level. An amendment was offered that stated the importance of ensuring that our policy specifically addresses individuals who are hearing impaired by specifically including access to sign language interpreters in our policy. Your Reference Committee agrees with the proffered amendment and, therefore, recommends that Resolution 201 be adopted as amended.

(7) RESOLUTION 203 – INTERNATIONAL MEDICAL GRADUATE EMPLOYMENT

RECOMMENDATION A:

Resolution 203 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association support federal legislation that reduces the ~~paperwork~~ <u>administrative</u> burden ~~on~~ <u>and streamlines the process of</u> hiring ~~of~~ International Medical Graduates ~~in rural communities~~. (New HOD Policy)

RECOMMENDATION B:

Resolution 203 be <u>adopted as amended</u>.

HOD ACTION: Resolution 203 <u>adopted as amended</u>.

RESOLVED, That our American Medical Association support federal legislation that reduces the paperwork burden on hiring of International Medical Graduates in rural communities. (New HOD Policy)

Your Reference Committee heard positive testimony on Resolution 203. Your Reference Committee heard that international medical graduates (IMGs) play a crucial role in providing care in underserved communities in the U.S. Testimony highlighted that IMGs disproportionately serve in rural and underserved communities but that the paperwork to hire and maintain these individuals is extremely burdensome and deters small rural practices from being able to hire these physicians, even though the need for them is great. Testimony also stated that our AMA is currently advocating for the smoother passage of IMGs through the immigration system and that this resolution would

complement our existing work. Some testimony did note that the use of the word "paperwork" within the original resolution is ambiguous and should be removed, since all physicians experience paperwork burdens. Moreover, your Reference Committee heard that IMGs, regardless of whether or not they serve in rural communities, face administrative burdens when being hired and maintaining a valid visa. Therefore, your Reference Committee recommends that Resolution 203 be adopted as amended.

(8) RESOLUTION 205 – WAIVER OF DUE PROCESS CLAUSES

RECOMMENDATION A:

Resolution 205 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association support legislation that bans the use of "Waiver of Due Process" provisions within physician employment contracts and declares such current provisions to be ~~declared~~ void. (New HOD Policy)

RECOMMENDATION B:

Resolution 205 be adopted as amended.

HOD ACTION: Resolution 205 adopted as amended.

RESOLVED, That our American Medical Association support legislation that bans the use of "Waiver of Due Process" provisions within employment contracts and declares such current provisions to be declared void. (New HOD Policy)

Your Reference Committee heard unanimous testimony in favor of adopting Resolution 205. Testimony indicated the need to ensure that physicians are entitled to full due process protections regardless of employer, and that our AMA should advocate strongly against any contract language that would waive those protections. Your Reference Committee heard testimony that our AMA is already developing legislation that prohibits and voids any such waiver language, and this model legislation will be available to all members of the Federation of Medicine when finalized. Testimony highlighted that our AMA will continue to support advocacy efforts and develop resources that support the rights of employed physicians. Your Reference Committee considered an amendment on collecting information concerning employed physician contracts; however, there was no further testimony in support of this amendment and your Reference Committee believes it departs from the original intent of the resolution. Two friendly amendments were offered to specify that our AMA support legislation concerning physician employment contracts. Therefore, your Reference Committee recommends that Resolution 205 be adopted as amended.

(9) RESOLUTION 206 – THE SHORTAGE OF BEDSIDE NURSES AND INTERSECTION WITH CONCERNS IN NURSE PRACTITIONER TRAINING

RECOMMENDATION A:

The first Resolve of Resolution 206 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association ~~study, and encourage relevant advocacy organizations to study, the links between the bedside nursing shortage, expansion of nurse practitioner programs, and the impact of this connection on patient health outcomes~~ review existing literature on the nursing workforce shortage, including the impact of increased enrollment in nurse practitioner programs (Directive to Take Action); and be it further

RECOMMENDATION B:

Resolution 206 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 206 be changed to read as follows:

NURSING SHORTAGE

HOD ACTION: Resolution 206 adopted as amended with a change of title.

NURSING SHORTAGE

RESOLVED, That our American Medical Association study, and encourage relevant advocacy organizations to study, the links between the bedside nursing shortage, expansion of nurse practitioner programs, and the impact of this connection on patient health outcomes (Directive to Take Action); and be it further

RESOLVED, That our AMA reaffirm existing policies H-160.947, Physician Assistants and Nurse Practitioners, and H-35.996, Status and Utilization of New or Expanding Health Professionals in Hospitals. (Reaffirm HOD Policy)

Your Reference Committee heard mixed testimony regarding Resolution 206. Your Reference Committee heard that the study as proposed in Resolution 206 is not possible due to a lack of available relevant data and because a causal connection cannot be

drawn between the nursing shortage/nurse practitioner programs and patient health outcomes. Many also testified that it would be more appropriate for nursing organizations to study this topic and expressed a general concern with how information from such a study would be used. Your Reference Committee received a proposed amendment that would require our AMA to conduct a review of existing literature on this topic, instead of designing and executing a novel study. Your Reference Committee heard testimony largely in support of this amendment. Based on the testimony, and because existing literature may shed light on the issue brought forth in the Resolution, your Reference Committee recommends that Resolution 206 be adopted as amended.

(10) RESOLUTION 215 – ELIMINATING PRACTICE BARRIERS FOR IMMIGRANT PHYSICIANS DURING PUBLIC HEALTH EMERGENCIES

RECOMMENDATION A:

The first Resolve of Resolution 215 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate ~~advise the state medical boards and other stakeholders~~ to allow currently practicing physicians, including international medical graduates, with valid licenses in states and territories of the U.S. in ~~the~~ health professional shortage areas to have temporary access to all unique and expedited licensing options, both inside and outside of the state of their practice during public health emergencies, to facilitate workforce utilization at the time of critical shortage (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 215 be deleted.

~~**RESOLVED, That our AMA advocate at the state and national level and advise the Department of Labor and the Department of Homeland Security to allow temporary provisions for such licensing inclusions for the physicians on a Visa during public health emergencies. (Directive to Take Action)**~~

RECOMMENDATION C:

Resolution 215 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 215 be changed to read as follows:

ELIMINATING PRACTICE BARRIERS FOR INTERNATIONAL MEDICAL GRADUATE PHYSICIANS DURING PUBLIC HEALTH EMERGENCIES

HOD ACTION: Resolution 215 be adopted as amended with a change of title.

ELIMINATING PRACTICE BARRIERS FOR INTERNATIONAL MEDICAL GRADUATE PHYSICIANS DURING PUBLIC HEALTH EMERGENCIES

RESOLVED, That our American Medical Association advise the state medical boards and other stakeholders to allow physicians in the health professional shortage areas to have temporary access to all unique and expedited licensing options, both inside and outside of the state of their practice during public health emergencies, to facilitate workforce utilization at the time of critical shortage (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate at the state and national level and advise the Department of Labor and the Department of Homeland Security to allow temporary provisions for such licensing inclusions for the physicians on a Visa during public health emergencies. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 215. Testimony stated that it is important to ensure that physicians can practice in areas where an emergency occurs regardless of licensure and as such, there should be expedient pathways for these individuals to gain temporary licensure to aid in times of need. Your Reference Committee heard that international medical graduates (IMGs) are an important part of our health care system and should be allowed to offer care to patients when there is a public health emergency. Moreover, your Reference Committee heard that if the MD/DO who is licensed is an IMG that wants to aid individuals in an emergency they are covered by our current advocacy, our policy does not differentiate or exclude these individuals from our advocacy to help ensure that physicians can go where needed in an emergency. In line with this policy, testimony stated that during COVID our AMA advocated for expedited processing times, lower burdens for location condition applications, extended visa times, and more for our IMGs. Your Reference Committee also heard that our AMA does not support expedited licensure for individuals that are not licensed due to the education and safety standards needed to ensure that patients receive the best care possible, especially those in a declared emergency. Your Reference Committee also heard considerable testimony that it was not the intent of the Resolution's authors to provide IMGs with an alternate licensing pathway if they are not already licensed, but instead to allow already licensed IMGs to be able to travel to, and help during, emergencies without the restrictions that their visas normally place upon them, such as the inability for an H-1B to work in any other location or in an any other capacity besides the one specifically listed on their visa. Your Reference Committee received an amendment clarifying this intent from the Resolution's authors and the

amendment received support from numerous individuals. In addition, to limit redundancy and expand our AMA advocacy the second resolve was struck. Since your Reference Committee supports the proffered amendment we have altered the title of the Resolution to better reflect the amended language. Therefore, your Reference Committee recommends that Resolution 215 be adopted as amended.

(11) RESOLUTION 216 – EXPANDING PARITY PROTECTIONS AND COVERAGE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE IN MEDICARE

RECOMMENDATION A:

Subpoint 2 of Resolution 216 be <u>amended by addition</u> to read as follows:

<u>2. Our AMA supports federal legislation, standards, policies, and funding that enforce and expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C and D).</u>

RECOMMENDATION B:

Resolution 216 be <u>amended by addition of a new resolve clause</u> to read as follows:

<u>RESOLVED, Our AMA support requirements of all health insurance plans to implement a compliance program to demonstrate compliance with state and federal mental health parity laws.</u>

RECOMMENDATION C:

Resolution 216 be <u>adopted as amended</u>.

RECOMMENDATION D:

The title of Resolution 216 be <u>changed</u> to read as follows:

EXPANDING PARITY PROTECTIONS AND COVERAGE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE

HOD ACTION: Resolution 216 be <u>adopted as amended</u> with a change of title.

EXPANDING PARITY PROTECTIONS AND COVERAGE OF MENTAL HEALTH AND SUBSTANCE USE DISORDER CARE

RESOLVED, That our American Medical Association amend policy H-185.974, "Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs," by addition and deletion to read as follows:

Parity for Mental ~~Illness~~ Health, ~~Alcoholism~~, and ~~Related~~ Substance Use Disorders in Health Insurance ~~Medical Benefits~~ Programs H-185.974

1. Our AMA supports parity of coverage for mental ~~illness, alcoholism~~, health, and substance use~~, and eating~~ disorders.

2. Our AMA supports federal legislation, standards, policies, and funding that expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C, and D).

3. Our AMA supports federal legislation, standards, policies, and funding that require Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance use disorder care, consistent with nationally recognized medical professional organization level of care criteria for mental health or substance use disorders. (Modify Current HOD Policy)

Your Reference Committee heard strong support for Resolution 216. Your Reference Committee agrees that more needs to be done to support—and enforce—strong patient protections with respect to mental health and substance use disorder parity. Testimony highlighted that our colleagues from across the Federation of Medicine have worked assiduously to strengthen state and federal mental health and substance use disorder parity laws. Your Reference Committee agrees with testimony that since the Mental Health Parity and Addiction Equity Act was enacted in 2008, health insurance companies have often violated the law. Testimony stated that parity protections should extend to Medicare. Your Reference Committee also heard that while there are strong policies in state and federal law, those policies must be strongly enforced. As such, your Reference Committee agrees with a proffered amendment that would add the word enforcement to the Resolution. Your Reference Committee, furthermore, agrees with an additional offered amendment, that would have our AMA support requirements that health insurers demonstrate compliance with parity laws as a regular matter of doing business and encourage state and federal regulators to take advantage of current laws that require health insurers to prove they are in compliance with parity laws as a condition of doing business. Therefore, your Reference Committee recommends that Resolution 216 be adopted as amended.

(12) RESOLUTION 219 – HOLD ACCOUNTABLE THE REGULATORY BODIES, HOSPITAL SYSTEMS, STAFFING ORGANIZATIONS, MEDICAL STAFF GROUPS, AND INDIVIDUAL PHYSICIANS SUPPORTING SYSTEMS OF CARE PROMOTING DIRECT SUPERVISION OF EMERGENCY DEPARTMENTS BY NURSE PRACTITIONERS

RECOMMENDATION A:

Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, That~~, in accordance with Centers for Medicare & Medical Services regulations and standards of practice for emergency medicine as defined by ACEP and AAEM,~~ our American Medical Association ~~hold accountable the regulatory bodies, hospital systems, staffing organizations, medical staff groups, and individual physicians supporting systems of care that promote direct supervision of emergency departments by nurse practitioners~~ advocate that physicians, ideally board certified emergency physicians, are the only members of the health care team qualified to supervise the provision of emergency care services in the emergency department. (New HOD Policy)

RECOMMENDATION B:

Resolution 219 be adopted as amended.

RECOMMENDATION C:

The title of Resolution 219 be changed to read as follows:

PROMOTING DIRECT SUPERVISION OF EMERGENCY DEPARTMENTS BY PHYSICIANS

HOD ACTION: Resolution 219 be referred for decision.

RESOLVED, That, in accordance with Centers for Medicare & Medical Services regulations and standards of practice for emergency medicine as defined by ACEP and AAEM, our American Medical Association hold accountable the regulatory bodies, hospital systems, staffing organizations, medical staff groups, and individual physicians supporting systems of care that promote direct supervision of emergency departments by nurse practitioners. (New HOD Policy)

Your Reference Committee heard testimony generally in favor of the spirit of Resolution 219. Your Reference Committee heard ample testimony indicating that direct supervision of emergency departments (EDs) by nurse practitioners (NPs) and other non-physicians puts patients at risk and cuts against existing AMA policy that supports physician-led care. Your Reference Committee also heard that the Resolution may be unsuitable for adoption as proposed. Your Reference Committee heard multiple concerns with the "hold accountable" language noting that our AMA does not enforce law or policy. Moreover, your Reference Committee heard that, as written, the policy inadvisably references policy of external organizations and references CMS regulations that do not clearly establish that NPs may not supervise Emergency Departments. Your Reference Committee heard several proposed amendments, including an amendment that would retain the driving principle behind Resolution 219 by calling upon our AMA to advocate that only physicians may supervise emergency care in an emergency department, in alignment with existing AMA policy and with the policies of the organizations referenced in the Resolution. Testimony generally supported the proposed amendment, including testimony from the American College of Emergency Physicians which supported the amendment and recommended additional language that physicians who supervise emergency departments ideally should be board certified in emergency medicine. Your Reference Committee also heard calls to expand the resolution to include other facilities such as urgent care centers and orthopedic surgery centers. Your Reference Committee considered such testimony and opted to honor the intent of the original resolution by limiting the focus to care provided in an emergency department, recognizing that abundant existing AMA policy and robust advocacy at the state and federal level supporting physician-led care covers the issue more broadly. Therefore, your Reference Committee changed the title of the Resolution to better reflect the content of the amended resolution. As such, Your Reference Committee recommends that Resolution 219 be adopted as amended.

(13) RESOLUTION 223 – CRIMINALIZATION OF PREGNANCY LOSS AS THE RESULT OF CANCER TREATMENT

RECOMMENDATION A:
Resolve 1 of Resolution 223 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association advocate that pregnancy loss ~~as a result of medically necessary treatment for cancer~~ shall not be criminalized for physicians or ~~pregnant~~ patients (Directive to Take Action); and

RECOMMENDATION B:

Resolve 2 of Resolution 223 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate that physicians and patients should not be held civilly and/or criminally liable for pregnancy loss as a result of medically necessary care ~~treatment for cancer~~. (Directive to Take Action)

RECOMMENDATION C:

Resolution 223 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 223 be changed to read as follows:

CRIMINALIZATION OF AND CIVIL LIABILITY FOR PREGNANCY LOSS AS THE RESULT OF MEDICALLY NECESSARY CARE

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

OPPOSITION TO CRIMINALIZATION OF AND CIVIL LIABILITY FOR PREGNANCY LOSS AS THE RESULT OF MEDICALLY NECESSARY CARE

RESOLVED, That our American Medical Association advocate that pregnancy loss as a result of medically necessary treatment for cancer shall not be criminalized for physicians or patients (Directive to Take Action); and

RESOLVED, That our AMA advocate that physicians should not be held civilly liable for pregnancy loss as a result of treatment for cancer. (Directive to Take Action)

Your Reference Committee heard unanimous testimony in support of the intention of Resolution 223. Testimony agreed that pregnancy loss as the result of medical care should not result in liability for physicians or patients. However, testimony was split as to whether it is appropriate to single out cancer treatment or whether the resolution should be broader. Your Reference Committee heard testimony shift towards supporting the inclusion of language that supports advocacy for broader medically necessary care. An amendment was offered to apply the resolution to all medically necessary care and to oppose criminal as well as civil liability for pregnancy loss. Significant support was heard for this amendment. Your Reference Committee agrees with the testimony supporting the amended language and altered the title of the resolution to better reflect the content of the amended language. Therefore, your Reference Committee recommends that Resolution 223 be adopted as amended.

(14) RESOLUTION 224 – FERTILITY PRESERVATION

RECOMMENDATION A:

Subpoint 1 of AMA Policy H-185.990 be amended by addition and deletion to read as follows:

1. Our AMA ~~encourages~~ advocate for third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.

RECOMMENDATION B:

Subpoint 2 of AMA Policy H-185.990 be amended by addition and deletion to read as follows:

2. Our AMA ~~supports~~ advocates for payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will ~~lobby for appropriate~~ support state and federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician~~.~~, including but not limited to cryopreservation of embryos, sperm, oocytes, and ovarian and testicular tissue.

RECOMMENDATION C:

Subpoint 3 of AMA Policy H-185.990 be amended by addition and deletion to read as follows:

3. Our AMA ~~encourages~~ advocates for the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility, and supports access to fertility preservation services for those affected.

RECOMMENDATION D:

AMA Policy H-185.990 be adopted as amended in lieu of Resolution 224.

RECOMMENDATION E:

That the following HOD policies be reaffirmed: D-5.999, Preserving Access to Reproductive Health Services, and H-160.946, The Criminalization of Health Care Decision Making

HOD ACTION: AMA Policy H-185.990 adopted as amended in lieu of Resolution 224 and AMA Policies D-5.999 and H-160.946 reaffirmed.

RESOLVED, That our American Medical Association advocate for state legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed treating physician (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that "fertility preservation therapy services" should include cryopreservation of embryos, sperm, and oocytes (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate against the prosecution of physicians for eliminating or transporting unused embryos created during and subsequent to the fertility preservation process. (Directive to Take Action)

Your Reference Committee heard testimony in support of coverage for payment for fertility preservation therapy services. An amendment was offered to add ovarian and testicular tissue cryopreservation to the definition of fertility preservation therapy services to ensure that individuals that need this additional care could access it regardless of their income status. Another amendment was offered to specify that advocacy for payment should target all private and public payers. Testimony was heard in opposition to the third resolve due to the fact that the third resolve clause singles out one clinical scenario. Testimony noted that our advocacy should not be constrained to one scenario, but rather should apply to a broader set of circumstances. Testimony also noted that the matters addressed by Resolution 224 are substantially addressed by existing policy and that amendment to existing policy would be preferable to new, separate policy. An amendment was offered to that end. Additionally, significant testimony highlighted the work that our AMA is already doing based on our current AMA policy and noted that it would be beneficial to reaffirm our existing relevant AMA policy. Therefore, your Reference Committee recommends that existing policy H-185.990 be adopted as amended in lieu of Resolution 224 and that existing AMA policies H-185.990, D-5.999, and H-160.946 be reaffirmed.

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will

lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
3. Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility, and supports access to fertility preservation services for those affected.

Preserving Access to Reproductive Health Services D-5.999

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at the 2022 Interim Meeting.

The Criminalization of Health Care Decision Making H-160.946

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

(15) RESOLUTION 227 – ACCESS TO METHOTREXATE BASED ON CLINICAL DECISIONS

RECOMMENDATION A:

Resolve 1 of Resolution 227 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association oppose ~~work to create a formal process to review pharmaceutical practices related to refusal of~~ restrictions on prescribing, distributing, or dispensing of methotrexate and other drugs on the basis that it could be used off-label for pregnancy termination; and be it further

RECOMMENDATION B:

Resolve 2 of Resolution 227 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with relevant stakeholders to provide educational guidance on ~~state-specific~~ laws, regulations, or other policies that ~~have impacted~~ impede ~~the~~ prescribing, distributing, or dispensing of methotrexate and other medications because of their impact or perceived impact on a pregnancy ~~given post Dobbs vs. Jackson Women's Health Organization restrictions.~~

RECOMMENDATION C:

Resolution 227 be adopted as amended.

RECOMMENDATION D:

The title of Resolution 227 be changed to read as follows:

ACCESS TO METHOTREXATE AND OTHER MEDICATIONS BASED ON CLINICAL DECISIONS

HOD ACTION: Resolution 227 adopted as amended with a change of title.

ACCESS TO METHOTREXATE AND OTHER MEDICATIONS BASED ON CLINICAL DECISIONS

RESOLVED, That our American Medical Association work to create a formal process to review pharmaceutical practices related to refusal of methotrexate and other drugs on

the basis that it could be used off-label for pregnancy termination (Directive to Take Action); and be it further

RESOLVED, That our AMA work to provide educational guidance on state-specific laws that have impacted the distribution of methotrexate given post Dobbs vs. Jackson Women's Health Organization restrictions. (Directive to Take Action)

Your Reference Committee heard testimony in support of the spirit of Resolution 227. Testimony stated that patients, particularly those living where abortion is now illegal and, in those states where abortion laws are unclear or changing, are facing access challenges to methotrexate. Testimony was also heard that some pharmacies and pharmacists are refusing to stock or dispense the drug. Testimony noted that methotrexate is a first-line treatment for several prevalent conditions and disruptions in care risk worsening health conditions, suffering, and death for patients that cannot safely access methotrexate. Testimony was not supportive of the development of a formal process for reviewing pharmaceuticals and instead several amendments were offered that would direct our AMA to monitor and oppose restrictions on pharmaceutical practices that limit access to medications such as methotrexate. Your Reference Committee heard considerable testimony in support of broadening the language to include all medications that could potentially terminate a pregnancy but are prescribed for other clinical reasons. Therefore, your Reference Committee recommends that Resolution 227 be adopted as amended.

(16) RESOLUTION 228 - REQUIREMENTS FOR PHYSICIAN SELF -REPORTING OF OUTPATIENT MENTAL HEALTH SERVICES, TREATMENTS OR MEDICATIONS TO CREDENTIALING AGENCIES AND INSURERS

RECOMMENDATION A:

The first Resolve of Resolution 228 be deleted.

~~**RESOLVED, That our American Medical Association compile a report summarizing which states have implemented the suggestions that medical boards should not require disclosure of mental health conditions as a condition for re-licensure, as listed in Policy H-275.945, "Self-Incriminating Questions on Applications for Licensure and Specialty Boards" (Directive to Take Action); and be if further**~~

RECOMMENDATION B:

The second Resolve of Resolution 228 be deleted.

~~**RESOLVED, That our AMA advocate to applicable organizations, such as Federation of State Medical Boards and Joint Commission, that state licensure boards, hospital credentialing committees, private and public health insurers and medical specialty boards refrain from asking whether physicians are currently receiving outpatient mental health care while continuing to ask whether they are currently impaired, as stated in AMA Policy H-295.858 (2), "Access to Confidential Health Services for Medical Students and Physicians" (Directive to Take Action); and be it further**~~

RECOMMENDATION C:

The third Resolve of Resolution 228 be amended by deletion to read as follows:

RESOLVED, That our AMA advocate ~~to applicable organizations, such as Federation of State Medical Boards and Joint Commission,~~ that Substance Use Disorder (SUD) conditions currently managed with the assistance of a state's Physicians' Health Program (PHP) (or similar entity) ~~need~~ not be reported on applications for re-credentialing by state licensure boards, hospital credentialing committees, private and public health insurers and medical specialty boards. ~~, because participation in a PHP ensures strict accountability on the part of physicians with a history of SUD, with this accountability enabling these physicians to such successfully and safely re-engage in the practice of medicine.~~ (New HOD Policy)

RECOMMENDATION D:

Resolution 228 be adopted as amended.

RECOMMENDATION E:

That AMA Policy H-295.858 be reaffirmed.

HOD ACTION: Resolution 228 adopted as amended and AMA Policy H-295.858 reaffirmed.

RESOLVED, That our American Medical Association compile a report summarizing which states have implemented the suggestions that medical boards should not require disclosure of mental health conditions as a condition for re-licensure, as listed in Policy H-275.945, "Self-Incriminating Questions on Applications for Licensure and Specialty Boards" (Directive to Take Action); and be if further

RESOLVED, That our AMA advocate to applicable organizations, such as Federation of State Medical Boards and Joint Commission, that state licensure boards, hospital credentialing committees, private and public health insurers and medical specialty boards refrain from asking whether physicians are currently receiving outpatient mental health care while continuing to ask whether they are currently impaired, as stated in AMA Policy H-295.858 (2), "Access to Confidential Health Services for Medical Students and Physicians" (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to applicable organizations, such as Federation of State Medical Boards and Joint Commission, that Substance Use Disorder (SUD) conditions currently managed with the assistance of a state's Physicians' Health Program (PHP) (or similar entity) need not be reported on applications for re-credentialing by state licensure boards, hospital credentialing committees, private and

public health insurers and medical specialty boards, because participation in a PHP ensures strict accountability on the part of physicians with a history of SUD, with this accountability enabling these physicians to such successfully and safely re-engage in the practice of medicine. (New HOD Policy)

Your Reference Committee heard compelling testimony in support of Resolution 228. Your Reference Committee agrees with the importance of removing inappropriate, stigmatizing questions about mental health and substance use disorders from medical licensing applications, credentialing applications, medical liability applications, and applications and other forms that medical trainees must complete for medical school, residency, and fellowship programs. Testimony also highlighted that our AMA is already working with myriad groups ranging from state medical boards to health systems, to liability insurance carriers, to implement AMA policy. Your Reference Committee appreciates the call for a report on our AMA activities, but also notes that our AMA regularly communicates on its wellness efforts, including efforts to advance the legislative and regulatory components of our AMA's physician health and wellness campaign as part of the AMA Recovery Plan. Your Reference Committee points to recent AMA support for state-level victories, such as a new Delaware law that makes clear that "a mental or physical disability or serious health condition does not prevent a physician's ability to practice medicine with reasonable skill and safety when the condition is reduced or ameliorated because of ongoing treatment," and that our AMA supported similar legislation in Arizona earlier this year. Testimony noted that Virginia enacted the country's first law in this area, and AMA resources and medical society advocacy also helped enact laws in South Dakota and Indiana. Other AMA advocacy highlights include AMA's partnership with the Federation of State Medical Boards (FSMB) and the Dr. Lorna Breen Heroes' Foundation to seek revision of inappropriate and stigmatizing questions on medical licensing applications; AMA ongoing analysis of state medical licensing applications and reflected online; AMA work with state medical societies and medical boards to obtain every licensing application for analysis and potential advocacy if the questions are not aligned with AMA policy; AMA advocacy and partnership with Henry Ford Health to revise its credentialing application; and AMA partnership with the Federation of State Physician Health Programs (FSPHP) to take action in support of physicians seeking confidential care for health, wellness, and impairment. Your Reference Committee agrees that physicians receiving care from a PHP should not be stigmatized vis-à-vis disclosure on a medical licensing, credentialing or other application given PHPs' success in effectively treating and safely returning physicians to work. Your Reference Committee encourages the House to review an AMA issue brief that outlines many of these advocacy issues and best practices for legislative and regulatory advocacy. Your Reference Committee received an amendment that would streamline the asks within the Resolution and align with current AMA policy to decrease redundancy. Your Reference Committee, therefore, recommends that Resolution 228 be adopted as amended in lieu of Resolution 228 and that existing AMA policies D-405.972, H-275.972, H-295.858, and H-95.913 be reaffirmed.

Access to Confidential Health Services for Medical Students and Physicians H-295.858

1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and

Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:
A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;
B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;
C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and
D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.
2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.
3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:
A. be available to all medical students on an opt-out basis;
B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and
D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.
4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.
5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying

and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

(17) RESOLUTION 233 (LATE RESOLUTION 1001) - URGENT AMA ASSISTANCE TO PUERTO RICO AND FLORIDA AND A LONG-RANGE PROJECT FOR PUERTO RICO

RECOMMENDATION A:

The first Resolve of Resolution 233 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our American Medical Association~~,~~ ~~particularly the Department of Advocacy, move urgently, meeting with the Biden Administration to work with the Agencies, in particular the US Health and Human Services Administration and its Center for Medicare and Medicaid Services, the US Department of Defense and the US Department of Homeland Security and its Federal Emergency Management Agency~~ <u>promptly urge all relevant government agencies and Congress</u> to provide ~~all~~ available <u>federal disaster</u> assistance to the Territory of Puerto Rico and the State of Florida ~~including emergent, short term adjustments, in Federal based health reimbursements to physicians, hospitals, clinics, and Rural Health Care systems~~ (Directive to Take Action); and be it further

RECOMMENDATION B:

The second Resolve of Resolution 233 be deleted.

~~**RESOLVED, That our AMA work with all pertinent stakeholders in Puerto Rico to develop LONG TERM strategies to solve LONG TERM health care financing in the Territory. (Directive to Take Action)**~~

RECOMMENDATION C:

Resolution 233 be amended by addition of a new resolve to read as follows:

RESOLVED, That AMA Policy H-390.953 (Medicare Payments for Physicians' Services in Puerto Rico), which calls on our AMA to support the elimination of inequities in Medicare reimbursement so that physicians' fees for Medicare patients in Puerto Rico are adjusted according to the Medicare regulations applicable in the continental United States, be reaffirmed.

RECOMMENDATION D:

Resolution 233 be adopted as amended.

RECOMMENDATION E:

AMA Policy D-290.975 be amended by addition and deletion to read as follows:

1. **Our AMA will urge and advocate the U.S. Congress to quickly pass legislation to provide adequate~~ly~~, stable, long-term funding for Puerto Rico~~'s~~, and, the U.S. Virgin Islands~~'~~, and other U.S. territories' Medicaid Programs.**
2. **Our AMA will urge and advocate for the Centers for Medicare and Medicaid Services to implement temporary emergency regulatory Medicare and Medicaid funding waivers to help restore access to health care services in Puerto Rico and the U.S. Virgin Islands.**

RECOMMENDATION F:

AMA Policy D-290.975 be adopted as amended.

HOD ACTION: Resolution 233 adopted as amended and AMA Policy D-290.975 adopted as amended.

RESOLVED, That our American Medical Association, particularly the Department of Advocacy, move urgently, meeting with the Biden Administration to work with the Agencies, in particular the US Health and Human Services Administration and its Center for Medicare and Medicaid Services, the US Department of Defense and the US Department of Homeland Security and its Federal Emergency Management Agency to provide all available assistance to the Territory of Puerto Rico and the State of Florida including emergent, short term adjustments, in Federal based health reimbursements to physicians, hospitals, clinics, and Rural Health Care systems (Directive to Take Action); and be it further

RESOLVED, That our AMA work with all pertinent stakeholders in Puerto Rico to develop LONG TERM strategies to solve LONG TERM health care financing in the Territory. (Directive to Take Action).

Your Reference Committee heard mostly positive testimony in favor of adopting Resolution 233. Your Reference Committee heard that both Puerto Rico and Florida were devastated by recent hurricanes Fiona and Ian, including suffering damage to health care infrastructure and services with total damage estimated in the billions of dollars. Testimony further highlighted that Puerto Rico has been severely impacted over the past five years by a series of disasters, including Hurricanes Irma and Maria in 2017, the 2019-2020 earthquakes, the COVID-19 public health emergency, and most recently Hurricane Fiona. Testimony stated that funding inequities have plagued Puerto Rico's health care system, including struggles with lower Medicaid caps and Federal Medical Assistance Percentages (FMAP), than most of the U.S. and that Puerto Rico needs both short-term funding and long-term solutions to help improve its health care infrastructure and Medicaid and Medicare financing. Your Reference Committee also heard that our AMA supports the underlying goal of providing sustained Medicare and Medicaid funding assistance to Puerto Rico other U.S. territories, and Southeastern states following a series of serious hurricanes. Testimony stated that, as drafted, the resolution conflates general financial disaster assistance from the federal government with the need for Congress to provide long-term Medicaid and Medicare funding solutions for the U.S. territories. In addition, your Reference Committee heard that Congress is expected to pass legislation in the upcoming lame duck session that separately addresses both long-term Medicaid payment stability in the U.S. territories and hurricane disaster relief. An amendment was offered to clarify that our AMA advocate in support of general disaster funding for Puerto Rico and the State of Florida to assist with the rebuilding effort following Hurricanes Fiona and Ian, and to modify existing AMA Policy D-290.975—related to Medicaid Funding and Assistance to Puerto Rico—to urge Congress to quickly pass legislation to provide adequate, stable, long-term funding the Puerto Rico and other U.S. territories' Medicaid programs. Your Reference Committee agrees with this amendment and, therefore, recommends that Resolution 233 be adopted as amended.

Medicare Payments for Physicians' Services in Puerto Rico H-390.953

The AMA supports the elimination of inequities in Medicare reimbursement so that physicians' fees for Medicare patients in Puerto Rico are adjusted according to the Medicare regulations applicable in the continental United States.

RECOMMENDED FOR REFERRAL

(18) RESOLUTION 214 – UNIVERSAL GOOD SAMARITAN STATUTE

RECOMMENDATION:

Resolution 214 be referred.

HOD ACTION: Resolution 214 referred.

RESOLVED, That our American Medical Association help protect patients in need of emergency care and protect physicians and other responders by advocating for a national "universal" Good Samaritan Statute (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the unification of the disparate statutes by creation of a national standard via either federal legislation or through policy directed by the Department of Health and Human Services [HHS] to specify terms that would protect rescuers from legal repercussion as long as the act by the rescuer meets the specified universal minimal standard of conduct and the good faith requirement, regardless of the event location; thus, effectively eliminating variations in the state statutes to facilitate the intent of the Good Samaritan statutes removing barriers that could impede the prompt rendering of emergency care. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning Resolution 214. Testimony noted that more needs to be done to support strong protections of physicians responding as Good Samaritans, regardless of location within the United States and regardless of the type of medical emergency they are called upon to address. Testimony highlighted that our AMA already has policy that promotes shielding physician Good Samaritans from liability while rendering treatment responsive to the Covid-19 public health emergency, the opioid overdose epidemic, and in-flight medical emergencies. However, testimony also stated that our AMA should not create policy that would preempt existing state law that is more protective than that of a national minimum standard. Your Reference Committee agrees with the goal of Resolution 214 but recognizes that there are numerous legal nuances that need to be more thoroughly considered before crafting policy that would create a national Good Samaritan protection. Therefore, your Reference Committee, due to the complexity of the interplay between state laws and federal law, recommends that Resolution 214 be referred.

(19) RESOLUTION 232 - OBTAINING PROFESSIONAL RECOGNITION FOR MEDICAL SERVICE PROFESSIONALS

RECOMMENDATION:

Resolution 232 be referred.

HOD ACTION: Resolution 232 referred.

RESOLVED, That our American Medical Association collaborate with leadership of the National Association of Medical Staff Services' Advocacy and Government Relations teams to advocate to the U.S. Department of Labor Statistics for obtaining a unique standard occupational classification code during the next revision for medical service professionals to maintain robust medical credentialing for patient safety (Directive to Take Action).

Your Reference Committee heard testimony generally supporting Resolution 232 and recognizing the support that medical service professionals (MSPs) give to medical staff by performing core functions such as credentialing. It was noted that the work that MSPs do helps make the credentialing process more efficient and less administratively burdensome on physicians. Your Reference Committee heard that MSPs have previously been denied a standard occupation classification by the Department of Labor Statistics but are unsure of the reason for this denial. Moreover, testimony expressed concerns that the Resolution raised several questions that required further information and consideration before determining what, if any, advocacy strategy might be most effective in order to support MSPs and to achieve the goals of Resolution 232. Therefore, your Reference Committee recommends that Resolution 232 be referred.

RECOMMENDED FOR ADOPTION IN LIEU OF

(20) RESOLUTION 208 – COMPARING STUDENT DEBT, EARNINGS, WORK HOURS, AND CAREER SATISFACTION METRICS IN PHYSICIANS V. OTHER HEALTH PROFESSIONALS

RECOMMENDATION A:

Alternate Resolution 208 be adopted in lieu of Resolution 208.

FACTORS CAUSING BURNOUT

RESOLVED, That our AMA recognize that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians. (New HOD Policy).

HOD ACTION: Alternate Resolution 208 adopted in lieu of Resolution 208.

RESOLVED, That our American Medical Association's advocacy efforts be informed by the fact that student debt burden is higher for physicians when compared to physician assistants and nurse practitioners (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders to study: (a) how total career earnings of physicians compare to those physician assistants and nurse practitioners in order to specifically discern if there is a financial disincentive to becoming a physician, considering the relatively high student debt burden and work hours of physicians; (b) if resident physicians provide a net financial benefit for hospitals and healthcare institutions; (c) best practices for increasing resident physician compensation so that their services may be more equitably reflected in their earnings; and (d) burnout metrics using a standardized system to compare differences among physicians, physician assistants and nurse practitioners (Directive to Take Action); and be it further

RESOLVED, That our AMA recognize that burnout-centered metrics do not fully characterize work-life balance, particularly for individuals with varying socioeconomic, racial and/or sexual minoritized backgrounds (New HOD Policy); and be it further

RESOLVED, That our AMA seek to publish its findings in a peer-reviewed medical journal. (Directive to Take Action)

Your Reference Committee heard limited testimony regarding Resolution 208. Your Reference Committee heard that it would not be possible to conduct the study as described in Resolution 208, as the data necessary to conduct a study as framed are not available and that even if the data were available they would not be collected comparably across professions. In addition, testimony noted that compensation is multifactorial and cannot be viewed in a vacuum as described in the original resolution. Your Reference Committee was offered an alternate resolution that recognizes the unique challenges facing medical students, resident physicians, and fellows that contribute to burnout during medical school and residency training. Testimony on the proposed alternate resolution also noted that the proposed alternate resolution would ensure that metrics and future studies include factors unique to medical students, resident physicians, and fellows, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, long work and study hours, and mistreatment among other factors. The authors of original Resolution 208 supported the alternate resolution. Therefore, your Reference Committee recommends that Alternate Resolution 208 be adopted in lieu of Resolution 208.

(21) RESOLUTION 229 - COVERAGE AND REIMBURSEMENT FOR ABORTION SERVICES
RESOLUTION 231 – EXPANDING SUPPORT FOR ACCESS TO ABORTION CARE

RECOMMENDATION:

Alternate Resolution 229 be <u>adopted in lieu of</u> Resolutions 229 and 231.

EXPANDING SUPPORT FOR ACCESS TO ABORTION CARE

RESOLVED, That our AMA advocate for broad and equitable access to abortion services, public and private coverage of abortion services, and funding of abortion services in public programs.

RESOLVED, That our AMA advocate for explicit codification of legal protections to ensure broad, equitable access to abortion services.

RESOLVED, That our AMA advocate for equitable participation by physicians who provide abortion care in insurance plans and public programs.

RESOLVED, That our AMA oppose the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care.

HOD ACTION: Alternate Resolution 229 adopted in lieu of Resolutions 229 and 231.

Resolution 229 – Coverage and Reimbursement For Abortion Services

RESOLVED, That our AMA advocate for legislation and regulation to (1) lift all restrictions on public funding for abortion services and (2) guarantee coverage of evidence-based abortion services by all plans and programs that are publicly funded or subsidized; and be it further

RESOLVED, That our AMA advocate for policies that guarantee evidence-based abortion services are covered without barriers by private health plans, including designating abortion services as an essential health benefit; and be it further

RESOLVED, That our AMA work with state medical societies to advocate for policies requiring abortion coverage in state private, public, and subsidized plans; and be it further

RESOLVED, That our AMA oppose restrictions on physicians and other health professionals who provide abortion care from participating in or being reimbursed by federal and state funded or subsidized health coverage.

Resolution 231 – Expanding Support for Access to Abortion Care

RESOLVED, That our AMA recognize that policies and legislation that limit access to abortion care are serious threats to public health; and be it further

RESOLVED, That our AMA will advocate for the explicit codification of protections for abortion care consistent with AMA policy into federal law; and be it further

RESOLVED, That our AMA oppose efforts to exclude provisions from spending bills which limit federal funds from being used for abortion care; and be it further

RESOLVED, That our AMA collaborate with relevant stakeholders including state medical societies to encourage amendments to existing state laws so that a “fetal heartbeat” is not inaccurately stated as synonymous with the first evidence of embryonic cardiac activity.

Your Reference Committee heard testimony on Resolutions 229 and 231. Testimony highlighted the importance of equitable access to abortion services, public and private coverage of abortion services, funding of abortion services in public programs, and the codification of protections to ensure broad, equitable access to abortion services. However, your Reference Committee heard that the resolve clauses for Resolutions 229 and 231 were redundant and needed to be streamlined in order to make cohesive policy. It was stated that adopting a version of Resolutions 229 and 231 would be a powerful statement by our AMA and would bolster AMA advocacy on all the issues related to abortion services. Your Reference Committee was offered an alternate resolution that conveys the spirit of both resolutions while concisely conveying the importance of the legalization and funding abortion services across all venues. The alternate resolution also opposed the use of false or inaccurate terminology and disinformation in policymaking to impose restrictions and bans on evidence-based health care, including reproductive health care and to advocate for equitable participation by physicians who provide abortion care in insurance plans and public programs. This alternate resolution received overwhelming support. Therefore, your Reference Committee recommends that Alternate Resolution 229 be adopted in lieu of Resolution 229 and Resolution 231.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(22) RESOLUTION 213 – HAZARD PAY DURING A DISASTER EMERGENCY

RECOMMENDATION:

That AMA Policies D-130.970 and D-390.947 be reaffirmed in lieu of Resolution 213.

HOD ACTION: AMA Policies D-130.970 and D-390.947 reaffirmed in lieu of Resolution 213.

RESOLVED, That our American Medical Association work with the federation of medicine to advocate for state or federal programs that would provide hazard pay bonuses to physicians and other healthcare staff delivering care during a state or federal disaster emergency. (Directive to Take Action)

Your Reference Committee heard limited testimony in favor of adopting Resolution 213 but also heard testimony in favor of reaffirmation of existing AMA policy in lieu of adoption. Your Reference Committee heard that New York was "ground zero" in terms of COVID-19, and its front-line physicians were greatly impacted. Testimony also highlighted that New York State provided hazard pay to front-line physicians through the state budget, and that this should be standard practice. Your Reference Committee also heard strong testimony that the issue of hazard pay bonuses for frontline essential workers, including physicians, was debated in Congress during the first year of the COVID-19 pandemic, and while our AMA advocated for physician hazard pay bonuses, they were included in legislation passed only by the House of Representatives. Your Reference Committee further heard that hazard pay bonuses for physicians is controversial in Congress, especially since Congress passed other financial packages for physicians through millions of dollars in funding for grant programs and loan programs to compensate them for losses incurred and extra expenses due to COVID-19. Testimony also stated that, regarding future disaster emergencies, our AMA has existing policies that provide direction for our AMA to advocate for additional funding for physicians, and that these policies should be reaffirmed. Therefore, your Reference Committee recommends that existing AMA policies D-390.947 and D-130.970 be reaffirmed in lieu of Resolution 213.

Development of Bridge Income Strategies for Physicians Impacted by Officially Declared Disasters D-130.970

Our AMA will evaluate strategies to create or support federal legislation and/or regulations which would provide bridge financial support to physicians following officially declared disasters to ensure an adequate supply of physicians to treat the population of the recovering areas.

Physician Payment Advocacy for Additional Work and Expenses Involved in Treating Patients During the Covid-19 Pandemic and Future Public Health Emergencies D-390.947

Our AMA: (1) will work with interested national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to recognize the additional uncompensated costs associated with COVID-19 incurred by physicians during the COVID-19 Public Health Emergency; (2) will work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; and (3) encourages interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency.

MISTER SPEAKER, THIS CONCLUDES THE REPORT OF REFERENCE COMMITTEE B. I WOULD LIKE TO THANK KENNETH BLUMENFELD, MD, TILDEN CHILDS, III, MD, DANIEL CHOI, MD, KELLY CLARK, MD, KARL STEINBERG, MD, KIERSTEN WOODYARD, AND ALL THOSE WHO TESTIFIED BEFORE THE COMMITTEE.

Kenneth Blumenfeld, MD
American Association of Neurological Surgeons

Kelly Clark, MD (Alternate)
American Society of Addiction Medicine

Tilden Childs, III, MD
American College of Radiology

Karl Steinberg, MD
Society for Post-Acute and Long-Term Care Medicine

Daniel Choi, MD (Alternate)
Private Practice Physician Section

Kiersten Woodyard (Alternate)
Ohio

Hillary Johnson-Jahangir
Iowa
Chair