

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1001
(I-22)

Introduced by: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Virginia, West Virginia

Subject: Urgent AMA Assistance to Puerto Rico and Florida and a Long-Range Project for Puerto Rico

Referred to: Reference Committee B

1 Whereas, Both the Territory of Puerto Rico and the state of Florida are important to the
2 American Medical Association (AMA) and the Southeastern Delegation to the AMA (SED); and
3

4 Whereas, As of December 31, 2021, the Territory had approximately 1,400 AMA member
5 physicians and the State had nearly 14,000 AMA member physicians; and
6

7 Whereas, Both were devastated by Hurricanes, Fiona striking Puerto Rico on or about
8 September 19, 2022 and Ian striking Florida on or about September 28, 2022 and the days
9 following, including damage to health care infrastructure and services; total damage estimates
10 are still rough, but stand at about \$25 Billion for Puerto Rico and about \$70 Billion for Florida;
11 and
12

13 Whereas, We have the established model for changes in short term health care financing from
14 the US Government and its Agencies from Hurricane Maria (five years ago), in particular to both
15 raise the 1108 Medicaid Allotment caps and to raise the Federal Medical Assistance Percentage
16 (FMAP) to 100% at least temporarily; and
17

18 Whereas, Puerto Rico in normal times struggles with lower Medicaid caps and FMAP
19 percentages than most of the American States; and
20

21 Whereas, In Puerto Rico there are about 250,000 Medicare Beneficiaries and about 1.6 million
22 Medicaid Beneficiaries out of a total population of about 2.7 million (so of course, the US
23 Federal Government provides the bulk (70%) of health care funding in Puerto Rico); about 60%
24 of the Puerto Rican Medicare Beneficiaries have earned incomes below the poverty standard
25 (about \$12,000.00 per year); and
26

27 Whereas, Puerto Rico has a Member of Congress (called a Resident Commissioner), currently
28 Jenniffer Gonzalez-Colon, but without vote; the current Member caucuses with the Republicans;
29 she has introduced model legislation proposed HR 7997 (June 9, 2022, with eight co-sponsors)
30 and proposed HR 1969 (March 17, 2021, with no co-sponsors); and
31

32 Whereas, The peoples of Puerto Rico and its physicians would greatly benefit from a better
33 funded health care system, at least to match what is provided from Federal Programs to the
34 mainland states of the US; and

1 Whereas, The lessons and systems learned from and in the AMA West Side Project in Chicago
2 might be brought to bear and be very useful in Puerto Rico; therefore be it
3

4 RESOLVED, That our American Medical Association, particularly the Department of Advocacy,
5 move urgently, meeting with the Biden Administration to work with the Agencies, in particular
6 the US Health and Human Services Administration and its Center for Medicare and Medicaid
7 Services, the US Department of Defense and the US Department of Homeland Security and its
8 Federal Emergency Management Agency to provide all available assistance to the Territory of
9 Puerto Rico and the State of Florida including emergent, short term adjustments, in Federal
10 based health reimbursements to physicians, hospitals, clinics, and Rural Health Care systems
11 (Directive to Take Action); and be it further
12

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

Fiscal Note: Estimated cost of \$124K to implement this resolution includes staffing, travel and meetings, and promotion (\$5K for 1st RESOLVED, \$119K for 2nd RESOLVED).

Received: 10/24/22

Sources

Google Search, Wikipedia and AMA data...also from Dr Yussef Galib-Frangie Fiol and the office of Member of Congress
Jenniffer Gonzalez-Colon.

References

Packet from the Congresswoman

JENNIFFER GONZALEZ-COLÓN
PUERTO RICO, AT LARGE

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Congress of the United States
House of Representatives
Washington, DC 20515-5400

COMMITTEES:
TRANSPORTATION & INFRASTRUCTURE

SUBCOMMITTEES
ECONOMIC DEVELOPMENT, PUBLIC BUILDINGS AND
EMERGENCY MANAGEMENT

WATER RESOURCES AND ENVIRONMENT
HIGHWAYS AND TRANSPORT

NATURAL RESOURCES

RANKING MEMBER FOR ISLAND AFFAIRS

SUBCOMMITTEES
WATER, OCEANS AND WILDLIFE

September 29, 2022

The Honorable Charles Schumer
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Speaker Pelosi, Minority Leader McCarthy, Majority Leader Schumer, and Minority Leader McConnell:

Hurricane Fiona made landfall in Puerto Rico on September 19, 2022, one day shy of the fifth anniversary of Hurricane Maria's landfall in Puerto Rico. During the 48 hours in which the rains associated with Hurricane Fiona battered the territorial extension of Puerto Rico, the approximate volume of Lake Pontchartrain fell upon soil already heavily saturated by the excessive rainfalls of the previous month. Hurricane Fiona was not Hurricane Maria, but to some extent, it was worse.

Puerto Rico suffered a complete blackout during the storm, also affecting the Island's water utility. After two days of around-the-clock efforts to restore power, only about 20% the Island's households got power back and about 55% had running water. Today, about 90% of the power has been restored, yet in some areas it is likely going to take months. While some of the flooding that occurred during Hurricane Maria reoccurred, many parts of Puerto Rico which had not suffered flooding during Maria were overrun with water. Bridges that were the only access to certain communities, rebuilt after Hurricane Maria, were again washed away. Other communities were left isolated by mudslides and transportation has been severely impaired by impassable roads and roads that no longer exist.

Federal agencies have quickly responded and are currently assessing the damages and determining how best to help. However, there are areas in which Congress, alone, can and must act; one of these areas is healthcare funding.

The precarious fiscal health of the Commonwealth of Puerto Rico is no secret. Although strides have been made in the past few years, the natural disasters that have struck Puerto Rico in the past 5 years—Hurricanes Irma and Maria in 2017, the 2019-20 earthquakes, the COVID-19 public health emergency—have maintained the government in a constant state of emergency. Federal assistance has been an invaluable component of the recovery process. However, the destruction caused by Hurricane Fiona will require the Government of Puerto Rico and its municipalities to incur in additional, unanticipated expenses.

In order to alleviate the financial burden on the Government of Puerto Rico and foster a healthy reconstruction process from the devastation caused by Hurricane Fiona, I ask Congress to temporarily increase the 1108 Medicaid allotment cap to \$5 billion for each of the next two fiscal years and, like it did in the aftermath of Hurricane Maria, to raise the federal medical assistance percentage (FMAP) for Puerto Rico's Medicaid program to 100%. I further ask support for an increase to the 1108 Medicaid allotment cap to \$21.5 billion and to raise the FMAP to 83% to provide for the federal funding required to finance Puerto Rico's Medicaid Program from FY25 to FY30. Having certainty in the future of our Medicaid program, that serves over 1.5 million Americans on the Island, will allow the Government of Puerto Rico to redirect the funds it currently uses to match the federal healthcare program to assist the reconstruction process. It will also allow the Puerto Rico Medicaid program to provide additional benefits which are crucial at this point, such as non-emergency transportation, adult vaccinations, diabetes supplies, and fairer rates to healthcare providers struggling to maintain their offices open in the face of this additional adversity.

I also ask Congress to provide additional funding for our 21 federal community health centers. Eighty-six percent of the patients served by community health centers in Puerto Rico have incomes below 100% of the federal poverty guidelines, as compared to 61% nationally. In addition, 67% of these patients are insured by Medicaid and CHIP, (as compared to 53%, nationally) which, because of the inherent deficiencies in our Medicaid funding, seriously restricts their sources of income. The number of patients served by these centers in the aftermath of Hurricane Maria increased almost 20% (in contrast to the 20% decrease experienced nationally during that same period), an increase is likewise expected in the economic and social conditions following Hurricane Fiona.¹

Finally, I ask Congress to provide additional funding for mental health screening, case management, and mobile crisis services for communities affected by Hurricane Fiona. Many of the residents of Puerto Rico are still dealing the psychological scars of Hurricane

¹ HEALTH RESOURCES & SERVICES ADMINISTRATION. *Puerto Rico Health Center Program Uniform Data System (UDS) Data Five-Year Summary*, available at <https://data.hrsa.gov/tools/data-reporting/program-data/state/PR>.

Maria and the recent earthquakes, and many feel like they just cannot find the heart to start anew again, after having lost everything only five years ago.

After Hurricane Maria, Congress made a great effort to stabilize Puerto Rico's healthcare system. That investment bore fruit and, today, Puerto Rico has a substantially more robust healthcare system that it had prior to 2017. I ask Congress, in this time of extraordinary need, to provide Puerto Rico with the tools to continue running a sustainable, stable Medicaid program which meets the needs of its most vulnerable populations and contributes to the well-being of the Island's healthcare system.

Thank you for your consideration of these requests.

Sincerely,

A handwritten signature in blue ink, appearing to read "Jenniffer González-Colón".

Jenniffer González-Colón
Member of Congress

Resident Committee
Yusuf Galis-Transil
Fidel



CONGRESSWOMAN JENNIFFER GONZÁLEZ-COLÓN

PUERTO RICO - AT LARGE

H.R. 1823: A BILL TO AMEND TITLE XIX OF THE SOCIAL SECURITY ACT TO REMOVE THE MATCHING REQUIREMENT FOR A TERRITORY TO USE SPECIALLY ALLOCATED FEDERAL FUNDS FOR MEDICARE-COVERED PART D DRUGS FOR LOW-INCOME INDIVIDUALS

The Enhanced Allotment Program (EAP) funds are provided to the territories to subsidize prescription drugs for the Medicare beneficiaries who participate in the territorial Medicaid program, *in lieu* of the low-income subsidy for which residents of Puerto Rico are ineligible.

FMAP does not apply to the low-income subsidy nor are States required to match funds for this program. However, to access the EAP funds, Puerto Rico is required to match federal dollars pursuant to the applicable Federal Matching Assistance Percentage which is set by statute at 55%.

This bill would remove the matching requirement for Puerto Rico to access these funds.



CONGRESSWOMAN JENNIFFER GONZÁLEZ-COLÓN

PUERTO RICO - AT LARGE

HR 1825: A BILL TO REMOVE THE MATCHING REQUIREMENT FOR MEDICARE PART D DRUGS

Medicare Part D is a voluntary outpatient prescription drug benefit for people with Medicare, provided through private plans approved by the federal government. Beneficiaries can choose to enroll in either a stand-alone prescription drug plan (PDP) to supplement traditional Medicare or a Medicare Advantage prescription drug plan (MA-PD), mainly HMOs and PPOs, that cover all Medicare benefits including drugs. In 2018, more than 43 million of the 60 million people with Medicare are enrolled in Part D plans.

Beneficiaries with low incomes and modest assets are eligible for assistance with Part D plan premiums and cost sharing. Through the Part D Low-Income Subsidy (LIS) program, additional premium and cost-sharing assistance is available for Part D enrollees with low incomes (less than 150% of poverty, or \$18,210 for individuals/\$24,690 for married couples in 2018) and modest assets (less than \$14,100 for individuals/\$28,150 for couples in 2018). While this assistance is available for Medicare beneficiaries in the States and in the District of Columbia, Medicare beneficiaries who reside in the territories are not eligible for the LIS.

In lieu of the LIS, the Social Security Act provides a fixed amount of funding to each territory to provide Medicaid coverage of prescription drugs for low-income Medicare beneficiaries. Before accessing the federal funds, each territory government is required to contribute, or "match", funds toward the payment of the Medicare Part D covered drugs. In the case of Puerto Rico, FMAP has been set by statute at 55%.¹

The territories (to varying degrees) have struggled to comply with the matching requirement and thus are not able to access the federal funding. Between Fiscal Year 2010 and Fiscal Year 2016, Puerto Rico has been able to draw down only about 51 percent of its available federal funding for prescription drugs for low-income Medicare beneficiaries.

H.R. 2172 amends title XIX of the Social Security Act to remove the matching requirement before a territory can access and draw down the territory's federal funds for Medicare Part D drugs. This bill is consistent with the recommendations made by the Congressional Task Force on Economic Growth in Puerto Rico.

¹ If Puerto Rico's FMAP were set using the formula used for the States, the FMAP would be 83%.



CONGRESSWOMAN JENNIFFER GONZÁLEZ-COLÓN

PUERTO RICO - AT LARGE

HR 1826: FAIRNESS IN MEDICARE PART B ENROLLMENT ACT

Medicare Part B provides coverage for physicians' services, outpatient hospital services, durable medical equipment, outpatient dialysis, and other medical services. Residents of every state and territory *other than Puerto Rico* who are receiving Social Security benefits are automatically enrolled in both Part A and Part B, with coverage beginning the first day of the month they turn 65.

Under federal law, when residents of Puerto Rico turn 65 and start receiving Social Security benefits, they are automatically enrolled in Part A, but not automatically enrolled in Part B. Instead, beneficiaries in Puerto Rico are required to take the affirmative step of enrolling in Part B during their seven-month initial enrollment period. If they fail to enroll, they are subject to a lifetime late-enrollment penalty of 10% for each 12-month period they were eligible but failed to enroll.

The lack of an automatic Part B enrollment process in Puerto Rico has resulted in a disproportionate number of Medicare beneficiaries in Puerto Rico paying the lifetime late-enrollment penalty. According to CMS, there are currently 35,940 Medicare beneficiaries in Puerto Rico who are paying lifetime penalties of \$18,832,722 a year for enrolling late in Part B. According to CMS, there are 202,931 individuals in Puerto Rico who are currently enrolled in Part A only, not Part B.¹ Many of those individuals, will be subject to a lifetime late-enrollment penalty if they do elect to enroll in Part B.

Data from the U.S. Census indicates that 43.1% of residents of Puerto Rico who are 60 years and over live below the poverty level.² Given that the U.S. Census determined the Poverty Threshold for 2019 for individuals 65 and over at \$12,261,³ the annual Part B premium of \$ 1,735.20—or 14% of the FPL—might be too costly for a large number of residents to pay.⁴ Thus, rather than propose the automatic enrollment in Part B of eligible Medicare beneficiaries in Puerto Rico, this bill maintains the automatic opt-out enrollment, but extends the period for Medicare beneficiaries in Puerto Rico to enroll in Medicare Part B, without penalty, to a total of five years. This extended period will allow beneficiaries to learn that, unlike the rest of the United States, they were not automatically enrolled in Part B and to determine if they can financially afford the cost of the Program.

¹ SOURCE: Medicare Premiums: Medicare Part B Premium Beneficiaries and Amounts, by Area of Residence, Calendar Year 2018. Available at <https://www.cms.gov/files/document/2018-mdcr-premiums-6.pdf>.

² SOURCE: U.S. Census Bureau, Puerto Rico QuickFacts. QuickFacts data are derived from: Population Estimates, American Community Survey, Census of Population and Housing, Current Population Survey, Small Area Health Insurance Estimates, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits. Available at <https://census.gov/quickfacts/PR>.

³ SOURCE: U.S. Census Bureau, Poverty Thresholds for 2019 by Size of Family and Number of Related Children Under 18 Years. Available at <https://www2.census.gov/programs-surveys/cps/tables/time-series/historical-poverty-thresholds/thresh19.xls>.

⁴ Residents of Puerto Rico are ineligible to receive assistance for paying their Medicare premiums through the four different Medicare Savings Programs (the QUALIFIED MEDICARE BENEFICIARY PROGRAM, the SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM, the QUALIFYING INDIVIDUAL PROGRAM, and the QUALIFIED DISABLED AND WORKING INDIVIDUAL PROGRAM).



CONGRESSWOMAN JENNIFFER GONZÁLEZ-COLÓN

PUERTO RICO - AT LARGE

H.R. 2217: TERRITORY FEDERAL MATCHING REQUIREMENT EQUITY ACT OF 2021

The federal government and the Government of Puerto Rico jointly finance Puerto Rico's Medicaid program. Puerto Rico must contribute its non-federal share of Medicaid spending to access federal dollars, which are matched at the designated federal medical assistance percentage (FMAP).

The FMAP for Puerto Rico and the territories is statutorily set at 55 percent, unlike that of the states that are set using a formula based on states' per capita incomes (§ 1905(b) of the Social Security Act). If the match rate were set using the same income-based formula used for states, it would be the maximum allowable at 83 percent.¹

This bill would remove the statutorily set FMAP for the territories.

¹ MACPAC. 2019. MEDICAID AND CHIP IN THE TERRITORIES. (March 2019b). Available at www.macpac.gov/wpcontent/uploads/2019/03/Medicaid-and-CHIP-in-the-Territories.pdf.

117TH CONGRESS
1ST SESSION

H. R. 1969

To amend title XVIII of the Social Security Act to address disparity in Medicare Advantage benchmark rates for regions with low Medicare fee-for-service penetration.

IN THE HOUSE OF REPRESENTATIVES

MARCH 17, 2021

Miss GONZÁLEZ-COLÓN introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

no response

A BILL

To amend title XVIII of the Social Security Act to address disparity in Medicare Advantage benchmark rates for regions with low Medicare fee-for-service penetration.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Advantage
5 Integrity Act”.

1 **SEC. 2. ADDRESSING DISPARITIES IN MEDICARE ADVAN-**
2 **TAGE BENCHMARK LEVELS BASED ON PENE-**
3 **TRATION.**

4 (a) IN GENERAL.—Section 1853(n) of the Social Se-
5 curity Act (42 U.S.C. 1395w-23(n)) is amended—

6 (1) in paragraph (1)(B), by striking “subse-
7 quent year” and inserting “subsequent year, subject
8 to paragraph (6),”; and

9 (2) by adding at the end the following new
10 paragraph:

11 “(6) AVERAGE GEOGRAPHIC ADJUSTMENT
12 FLOOR.—For 2022 and each subsequent year, when
13 calculating the adjusted average per capita cost
14 under section 1876(a)(4) for the purposes of estab-
15 lishing the base payment amount specified in para-
16 graph (2)(E), the average geographic adjustment
17 shall not be less than 0.70 for any area. For pur-
18 poses of the previous sentence, the Secretary may
19 define the term ‘average geographic adjustment’ by
20 program instruction or otherwise.”.

21 (b) ENSURING PLAN PAYMENTS FLOW TO PRO-
22 VIDERS.—Section 1857(e) of the Social Security Act (42
23 U.S.C. 1395w-27(e)) is amended by adding at the end
24 the following new paragraph:

25 “(6) STRENGTHENING SUPPORT TO HEALTH
26 CARE PROVIDERS.—A contract under this section

1 with an MA organization shall require that, with re-
2 spect to any increase in blended benchmark amount
3 attributable to section 1853(n)(6), the plan shall
4 provide that no less than 50 percent of such increase
5 is directed toward provider compensation.”.

○

117TH CONGRESS
2D SESSION

H. R. 7997

To amend title XVIII of the Social Security Act to establish a floor in Medicare Advantage benchmark rates for regions with low Medicare fee-for-service penetration and to make the Medicare Savings Program available in all jurisdictions.

IN THE HOUSE OF REPRESENTATIVES

JUNE 9, 2022

Miss GONZÁLEZ-COLÓN (for herself, Mr. SOTO, Ms. VELÁZQUEZ, Ms. SALAZAR, Mr. CRIST, Mr. FITZPATRICK, Mr. BACON, Mr. ESPAILLAT, and Mrs. RADEWAGEN) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

g w 9 pers

A BILL

To amend title XVIII of the Social Security Act to establish a floor in Medicare Advantage benchmark rates for regions with low Medicare fee-for-service penetration and to make the Medicare Savings Program available in all jurisdictions.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Achieving Equity in
5 the Treatment of Dual Eligible Beneficiaries Act”.

1 **SEC. 2. ADDRESSING DISPARITIES IN MEDICARE ADVAN-**
2 **TAGE BENCHMARK LEVELS BASED ON PENE-**
3 **TRATION.**

4 (a) IN GENERAL.—Section 1853(n) of the Social Se-
5 curity Act (42 U.S.C. 1395w–23(n)) is amended—

6 (1) in paragraph (1)(B), by striking “subse-
7 quent year” and inserting “subsequent year, subject
8 to paragraph (6),”; and

9 (2) by adding at the end the following new
10 paragraph:

11 “(6) AVERAGE GEOGRAPHIC ADJUSTMENT
12 FLOOR.—For 2024 and subsequent years, when cal-
13 culating the adjusted average per capita cost under
14 section 1876(a)(4) for the purposes of establishing
15 the base payment amount specified in paragraph
16 (2)(E), the average geographic adjustment shall not
17 be less than 0.70 for any area. For the purposes of
18 the previous sentence, the Secretary may define the
19 term ‘average geographic adjustment’ under sub-
20 paragraph (A) by program instruction or other-
21 wise.”.

22 (b) ENSURING PLAN PAYMENTS FLOW TO PRO-
23 VIDERS AND PATIENTS.—Section 1854(a)(6) of the Social
24 Security Act (42 U.S.C. 1395w–24(a)(6)) is amended by
25 adding at the end the following new subparagraph:

1 “(C) ENSURING INCREASED PAYMENTS
2 SUPPORT CARE.—With respect to the increase
3 in blended benchmark amount attributable to
4 the application of section 1853(n)(6), no less
5 than 50 percent shall be directed toward pay-
6 ment for basic benefits as defined in section
7 1852(a)(1)(B).”.

8 **SEC. 3. EXPANDING THE MEDICARE SAVINGS PROGRAM TO**
9 **THE TERRITORIES.**

10 Section 1905(p)(4) of the Social Security Act (42
11 U.S.C. 1396d(p)(4)) is amended by inserting “for fiscal
12 years through 2022” after “Columbia”).

○

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: Late 1002
(I-22)

Introduced by: American Association of Public Health Physicians

Subject: AMA Declares its Support for Turkish Physicians Imprisoned in Turkey in Violation of their Human and Professional Rights

Referred to: Reference Committee F

Whereas, Our American Medical Association has long declared its support for “physicians who have been subject to imprisonment or torture because of their humanitarian efforts to improve the health of their patients,” (H-65.991); and

Whereas, Our AMA policy concerning healthcare in “countries in turmoil...urges appropriate organizations to transmit these concerns to the affected country's government; and asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries,” (H-65.994); and

Whereas, Dr. Şebnem Korur Fincancı, President of the Turkish Medical Association (TMA) is in detention since 26 October 2022, after she called for an independent investigation into allegations that Turkish armed forces might have used chemical weapons in Kurdistan Region of Iraq¹; and

Whereas, The Ankara Prosecutor General's Office has initiated legal proceedings to dismiss the Council Members of the Turkish Medical Association, for their actions or statements in favour of “*terrorist organisations*”¹; therefore be it

RESOLVED, That our American Medical Association reaffirm Resolution H-65.991, “Persecution of Physicians for Political Reasons and Participation by Doctors in Violations of Human Rights”, and H-65.994, “Medical Care in Countries in Turmoil” (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA recommend to its Delegation to the World Medical Association (WMA) to offer AMA's assistance to the WMA with efforts to free unjustly imprisoned health professionals and to preserve the independence of the Turkish Medical Association (Directive to Take Action); and be it further

RESOLVED, That the President of the AMA write to the U.S. Secretary of State to express AMA's concerns and to ask the Secretary to intervene in support of these Turkish health professionals and the independence of the Turkish Medical Association. (Directive to Take Action).

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

Received: 11/10/22

REFERENCES:

From: **World Medical Association** <communications@wma.net>

Date: Fri, Nov 4, 2022 at 12:17 PM

Subject: Support to Şebnem Korur Fincancı and to the Turkish Medical Association



Dear colleagues,

With this mail, I would like to give a short update of the latest developments regarding the grave threats against the Turkish Medical Association and its members:

- Prof Şebnem Korur Fincancı, President of the Turkish Medical Association (TMA) is in detention since 26 October 2022, after she called for an independent investigation into allegations that Turkish armed forces might have used chemical weapons in Kurdistan Region of Iraq during a live TV interview in Germany on 19 October 2022. The Ankara 3rd Criminal Court ordered her arrest on charges of “*propaganda for a terrorist organisation*.” The date of the Court hearing, to confirm or not her indictment, is not yet known.
- In parallel, on 30 October, the Ankara Prosecutor General's Office has initiated legal proceedings to dismiss the Council Members of the Turkish Medical Association, for their actions or statements in favour of “*terrorist organisations*”.

We are in close contact with TMA, waiting for their guidance on the best way to act in support of Sebnem and TMA. The global health and human rights community (Physicians for Human Rights-PHR, Amnesty International, CPME, IRCT and others) is mobilized. Yesterday PHR organized an online meeting with the participation of TMA and their lawyer to coordinate our advocacy work. One of the actions agreed was to disseminate the information widely and to raise the issue with decision-makers to put pressure on the Turkish government.

We would therefore appreciate if you could contact the authorities of your country: (1) to inform them about the detention of Sebnem and threats against TMA, and (2) to ask them to intervene with the Turkish authorities to put an end to the oppression against the medical profession in the country. To that end, feel free to use the following [model letter](#) or part of it.

I would be grateful if you could keep me informed of any actions taken on your side.

Thank you very much in advance and kind regards,

Clarisse Delorme

World Medical Association

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RELEVANT AMA POLICY

Persecution of Physicians for Political Reasons and Participation by Doctors in Violations of Human Rights H-65.991

The AMA (1) reiterates its endorsement of the 1975 World Medical Association Declaration of Tokyo which provides guidelines for physicians in cases of torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment; (2) opposes participation by physicians in the torture or inhuman treatment or punishment of individuals in relation to detention and imprisonment; and (3) expresses its sympathy to those physicians who have been subject to imprisonment or torture because of their humanitarian efforts to improve the health of their patients.

Citation: (Res. 91, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15)

Medical Care in Countries in Turmoil H-65.994

The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

Citation: (Sub. Res. 133, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05; Reaffirmed: CEJA Rep. 5, A-15)

REFERRAL CHANGES AND OTHER REVISIONS

2022 Interim Meeting

WITHDRAWN RESOLUTIONS

- Resolution 013 – Hospital Bans on Trial of Labor After Cesarean (Medical Student Section)
- Resolution 209 – Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training (Resident and Fellow Section)
- Resolution 920 - Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings (Medical Student Section)

RESOLUTIONS WITH ADDITIONAL SPONSORS*

- Resolution 007 - Consent for Sexual and Reproductive Healthcare (International Medical Graduates Section, American Psychiatric Association, American Academy of Psychiatry and the Law, American Association for Geriatric Psychiatry)
- Resolution 008 - Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era (Colorado, Arizona)
- Resolution 313 - Request a Two-Year Delay in ACCME Changes to State Medical Society Recognition Program (Oklahoma, Arizona, District of Columbia, Hawaii, Iowa, Kansas, Kentucky, Maine, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Utah, Virginia, Alabama, Illinois)
- Resolution 819 - Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA (American College of Preventive Medicine, American Association of Public Health Physicians, American College of Surgeons)
- Resolution 820 - Third-Party Pharmacy Benefit Administrators (American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, American Academy of Neurology, American Academy of Ophthalmology, American College of Gastroenterology, American Society of Hematology, Association for Clinical Oncology, North American Neuro-Ophthalmology Society, American Gastroenterological Association, American Contact Dermatitis Society, American Society of Dermatopathology, Florida, Iowa, Arizona, Utah, American Society for Dermatologic Surgery, American College of Mohs Surgery)
- Resolution 911 - Critical Need for National Emergency Cardiac Care (ECC) System to Ensure Individualized, State-Wide, Care for ST Segment Elevation Myocardial Infarction (STEMI), Cardiogenic Shock (CS) and Out-of-Hospital Cardiac Arrest (OHCA), and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies (Society for Cardiovascular Angiography & Interventions, Georgia)

* Additional sponsors underlined.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Supplementary Report of Committee on Rules and Credentials (I-22)

Presented by: Marilyn K. Laughead, MD, Chair

Sunday, November 13, 2022

1 Mister Speaker, Members of the House of Delegates:

2
3 (1) LATE RESOLUTION(S)
4

5 The Committee on Rules and Credentials met Saturday, November 12, to discuss Late Resolutions
6 1001 and 1002. The sponsor of the late resolutions met with the committee to consider late
7 resolutions and was given the opportunity to present for the committee's consideration the reason
8 the resolution could not be submitted in a timely fashion and the urgency of consideration by the
9 House of Delegates at this meeting.

10
11 Recommended for acceptance:

- 12
13 • Late 1001 - Urgent AMA Assistance to Puerto Rico and Florida and a Long-Range Project
14 for Puerto Rico
15 • Late 1002 – AMA Declares Its Support for Turkish Physicians Imprisoned in Turkey in
16 Violation of the Human and Professional Rights
17

18 (2) REAFFIRMATION RESOLUTIONS
19

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

- 29 • Resolution 007 – Consent for Sexual and Reproductive Healthcare
30 • Resolution 009 – Medical Decision-Making Autonomy of the Attending Physician
31 • Resolution 201 – Physician Reimbursement for Interpreter Services
32 • Resolution 202 – Advocating for State GME Funding
33 • Resolution 206 – The Shortage of Bedside Nurses and Intersection with Concerns in Nurse
34 Practitioner Training
35 • Resolution 207 – Preserving Physician Leadership in Patient Care
36 • Resolution 217 – Restrictions on the Ownership of Hospitals by Physicians
37 • Resolution 218 – Screening and Approval Process for the Over-the-Counter Sale of
38 Substances with Potential for Recreational Use and Abuse
39 • Resolution 220 – Extend Telemedicine to Out of State Enrolled College Students to Avoid
40 Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis
41 • Resolution 223 – Criminalization of Pregnancy Loss as the Result of Cancer Treatment
42 • Resolution 224 – Fertility Preservation
43 • Resolution 304 – Protecting State Medical Licensing Boards from External Political Influence
44 • Resolution 314 – Balancing Supply and Demand for Physicians by 2030

- 1 • Resolution 315 – Bedside Nursing and Health Care Staff Shortages
- 2 • Resolution 801 – Parity in Military Reproductive Health Insurance Coverage for All Service
- 3 Members and Veterans
- 4 • Resolution 803 – Patient Centered Medical Home – Administrative Burdens
- 5 • Resolution 804 – Centers for Medicare & Medicaid Innovation Projects
- 6 • Resolution 806 – Healthcare Marketplace Plan Selection
- 7 • Resolution 807 – Medicare Advantage Record Requests
- 8 • Resolution 808 – Reinstatement of Consultation Codes
- 9 • Resolution 810 – Medicare Drug Pricing and Pharmacy Costs
- 10 • Resolution 811 – Covering Vaccinations for Seniors through Medicare Part B
- 11 • Resolution 813 – Amending Policy on a Public Option to Maximize AMA Advocacy
- 12 • Resolution 814 – Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
- 13 • Resolution 815 – Opposition to Medical Debt Litigation Against Patients
- 14 • Resolution 821 – PrEP is an Essential Health Benefit
- 15 • Resolution 822 – Monitoring of Alternative Payment Models withing Traditional Medicare
- 16 • Resolution 823 – Health Insurers and Collection of Co-Pays and Deductibles
- 17 • Resolution 824 – Enabling and Enhancing the Delivery of Continuity of Care when Physicians
- 18 Deliver Care Across Diverse Problem Sets
- 19 • Resolution 908 – Older Adults and the 988 Suicide and Crisis Lifeline
- 20 • Resolution 917 – Care for Children with Obesity
- 21 • Resolution 919 – Decreasing Youth Access to E-cigarettes
- 22 • Resolution 922 – Firearm Safety and Technology
- 23 • Resolution 923 – Physician Education and Intervention to Improve Patient Firearm Safety
- 24 • Resolution 924 – Domestic Production of Personal Protective Equipment
- 25 • Resolution 927 – Off-Label Policy
- 26 • Resolution 933 – Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis
- 27 (PrEP) for HIV

Mister Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials. I would like to thank Jerry P. Abraham, MD, Mark N. Bair, MD, Cheryl Hurd, MD, Niva Lubin-Johnson, MD, Chand Rohatgi, MD, and Whitney Stuard; and on behalf of the committee those who appeared before the committee.

Jerry P. Abraham, MD
California

Chand Rohatgi, MD
American Association of Physicians of
Indian Origin

Mark N. Bair, MD
Utah

Whitney Stuard*
Texas

Cheryl Hurd, MD
American Psychiatric Association

Marilyn K. Laughead, MD, Chair
American Institute of Ultrasound in
Medicine

Niva Lubin-Johnson, MD
Illinois

* Alternate Delegate

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

Resolution 007 – Consent for Sexual and Reproductive Healthcare

- Confidential Healthcare for Minors 2.2.2
- Mandatory Parental Consent to Abortion 2.2.3
- In addition, at the A-22 meeting, “Resolution 621 - Establishing a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care is Banned or Restricted” was adopted and created a taskforce to preserve the patient-physician relationship against bans or restrictions of abortion and other evidence-based care. This task force responds to third part of Resolution 007’s resolved clause which asks for: “protecting physician autonomy to provide sexual and reproductive health care with minor consent, without parental consent.”

Resolution 009 – Medical Decision-Making Autonomy of the Attending Physician

- Government Interference in Patient Counseling H-373.995
- AMA Response to Hospital Governing Bodies in Challenging Medical Staff Self-Governance H-235.983
- Freedom of Communication Between Physicians and Patients H-5.989
- Ethics Guidance for Physicians in Non-Clinical Roles 10.1
- Ethical Obligations of Medical Directors 10.1.1
- Physician Employment by a Nonphysician Supervisee 10.2
- Professionalism in Healthcare Systems 11.2.1

Resolution 201 – Physician Reimbursement for Interpreter Services

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

Resolution 202 – Advocating for State GME Funding

- The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

Resolution 206 – The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training

- Physician Assistants and Nurse Practitioners H-160.947
- Status and Utilization of New or Expanding Health Professionals in Hospitals H-35.996

Resolution 207 – Preserving Physician Leadership in Patient Care

- Protection of the Titles "Doctor," "Resident" and "Residency" H-275.925
- Definition and Use of the Term Physician H-405.951
- Definition of a Physician H-405.969

Resolution 217 – Restrictions on the Ownership of Hospitals by Physicians

- Hospital Consolidation H-215.960

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Resolution 218 – Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse

- Addressing Emerging Trends in Illicit Drug Use H-95.940

Resolution 220 – Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis

- Licensure and Telehealth D-480.960

Resolution 223 – Criminalization of Pregnancy Loss as the Result of Cancer Treatment

- Preserving Access to Reproductive Health Services D-5.999
- Freedom of Communication Between Physicians and Patients H-5.989
- Right to Privacy in Termination of Pregnancy H-5.993
- The Criminalization of Health Care Decision Making H-160.946

Resolution 224 – Fertility Preservation

- Infertility and Fertility Preservation Insurance Coverage H-185.990
- Preserving Access to Reproductive Health Services D-5.999
- The Criminalization of Health Care Decision Making H-160.946

Resolution 304 – Protecting State Medical Licensing Boards from External Political Influence

- Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914

Resolution 314 – Balancing Supply and Demand for Physicians by 2030

- US Physician Shortage H-200.954
- Revisions to AMA Policy on the Physician Workforce H-200.955
- Primary Care Physicians in Underserved Areas H-200.972
- Educational Strategies for Meeting Rural Health Physician Shortage H-465.988
- Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958

Resolution 315 – Bedside Nursing and Health Care Staff Shortages

- The Growing Nursing Shortage in the United States D-360.998

Resolution 801 – Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans

- Reproductive Health Insurance Coverage H-185.926
- Support for Access to Preventive and Reproductive Health Services H-425.969
- Infertility Benefits for Veterans H-510.984
- Infertility and Fertility Preservation Insurance Coverage H-185.990
- Right for Gamete Preservation Therapies H-65.956
- Right for Gamete Preservation Therapies H-185.922
- Preserving Access to Reproductive Health Services D-5.999
- Recognition of Infertility as a Disease H-420.952

Resolution 803 – Patient Centered Medical Home – Administrative Burdens

- Physician Burnout D-405.972

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Resolution 804 – Centers for Medicare & Medicaid Innovation Projects

- CMMI Payment Reform Models D-385.950
- Demonstration Project Regarding Medicare Part D H-330.894

Resolution 806 – Healthcare Marketplace Plan Selection

- Health Insurance Exchange Authority and Operation H-165.839
- Sale of Health Insurance Across State Lines H-180.946
- Network Adequacy H-285.908

Resolution 807 – Medicare Advantage Record Requests

- Limiting Access to Medical Records H-315.987

Resolution 808 – Reinstatement of Consultation Codes

- Consultation Codes and Private Payers D-385.955
- Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953
- Medicare Reimbursement of Telephone Consultations H-390.889
- Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917

Resolution 810 – Medicare Drug Pricing and Pharmacy Costs

- Prescription Drug Prices and Medicare D-330.954
- Pharmaceutical Costs H-110.987
- Inappropriate Extension of Patent Life of Pharmaceuticals D-110.994
- Patient Protection from Forced Switching of Patent-Protected Drugs H-125.978
- Direct-to-Consumer Advertising (DCTA) of Prescription Drugs and Implantable Devices H-105.988

Resolution 811 – Covering Vaccinations for Seniors through Medicare Part B

- Appropriate Reimbursements and Carve-outs for Vaccines D-440.981
- Medicare Prescription Drug and Vaccine Coverage and Payment D-330.898
- Reimbursement for Influenza Vaccine H-440.848
- Financing of Adult Vaccines: Recommendations for Action H-440.860
- Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875
- Appropriate Payments for Vaccine Price Increases D-385.960

Resolution 813 – Amending Policy on a Public Option to Maximize AMA Advocacy

- Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

Resolution 814 – Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?

- Preventive Services H-425.997
- Health Insurance Market Regulation H-165.856

Resolution 815 – Opposition to Medical Debt Litigation Against Patients

- Physician Review of Accounts Sent for Collection H-385.963

Resolution 821 – PrEP is an Essential Health Benefit

- Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
- Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act H-185.925
- Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act D-185.981

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

Resolution 822 – Monitoring of Alternative Payment Models within Traditional Medicare

- Accountable Care Organization Principles H-160.915
- Due Diligence for Physicians and Practices Joining an ACO with Risk Based Models (Up Side and Down Side Risk) D-385.953
- Health Care Reform Physician Payment Models D-385.963
- Urge AMA to Release a White Paper on ACOs D-160.923

Resolution 823 - Health Insurers and Collection of Co-Pays and Deductibles

- Remuneration for Physician Services H-385.951
- Health Plan Payment of Patient Cost-Sharing D-180.979
- Update on HSAs, HRAs, and other Consumer-Driven Health Care Plans H-165.849

Resolution 824 – Enabling and Enhancing the Delivery of Continuity of Care when Physicians Deliver Care Across Diverse Problem Sets

- Uses and Abuses of CPT Modifier-25 D-70.971
- Opposition to Reduced Payment for the 25 Modifier D-385.956

Resolution 908 - Older Adults and the 988 Suicide and Crisis Lifeline

- Awareness Campaign for 988 National Suicide Prevention Lifeline D-345.974

Resolution 917 - Care for Children with Obesity

- Addressing Obesity D-440.954
- Obesity as a Major Public Health Problem H-150.953

Resolution 919 - Decreasing Youth Access to E-cigarettes

- FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973
- Legal Action to Compel FDA to Regulate E-Cigarettes D-495.992
- Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

Resolution 922 - Firearm Safety and Technology

- Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
- Ban on Handguns and Automatic Repeating Weapons H-145.985

Resolution 923 – Physician Education and Intervention to Improve Patient Firearm Safety

- Prevention of Firearm Accidents in Children H-145.990
- Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976

Resolution 924 - Domestic Production of Personal Protective Equipment

- Pandemic Preparedness H-440.847

Resolution 927 - Off-Label Policy

- Patient Access to Treatments Prescribed by Their Physicians H-120.988

Resolution 933 – Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

- Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895
- HIV/AIDS Education and Training H-20.904

SUMMARY OF FISCAL NOTES (I-22)

BOT Report(s)

- 01 Opposition to Requirements for Gender-Based Treatments for Athletes: Minimal
- 02 Further Action to Respond to the Gun Violence Public Health Crisis: None
- 03 Delegate Apportionment and Pending Members: Minimal
- 04 Preserving Access to Reproductive Health Services: Minimal
- 05 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA: Within current budget
- 06 Informal Inter-Member Mentoring: Informational report
- 07 Transparency of Resolution Fiscal Notes: None
- 08 The Resolution Committee as a Standing Committee of the House: Within current budget
- 09 Employed Physicians: Modest
- 10 Redefining the AMA's Position on ACA and Healthcare Reform: Informational report
- 11 2022 AMA Advocacy Efforts: Informational report
- 12 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment: Minimal
- 13# Structural Urbanism and the Impact on Rural Workforce Disparities: Informational Report
- 14# Specialty Society Representation in the House of Delegates - Five-Year Review: Minimal

CC&B Report(s)

- 01 Updated Bylaws: Delegate Apportionment and Pending Members: Minimal

CEJA Opinion(s)

- 01 Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment": Informational report

CEJA Report(s)

- 01 Amendment to Opinion 4.2.7, "Abortion": Minimal
- 02 Amendment to Opinion 10.8, "Collaborative Care": Minimal
- 03 Pandemic Ethics and the Duty of Care: Minimal
- 04 Research Handling of De-Identified Patient Information: Informational report

CLRPD Report(s)

- 01 Senior Physicians Section Five-Year Review: Within current budget

CME Report(s)

- 01 The Impact of Private Equity on Medical Training: Minimal
- 02 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process: Minimal

CMS Report(s)

- 01 Incentives to Encourage Efficient Use of Emergency Departments: Minimal
- 02 Corporate Practice of Medicine: Minimal
- 03 Health System Consolidation: Informational report

CSAPH Report(s)

- 01 Drug Shortages: 2022 Update: Minimal
- 02 Climate Change and Human Health: Minimal

SUMMARY OF FISCAL NOTES (I-22)

HOD Comm on Compensation of the Officers

01 Report of the HOD Committee on Compensation of the Officers: none

Report of the Speakers

01 Election Committee - Interim Report: Up to \$5,000 annually

Resolution(s)

- 002 Assessing the Humanitarian Impact of Sanctions: Modest
- 003 Indigenous Data Sovereignty: Minimal
- 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants: Modest
- 006 Assessing the Humanitarian Impact of Sanctions: Modest
- 007 Consent for Sexual and Reproductive Healthcare: Modest
- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era: Estimated cost of \$58,000 for staff costs and for work with external legal counsel to develop strategies and guidance to assist affected physicians.
- 009* Medical Decision-Making Autonomy of the Attending Physician: Minimal
- 011* Advocating for the Informed Consent for Access to Transgender Health Care: Modest
- 012* Guidelines on Chaperones for Sensitive Exams: Modest
- 013* WITHDRAWN: n/a
- 015* Restricting Derogatory and Stigmatizing Language of ICD-10 Codes: Minimal
- 016# Increasing Female Representation in Oncology Clinical Trials: Minimal
- 017# Supervision of Non-Physician Providers by Physicians: Modest
- 201 Physician Reimbursement for Interpreter Services: Modest
- 202 Advocating for State GME Funding: Modest
- 203 International Medical Graduate Employment: Minimal
- 205 Waiver of Due Process Clauses: Minimal
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training: Estimated cost of \$50,000 includes staffing and professional fees.
- 207 Preserving Physician Leadership in Patient Care: Estimated cost of \$255K for a national targeted ad campaign includes professional fees and staffing.
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals: Estimated cost to implement resolution is \$306K. Primary expense is for contracting externally to conduct research.
- 209 WITHDRAWN: n/a
- 211 Illicit Drug Use Harm Reduction Strategies: Minimal
- 213 Hazard Pay During a Disaster Emergency: Modest
- 214 Universal Good Samaritan Statute: Modest
- 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies: Modest
- 216* Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare: Minimal
- 217* Restrictions on the Ownership of Hospitals by Physicians: Modest
- 218* Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse: Estimated costs of \$25M includes hire advertising agency to develop creative and media strategy; develop and launch ama-assn.org campaign, landing page(s) and core content pages, launch and integrate media plan with AMA owned channels, measure, analyze,
- 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: Minimal
- 220* Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis: Modest
- 222* Allocate Opioid Funds to Train More Addiction Treatment Physicians: Minimal

SUMMARY OF FISCAL NOTES (I-22)

Resolution(s)

- 223* Criminalization of Pregnancy Loss as the Result of Cancer Treatment: Modest
- 224* Fertility Preservation: Modest
- 227* Access to Methotrexate Based on Clinical Decisions: Modest
- 228# Requirements for Physician Self-reporting of Outpatient Mental Health Services, Treatments or Medications to Credentialing Agencies and Insurers: Modest
- 229# Coverage and Reimbursement for Abortion Services: Modest
- 230# Increased Health Privacy on Mobile Apps in Light of Roe v. Wade: Modest
- 231# Expanding Support for Access to Abortion Care: Modest
- 232# Obtaining Professional Recognition for Medical Service Professionals: Modest
- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth: Minimal
- 303 Medical Student Leave Policy: Minimal
- 304 Protecting State Medical Licensing Boards from External Political Influence: Modest
- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups: Minimal
- 306 Increased Credit for Continuing Medical Education Preparation: Modest
- 307 Fair Compensation of Residents and Fellows: Modest
- 308 Paid Family/Medical Leave in Medicine: Minimal
- 309 Bereavement Leave for Medical Students and Physicians: Minimal
- 310* Enforce AMA Principles on Continuing Board Certification: Modest
- 311* Supporting a Hybrid Residency and Fellowship Interview Process: Modest
- 313* Request a Two-Year Delay in ACCME Changes to State Medical Society Recognition Program: Modest
- 314* Balancing Supply and Demand for Physicians by 2030: Modest
- 315* Bedside Nursing and Health Care Staff Shortages: Modest
- 316# Recognizing Specialty Certification for Physicians: Modest
- 317# Support for GME Training in Reproductive Services: Minimal
- 601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity: Estimated cost of \$415,000 to clarify sections of SP to be rewritten, rewrite, engage stakeholders, redo layout and design, production and printing, includes staffing, travel/meetings, and professional staff.
- 602 Finding Cities for Future AMA Conventions/Meetings: Minimal
- 606* Patient-Centered Health Equity Strategic Plan and Sustainable Funding: Modest
- 607* Accountability for Election Rules Violations: Minimal
- 801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans: Minimal
- 802 FAIR Health Database: Modest
- 803 Patient Centered Medical Home – Administrative Burdens: Modest
- 804 Centers for Medicare & Medicaid Innovation Projects: Modest
- 805 COVID Vaccine Administration Fee: Minimal
- 806 Healthcare Marketplace Plan Selection: Modest
- 807 Medicare Advantage Record Requests: Modest
- 808 Reinstatement of Consultation Codes: Modest
- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations: Modest
- 810 Medicare Drug Pricing and Pharmacy Costs: Modest
- 811 Covering Vaccinations for Seniors Through Medicare Part B: Modest
- 812 Implant-Associated Anaplastic Large Cell Lymphoma: Minimal

SUMMARY OF FISCAL NOTES (I-22)

Resolution(s)

- 813 Amending Policy on a Public Option to Maximize AMA Advocacy: Minimal
- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?: Modest
- 815* Opposition to Debt Litigation Against Patients: Minimal
- 816* Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes: Modest
- 817* Promoting Oral Anticancer Drug Parity: Minimal
- 818* Pediatric Obesity Treatment Insurance Coverage: Modest
- 819* Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA: Modest
- 820* Third-Party Pharmacy Benefit Administrators: Modest
- 821# PrEP is an Essential Health Benefit: Minimal
- 822# Monitoring of Alternative Payment Models Within Traditional Medicare: Major-\$25,000 includes educational materials
- 823# Health Insurers and Collection of Co-pays and Deductibles: Modest
- 824# Enabling and Enhancing the Delivery of Continuity of Care When Physicians Deliver Care Across Diverse Problem Sets: Modest
- 826# Leveling the Playing Field: Modest
- 902 Reducing the Burden of Incarceration on Public Health: Modest
- 904 Immigration Status is a Public Health Issue: Moderate
- 905 Minimal Age of Juvenile Justice Jurisdiction in the United States: Modest
- 906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized: Minimal
- 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury: Est @ \$5M includes staffing, travel & meetings (\$500K), promotion (\$750K), printing, production, additional staffing (\$1M) and prof service firm (\$2.5M) to conduct IDIs/Focus groups and summarize findings, facilitate convening national public forums
- 908 Older Adults and the 988 Suicide and Crisis Timeline: Modest
- 909 Decreasing Gun Violence and Suicide in Seniors: Est @ \$500K includes publication costs, professional fees, printing, production, promotion, and staffing
- 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use: Minimal
- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies: Minimal
- 912* Reevaluating the Food and Drug Administration's Citizen Petition Process: Modest
- 913* Supporting and Funding Sobering Centers: Minimal
- 915* Pulse Oximetry in Patients with Pigmented Skin: Modest
- 916* Non-Cervical HPV Associated Cancer Prevention: Minimal
- 917* Care for Children with Obesity: Modest
- 918* Opposition to Alcohol Industry Marketing Self-Regulation: Minimal
- 919* Decreasing Youth Access to E-cigarettes: Minimal
- 920* WITHDRAWN: n/a
- 921* Firearm Injury and Death Research and Prevention: Modest
- 922* Firearm Safety and Technology: Modest
- 923* Physician Education and Intervention to Improve Patient Firearm Safety: Moderate
- 924* Domestic Production of Personal Protective Equipment: Minimal
- 926* Limit the Pornography Viewing by Minors Over the Internet: Minimal
- 927* Off-Label Policy: Minimal
- 928* Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements: Minimal

SUMMARY OF FISCAL NOTES (I-22)

Resolution(s)

- 929* Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations: Modest
- 930* Addressing Longitudinal Health Care Needs of Children in Foster Care: Modest
- 931* Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs: Modest
- 933* Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV: Minimal
- 935* Government Manufacturing of Generic Drugs to Address Market Failures: Modest
- 936* Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room: Modest
- 937# Indications for Metabolic and Bariatric Surgery: Modest
- 938# AMA study of efficacy of requirements for metal detection/weapons interdiction systems in health care facilities: Modest

Resolutions not for consideration

- 001 Updating Physician Job Description for Disability Insurance: Modest
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave: Minimal
- 010* Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates: Bylaws amendment minimal, ensuring steps up to \$10K depending on implementation
- 014* Gender-Neutral Language in AMA Policy: Modest
- 204 Elimination of Seasonal Time Change: Modest
- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time: Minimal
- 212 SNAP Expansion for DACA Recipients: Modest
- 221* Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses: Minimal
- 225* Drug Policy Reform: Modest
- 226* Support for Mental Health Courts: Minimal
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education: Minimal
- 312* Reporting of Residency Demographic Data: Minimal
- 603 AMA House of Delegates Resolution Process Review: Minimal
- 604 Solicitation Using the AMA Brand: Minimal
- 605* Decreasing Political Advantage Within AMA Elections: Minimal
- 608* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development: Modest
- 825# Minimal Sustainable Reimbursement for Community Practices: Modest
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies: Minimal
- 903 Supporting Further Study of Kratom: Minimal
- 914* Greenhouse Gas Emissions from Health Care: Modest
- 925* Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA: Minimal
- 932* Increase Employment Services Funding for People with Disabilities: Minimal
- 934* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Modest
- 939# Mattress Safety in the Hospital Setting: Modest

SUMMARY OF FISCAL NOTES (I-22)

Minimal - less than \$1,000

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

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

*** Contained in the Handbook Addendum**

Contained in the Sunday Tote

**ORDER OF BUSINESS
SECOND SESSION**

**Sunday, November 13, 2022
8:00 AM**

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

2. Report of the Rules and Credentials Committee - Marilyn K. Laughead, MD, Chair

3. Presentation, Correction and Adoption of Minutes of the June 2022 Annual Meeting

4. Acceptance of Business

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

- 01 Opposition to Requirements for Gender-Based Treatments for Athletes (Amendments to C&B)
- 02 Further Action to Respond to the Gun Violence Public Health Crisis (F)
- 03 Delegate Apportionment and Pending Members (Amendments to C&B)
- 04 Preserving Access to Reproductive Health Services (Amendments to C&B)
- 05 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA (Amendments to C&B)
- 06 Informal Inter-Member Mentoring (Info. Report)
- 07 Transparency of Resolution Fiscal Notes (F)
- 08 The Resolution Committee as a Standing Committee of the House (F)
- 09 Employed Physicians (F)
- 10 Redefining the AMA's Position on ACA and Healthcare Reform (Info. Report)
- 11 2022 AMA Advocacy Efforts (Info. Report)
- 12 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment (Amendments to C&B)
- 13# Structural Urbanism and the Impact on Rural Workforce Disparities (Info. Report)
- 14# Specialty Society Representation in the House of Delegates - Five-Year Review (Amendments to C&B)

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

- 01 Updated Bylaws: Delegate Apportionment and Pending Members (Amendments to C&B)

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

- 01 Amendment to Opinion 4.2.7, "Abortion" (Amendments to C&B)
- 02 Amendment to Opinion 10.8, "Collaborative Care" (Amendments to C&B)
- 03 Pandemic Ethics and the Duty of Care (Amendments to C&B)
- 04 Research Handling of De-Identified Patient Information (Info. Report)

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

- 01 Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment" (Info. Report)

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

- 01 Senior Physicians Section Five-Year Review (F)

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

- 01 The Impact of Private Equity on Medical Training (C)
- 02 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process (C)

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

- 01 Incentives to Encourage Efficient Use of Emergency Departments (J)
- 02 Corporate Practice of Medicine (J)
- 03 Health System Consolidation (Info. Report)

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

- 01 Drug Shortages: 2022 Update (K)
- 02 Climate Change and Human Health (K)

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

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

Report(s) of the Speakers - Bruce A. Scott, MD, Speaker; Lisa Bohman Egbert, MD, Vice Speaker

01 Election Committee - Interim Report (F)

--EXTRACTION OF INFORMATIONAL REPORTS--

Resolutions

- 002 Assessing the Humanitarian Impact of Sanctions (Amendments to C&B)
- 003 Indigenous Data Sovereignty (Amendments to C&B)
- 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants (Amendments to C&B)
- 006 Assessing the Humanitarian Impact of Sanctions (Amendments to C&B)
- 007 Consent for Sexual and Reproductive Healthcare (Amendments to C&B)
- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era (Amendments to C&B)
- 009* Medical Decision-Making Autonomy of the Attending Physician (Amendments to C&B)
- 011* Advocating for the Informed Consent for Access to Transgender Health Care (Amendments to C&B)
- 012* Guidelines on Chaperones for Sensitive Exams (Amendments to C&B)
- 013* WITHDRAWN (Amendments to C&B)
- 015* Restricting Derogatory and Stigmatizing Language of ICD-10 Codes (Amendments to C&B)
- 016# Increasing Female Representation in Oncology Clinical Trials (Amendments to C&B)
- 017# Supervision of Non-Physician Providers by Physicians (Amendments to C&B)
- 201 Physician Reimbursement for Interpreter Services (B)
- 202 Advocating for State GME Funding (B)
- 203 International Medical Graduate Employment (B)
- 205 Waiver of Due Process Clauses (B)
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training (B)
- 207 Preserving Physician Leadership in Patient Care (B)
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals (B)
- 209 WITHDRAWN (B)
- 211 Illicit Drug Use Harm Reduction Strategies (B)
- 213 Hazard Pay During a Disaster Emergency (B)
- 214 Universal Good Samaritan Statute (B)
- 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies (B)
- 216* Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare (B)
- 217* Restrictions on the Ownership of Hospitals by Physicians (B)
- 218* Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse (B)
- 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 (B)
- 220* Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis (B)
- 222* Allocate Opioid Funds to Train More Addiction Treatment Physicians (B)
- 223* Criminalization of Pregnancy Loss as the Result of Cancer Treatment (B)
- 224* Fertility Preservation (B)
- 227* Access to Methotrexate Based on Clinical Decisions (B)
- 228# Requirements for Physician Self-reporting of Outpatient Mental Health Services, Treatments or Medications to Credentialing Agencies and Insurers (B)
- 229# Coverage and Reimbursement for Abortion Services (B)
- 230# Increased Health Privacy on Mobile Apps in Light of Roe v. Wade (B)
- 231# Expanding Support for Access to Abortion Care (B)
- 232# Obtaining Professional Recognition for Medical Service Professionals (B)

302 Expanding Employee Leave to Include Miscarriage and Stillbirth (C)
303 Medical Student Leave Policy (C)
304 Protecting State Medical Licensing Boards from External Political Influence (C)
305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups (C)
306 Increased Credit for Continuing Medical Education Preparation (C)
307 Fair Compensation of Residents and Fellows (C)
308 Paid Family/Medical Leave in Medicine (C)
309 Bereavement Leave for Medical Students and Physicians (C)
310* Enforce AMA Principles on Continuing Board Certification (C)
311* Supporting a Hybrid Residency and Fellowship Interview Process (C)
313* Request a Two-Year Delay in ACCME Changes to State Medical Society Recognition Program (C)
314* Balancing Supply and Demand for Physicians by 2030 (C)
315* Bedside Nursing and Health Care Staff Shortages (C)
316# Recognizing Specialty Certification for Physicians (C)
317# Support for GME Training in Reproductive Services (C)
601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity (F)
602 Finding Cities for Future AMA Conventions/Meetings (F)
606* Patient-Centered Health Equity Strategic Plan and Sustainable Funding (F)
607* Accountability for Election Rules Violations (F)
801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans (J)
802 FAIR Health Database (J)
803 Patient Centered Medical Home – Administrative Burdens (J)
804 Centers for Medicare & Medicaid Innovation Projects (J)
805 COVID Vaccine Administration Fee (J)
806 Healthcare Marketplace Plan Selection (J)
807 Medicare Advantage Record Requests (J)
808 Reinstatement of Consultation Codes (J)
809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations (J)
810 Medicare Drug Pricing and Pharmacy Costs (J)
811 Covering Vaccinations for Seniors Through Medicare Part B (J)
812 Implant-Associated Anaplastic Large Cell Lymphoma (J)
813 Amending Policy on a Public Option to Maximize AMA Advocacy (J)
814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored? (J)
815* Opposition to Debt Litigation Against Patients (J)
816* Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes (J)
817* Promoting Oral Anticancer Drug Parity (J)
818* Pediatric Obesity Treatment Insurance Coverage (J)
819* Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA (J)
820* Third-Party Pharmacy Benefit Administrators (J)
821# PrEP is an Essential Health Benefit (J)
822# Monitoring of Alternative Payment Models Within Traditional Medicare (J)
823# Health Insurers and Collection of Co-pays and Deductibles (J)
824# Enabling and Enhancing the Delivery of Continuity of Care When Physicians Deliver Care Across Diverse Problem Sets (J)
826# Leveling the Playing Field (J)
902 Reducing the Burden of Incarceration on Public Health (K)
904 Immigration Status is a Public Health Issue (K)
905 Minimal Age of Juvenile Justice Jurisdiction in the United States (K)
906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized (K)
907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury (K)

- 908 Older Adults and the 988 Suicide and Crisis Timeline (K)
- 909 Decreasing Gun Violence and Suicide in Seniors (K)
- 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use (K)
- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies (K)
- 912* Reevaluating the Food and Drug Administration's Citizen Petition Process (K)
- 913* Supporting and Funding Sobering Centers (K)
- 915* Pulse Oximetry in Patients with Pigmented Skin (K)
- 916* Non-Cervical HPV Associated Cancer Prevention (K)
- 917* Care for Children with Obesity (K)
- 918* Opposition to Alcohol Industry Marketing Self-Regulation (K)
- 919* Decreasing Youth Access to E-cigarettes (K)
- 920* WITHDRAWN (K)
- 921* Firearm Injury and Death Research and Prevention (K)
- 922* Firearm Safety and Technology (K)
- 923* Physician Education and Intervention to Improve Patient Firearm Safety (K)
- 924* Domestic Production of Personal Protective Equipment (K)
- 926* Limit the Pornography Viewing by Minors Over the Internet (K)
- 927* Off-Label Policy (K)
- 928* Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements (K)
- 929* Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations (K)
- 930* Addressing Longitudinal Health Care Needs of Children in Foster Care (K)
- 931* Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs (K)
- 933* Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV (K)
- 935* Government Manufacturing of Generic Drugs to Address Market Failures (K)
- 936* Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room (K)
- 937# Indications for Metabolic and Bariatric Surgery (K)
- 938# AMA study of efficacy of requirements for metal detection/weapons interdiction systems in health care facilities (K)

Presentation of Recommendations for Items of Business to Not be Considered at Interim Meeting

- 001 Updating Physician Job Description for Disability Insurance (Not for consideration)
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave (Not for consideration)
- 010* Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates (Not for consideration)
- 014* Gender-Neutral Language in AMA Policy (Not for consideration)
- 204 Elimination of Seasonal Time Change (Not for consideration)
- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time (Not for consideration)
- 212 SNAP Expansion for DACA Recipients (Not for consideration)
- 221* Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses (Not for consideration)
- 225* Drug Policy Reform (Not for consideration)
- 226* Support for Mental Health Courts (Not for consideration)
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education (Not for consideration)
- 312* Reporting of Residency Demographic Data (Not for consideration)
- 603 AMA House of Delegates Resolution Process Review (Not for consideration)
- 604 Solicitation Using the AMA Brand (Not for consideration)
- 605* Decreasing Political Advantage Within AMA Elections (Not for consideration)
- 608* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development (Not for consideration)
- 825# Minimal Sustainable Reimbursement for Community Practices (Not for consideration)
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies (Not for consideration)

- 903 Supporting Further Study of Kratom (Not for consideration)
914* Greenhouse Gas Emissions from Health Care (Not for consideration)
925* Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA (Not for consideration)
932* Increase Employment Services Funding for People with Disabilities (Not for consideration)
934* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers (Not for consideration)
939# Mattress Safety in the Hospital Setting (Not for consideration)

--Memorial Resolutions--

**5. Report of the Committee on Rules and Credentials - Marilyn K. Laughead, MD,
Chair**

- Late Resolutions

- Proposed Reaffirmations

6. Unfinished Business and Announcements

contained in the Handbook Addendum

** contained in the Sunday Tote*

ORDER OF BUSINESS

Reference Committee on Amendments to Constitution and Bylaws (I-22)
Susan Hubbell, MD, Chair

Sunday, November 13, 2022
8:30am – 1:30pm, 313A/B (Convention Center – 3rd floor)
[Zoom Meeting Link](#) (view only)

1. Board of Trustees Report 01 - Opposition to Requirements for Gender-Based Treatments for Athletes
2. Board of Trustees Report 03 - Delegate Apportionment and Pending Members
3. Board of Trustees Report 04 - Preserving Access to Reproductive Health Services
4. Board of Trustees Report 05 - Towards Diversity and Inclusion: A Global Non-discrimination Policy Statement and Benchmark for our AMA
5. Board of Trustees Report 12 - Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment
6. Board of Trustees Report 14 - Specialty Society Representation in the House of Delegates - Five-Year Review
7. Council on Constitution and Bylaws Report 1 - Updated Bylaws: Delegate Apportionment and Pending Members
8. Council on Ethical and Judicial Affairs Report 1 - Amendment to Opinion 4.2.7, "Abortion"
9. Council on Ethical and Judicial Affairs Report 2 - Amendment to Opinion 10.8, "Collaborative Care"
10. Council on Ethical and Judicial Affairs Report 3 - Pandemic Ethics and the Duty of Care
11. *Resolution 001 – Updating Physician Job Description for Disability Insurance*
12. Resolution 002 - Assessing the Humanitarian Impact of Sanctions and Resolution 006 – Assessing the Humanitarian Impact of Sanctions

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

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

13. Resolution 003 – Indigenous Data Sovereignty
14. *Resolution 004 - Supporting Intimate Partner and Sexual Violence Safe Leave*
15. Resolution 005 - Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants
16. *Resolution 007 - Consent for Sexual and Reproductive Healthcare*
17. Resolution 008 - Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era
18. *Resolution 009 - Medical Decision-Making Autonomy of the Attending Physician*
19. *Resolution 010 - Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates*
20. Resolution 011 - Advocating for the Informed Consent for Access to Transgender Health Care
21. Resolution 012 - Guidelines on Chaperones for Sensitive Exams
22. Resolution 013 - Hospital Bans on Trial of Labor After Cesarean
23. *Resolution 014 - Gender-Neutral Language in AMA Policy*
24. Resolution 015 - Restricting Derogatory and Stigmatizing Language of ICD-10 Codes
25. Resolution 016 - Increasing Female Representation in Oncology Clinical Trials
26. Resolution 017 - Supervision of Non-Physician Providers by Physicians

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

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

ORDER OF BUSINESS

Reference Committee B (Interim 2022 Meeting)
Hillary Johnson-Jahangir, MD, PhD, Chair

November 13, 2022
8:30 am HST

Zoom Link:

<https://zoom.us/j/99849760505>

1. Resolution 206 – The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training
2. 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
3. Resolution 207 – Preserving Physician Leadership in Patient Care
4. Resolution 220 – Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis
5. Resolution 232 - Obtaining Professional Recognition for Medical Service Professionals
6. Resolution 215 – Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies
7. Resolution 222 – Allocate Opioid Funds to Train More Addiction Treatment Physicians
8. Resolution 202 – Advocating for State GME Funding
9. Resolution 208 – Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v Other Health Professionals
10. Resolution 203 – International Medical Graduate Employment
11. Resolution 201 – Physician Reimbursement for Interpreter Services
12. Resolution 214 – Universal Good Samaritan Statute
13. Resolution 217 – Restriction on the Ownership of Hospitals by Physicians
14. Resolution 213 – Hazard Pay During a Disaster Emergency
15. Resolution 205 – Waiver of Due Process Clauses
16. Resolution 223 – Criminalization of Pregnancy Loss as the Result of Cancer Treatment
17. Resolution 224 – Fertility Preservation
18. Resolution 227 – Access to Methotrexate Based on Clinical Decisions
19. Resolution 229 - Coverage and Reimbursement for Abortion Services
- Resolution 231 - Expanding Support for Access to Abortion Care
20. Resolution 230 - Increased Health Privacy on Mobile Acts in Light of Roe v. Wade
21. Resolution 216 – Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare
22. Resolution 218 – Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse
23. Resolution 211 – Illicit Drug Use Harm Reduction Strategies

Note: During the reference committee hearing, supplemental material may be sent to alexis.pierce@ama-assn.org. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Forum or orally to the committee.

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

24. *Resolution 221 – Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses*
25. *Resolution 225 – Drug Policy Reform*
26. *Resolution 226 – Support for Mental Health Courts*
27. *Resolution 228 - Requirements for Physician Self-reporting of Outpatient Mental Health Services, Treatments or Medications to Credentialing Agencies and Insurers*
28. *Resolution 212 – SNAP Expansion for DACA Recipients*
29. *Resolution 204 – Elimination of Seasonal Time Change*
Resolution 210 – Elimination of Seasonal Time Change and Establishment of Permanent Standard Time
30. *Late Resolution 1001 - Urgent AMA Assistance to Puerto Rico and Florida and a Long-Range Project for Puerto Rico*

Note: During the reference committee hearing, supplemental material may be sent to alexis.pierce@ama-assn.org. Supplemental material includes items that have been referenced in testimony such as alternative wording, proposed amendments, and supporting documents. This email address is NOT intended as a means to provide testimony, which should be only be presented in on the Online Forum or orally to the committee.

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

ORDER OF BUSINESS

Reference Committee C, 2022 Interim Meeting
Ramin Manshadi, MD, Chair

Sunday, November 13, 2022
8:30 a.m. – 1:30 pm Hawaii time

Convention Center, Room 311
[Zoom link](#) (view only)

1. Council on Medical Education Report 1 – The Impact of Private Equity on Medical Training
2. Resolution 307 – Fair Compensation of Residents and Fellows
3. Resolution 311 – Supporting a Hybrid Residency and Fellowship Interview Process
4. *Resolution 312 - Reporting of Residency Demographic Data*
5. Resolution 302 – Expanding Employee Leave to Include Miscarriage and Stillbirth
6. Resolution 303 – Medical Student Leave Policy
7. Resolution 308 – Paid Family/Medical Leave in Medicine
8. Resolution 309 – Bereavement Leave for Medical Students and Physicians
9. Council on Medical Education Report 2 – Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process
10. Resolution 305 – Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups
11. Resolution 310 – Enforce AMA Principles on Continuing Board Certification
12. Resolution 316 – Recognizing Specialty Certifications for Physicians
13. *Resolution 304 – Protecting State Medical Licensing Boards from External Political Influence*
14. Resolution 306 – Increased Credit for Continuing Medical Education Preparation
15. Resolution 313 – Request a two-year delay in ACCME Changes to State Medical Society Recognition Program
16. *Resolution 314 – Balancing Supply and Demand for Physicians by 2030*
17. *Resolution 315 – Bedside Nursing and Health Care Staff Shortages*
18. Resolution 317 - Support for GME Training in Reproductive Services
19. *Resolution 301 - Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education Through Inclusion of Osteopathic Manual Therapy Education*

- Items in *italics* were placed on Not For Consideration list or the Reaffirmation Consent Calendar. The Chair will address these items at the start of the hearing.
- Amendments and supplemental material for Reference Committee C must be sent to meded@ama-assn.org.
- Link to [business](#) documents (e.g., Preliminary Document, Handbook and Addendum).
- For technical assistance, email HODMeetingSupport@ama-assn.org or call 800-337-1599.

ORDER OF BUSINESS

Reference Committee F (I-22)
Cheryl Gibson Fountain, MD, Chair

November 13, 2022
Kalakaua Ballroom

Hawaii Convention Center
Honolulu

PUBLIC HEALTH

1. Board of Trustees Report 2 – Further Action to Respond to the Gun Violence Public Health Crisis

GOVERNANCE

2. Board of Trustees Report 9 – Employed Physicians
3. CLRPD Report 01 – Senior Physicians Section Five-Year Review
4. Resolution 601 – AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity
5. Resolution 606 – Patient-Centered Health Equity Strategic Plan and Sustainable Funding
6. *Resolution 604 – Solicitation Using the AMA Brand*
7. *Resolution 608 – Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development*

FINANCIAL

8. Report of the House of Delegates Committee on the Compensation of the Officers

HOUSE OF DELEGATES

9. Board of Trustees Report 7 – Transparency of Resolution Fiscal Notes
10. Board of Trustees Report 8 – The Resolution Committee as a Standing Committee of the House
11. Resolution 602 – Finding Cities for Future AMA Conventions/Meetings
12. *Resolution 603 – AMA House of Delegates Resolution Process Review*
13. Speakers Report 1 – Election Committee–Interim Report

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

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

14. *Resolution 605 – Decreasing Political Advantage Within AMA Elections*

15. Resolution 607 – Accountability for Election Rules Violations

INTERNATIONAL RELATIONS

16. *Late Resolution 1003 – AMA Declares its Support for Turkish Physicians Imprisoned in Turkey in Violation of their Human and Professional Rights*

ORDER OF BUSINESS

Reference Committee J (I-22)
Brigitta J. Robinson, MD, Chair

November 13, 2022
Room 316 A-C

Hawai'i Convention Center
Honolulu, HI

1. Council on Medical Service Report 01 – Incentives to Encourage Efficient Use of Emergency Departments
2. Council on Medical Service Report 02 – Corporate Practice of Medicine
3. *Resolution 801 – Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans*
4. Resolution 802 – FAIR Health Database
5. *Resolution 803 – Patient Centered Medical Home – Administrative Burdens*
6. *Resolution 804 – Centers for Medicare & Medicaid Innovation Projects*
7. Resolution 805 – COVID Vaccine Administration Fee
8. *Resolution 806 – Healthcare Marketplace Plan Selection*
9. *Resolution 807 – Medicare Advantage Record Requests*
10. *Resolution 808 – Reinstatement of Consultation Codes*
11. Resolution 809 – Uniformity and Enforcement of Medicare Advantage Plans and Regulations
12. *Resolution 810 – Medicare Drug Pricing and Pharmacy Costs*
13. *Resolution 811 – Covering Vaccinations for Seniors through Medicare Part B*
14. Resolution 812 – Implant-Associated Anaplastic Large Cell Lymphoma
15. *Resolution 813 – Amending Policy on a Public Option to Maximize AMA Advocacy*
16. *Resolution 814 – Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?*

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

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

A Zoom webinar link is provided here <https://zoom.us/j/94662717063>. This link is view-only. Testimony cannot be accepted via Zoom.

17. *Resolution 815 – Opposition to Debt Litigation Against Patients*
18. Resolution 816 – Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes
19. Resolution 817 – Promoting Oral Anticancer Drug Parity
20. Resolution 818 – Pediatric Obesity Treatment Insurance Coverage
21. Resolution 819 – Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA
22. Resolution 820 – Third-Party Pharmacy Benefit Administrators
23. *Resolution 821 – PrEP is an Essential Health Benefit*
24. *Resolution 822 – Monitoring of Alternative Payment Models within Traditional Medicare*
25. *Resolution 823 – Health Insurers and Collection of Co-Pays and Deductibles*
26. *Resolution 824 – Enabling and Enhancing the Delivery of Continuity of Care When Physicians Deliver Care Across Diverse Problem Sets*
27. *Resolution 825 – Minimal Sustainable Reimbursement for Community Practices*
28. Resolution 826 – Leveling the Playing Field

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ORDER OF BUSINESS

Reference Committee K (November 2022 Meeting)

Robert H. Emmick, Jr., MD, Chair

November 13, 2022

Room 323 A-C

8:30 am – 1:30 pm Local Time (GMT -10)

Zoom link below (view only)

1. Council on Science and Public Health Report 1 – Drug Shortages: 2022 Update
2. Council on Science and Public Health Report 2 – Climate Change and Human Health
3. *Resolution 914 – Greenhouse Gas Emissions from Health Care#*
4. Resolution 936 – Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
5. *Resolution 925 – Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA#*
6. *Resolution 933 – Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV**
7. *Resolution 939 – Mattress Safety in the Hospital Setting#*
8. Resolution 916 – Non-Cervical HPV Associated Cancer Prevention
9. Resolution 906 – Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized
10. *Resolution 917 – Care for Children with Obesity**
11. Resolution 937 – Indications for Metabolic and Bariatric Surgery
12. Resolution 915 – Pulse Oximetry in Patients with Pigmented Skin
13. Resolution 911 – Critical Need for National Emergency Cardiac Care (ECC) System to Ensure Individualized, State-Wide, Care for ST Segment Elevation Myocardial Infarction (STEMI), Cardiogenic Shock (CS) and Out-of-Hospital Cardiac Arrest (OHCA), and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies
14. Resolution 910 – Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use
15. Resolution 931 – Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs
16. Resolution 904 – Immigration Status Is a Public Health Issue
17. *Resolution 932 – Increase Employment Services Funding for People with Disabilities#*
18. Resolution 930 – Addressing Longitudinal Health Care Needs of Children in Foster Care
19. Resolution 926 – Limit the Pornography Viewing by Minors Over the Internet
20. *Resolution 919 – Decreasing Youth Access to E-cigarettes**
21. Resolution 918 – Opposition to Alcohol Industry Marketing Self-Regulation

Items in *italics* were placed on the Reaffirmation Consent Calendar or placed under “not for consideration.” The asterisk (*) denotes items on the Reaffirmation Consent Calendar and the pound (#) indicates items placed under “not for consideration.” At the beginning of this hearing, the chair will identify those items that were not extracted and therefore will not be discussed in this hearing.

Zoom link to hearing (view only webinar) <https://zoom.us/j/99879306143>

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22. Resolution 913 – Supporting and Funding Sobering Centers
23. Resolution 928 – Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements
24. *Resolution 903 – Supporting Further Study of Kratom#*
25. *Resolution 927 – Off-Label Policy**
26. Resolution 935 – Government Manufacturing of Generic Drugs to Address Market Failures
27. Resolution 912 – Reevaluating the Food and Drug Administration's Citizen Petition Process
28. *Resolution 924 – Domestic Production of Personal Protective Equipment**
29. *Resolution 908 – Older Adults and the 988 Suicide and Crisis Lifeline**
30. Resolution 909 – Decreasing Gun Violence and Suicide in Seniors
31. *Resolution 922 – Firearm Safety and Technology**
32. *Resolution 923 – Physician Education and Intervention to Improve Patient Firearm Safety**
33. Resolution 938 – AMA Study of Efficacy of Requirements for Metal Detection/Weapons Interdiction Systems in Health Care Facilities
34. Resolution 921 – Firearm Injury and Death Research and Prevention
35. Resolution 907 – A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury
36. *Resolution 901 – Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies#*
37. *Resolution 934 – Denouncing the use of Solitary Confinement in Correctional Facilities and Detention Centers#*
38. Resolution 902 – Reducing the Burden of Incarceration on Public Health
39. Resolution 905 - Minimal Age of Juvenile Justice Jurisdiction in the United States
40. Resolution 929 – Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations

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Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 01 Opposition to Requirements for Gender-Based Treatments for Athletes
- 03 Delegate Apportionment and Pending Members
- 04 Preserving Access to Reproductive Health Services
- 05 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA
- 12 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment
- 14# Specialty Society Representation in the House of Delegates - Five-Year Review

CC&B Report(s)

- 01 Updated Bylaws: Delegate Apportionment and Pending Members

CEJA Report(s)

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

Resolution(s)

- 002 Assessing the Humanitarian Impact of Sanctions
- 003 Indigenous Data Sovereignty
- 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants
- 006 Assessing the Humanitarian Impact of Sanctions
- 007 Consent for Sexual and Reproductive Healthcare
- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era
- 009* Medical Decision-Making Autonomy of the Attending Physician
- 011* Advocating for the Informed Consent for Access to Transgender Health Care
- 012* Guidelines on Chaperones for Sensitive Exams
- 013* WITHDRAWN
- 015* Restricting Derogatory and Stigmatizing Language of ICD-10 Codes
- 016# Increasing Female Representation in Oncology Clinical Trials
- 017# Supervision of Non-Physician Providers by Physicians

* Contained in the Handbook Addendum

Contained in the Sunday Tote

Reference Committee B

Resolution(s)

- 201 Physician Reimbursement for Interpreter Services
- 202 Advocating for State GME Funding
- 203 International Medical Graduate Employment
- 205 Waiver of Due Process Clauses
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training
- 207 Preserving Physician Leadership in Patient Care
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals
- 209 WITHDRAWN
- 211 Illicit Drug Use Harm Reduction Strategies
- 213 Hazard Pay During a Disaster Emergency
- 214 Universal Good Samaritan Statute
- 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies
- 216* Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare
- 217* Restrictions on the Ownership of Hospitals by Physicians
- 218* Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse
- 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
- 220* Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis
- 222* Allocate Opioid Funds to Train More Addiction Treatment Physicians
- 223* Criminalization of Pregnancy Loss as the Result of Cancer Treatment
- 224* Fertility Preservation
- 227* Access to Methotrexate Based on Clinical Decisions
- 228# Requirements for Physician Self-reporting of Outpatient Mental Health Services, Treatments or Medications to Credentialing Agencies and Insurers
- 229# Coverage and Reimbursement for Abortion Services
- 230# Increased Health Privacy on Mobile Apps in Light of Roe v. Wade
- 231# Expanding Support for Access to Abortion Care
- 232# Obtaining Professional Recognition for Medical Service Professionals

* Contained in the Handbook Addendum

Contained in the Sunday Tote

Reference Committee C

CME Report(s)

- 01 The Impact of Private Equity on Medical Training
- 02 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

Resolution(s)

- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth
- 303 Medical Student Leave Policy
- 304 Protecting State Medical Licensing Boards from External Political Influence
- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups
- 306 Increased Credit for Continuing Medical Education Preparation
- 307 Fair Compensation of Residents and Fellows
- 308 Paid Family/Medical Leave in Medicine
- 309 Bereavement Leave for Medical Students and Physicians
- 310* Enforce AMA Principles on Continuing Board Certification
- 311* Supporting a Hybrid Residency and Fellowship Interview Process
- 313* Request a Two-Year Delay in ACCME Changes to State Medical Society Recognition Program
- 314* Balancing Supply and Demand for Physicians by 2030
- 315* Bedside Nursing and Health Care Staff Shortages
- 316# Recognizing Specialty Certification for Physicians
- 317# Support for GME Training in Reproductive Services

* Contained in the Handbook Addendum

Contained in the Sunday Tote

Reference Committee F

BOT Report(s)

- 02 Further Action to Respond to the Gun Violence Public Health Crisis
- 07 Transparency of Resolution Fiscal Notes
- 08 The Resolution Committee as a Standing Committee of the House
- 09 Employed Physicians

CLRPD Report(s)

- 01 Senior Physicians Section Five-Year Review

HOD Comm on Compensation of the Officers

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

Report of the Speakers

- 01 Election Committee - Interim Report

Resolution(s)

- 601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity
- 602 Finding Cities for Future AMA Conventions/Meetings
- 606* Patient-Centered Health Equity Strategic Plan and Sustainable Funding
- 607* Accountability for Election Rules Violations

* Contained in the Handbook Addendum

Contained in the Sunday Tote

Reference Committee J

CMS Report(s)

- 01 Incentives to Encourage Efficient Use of Emergency Departments
- 02 Corporate Practice of Medicine

Resolution(s)

- 801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans
- 802 FAIR Health Database
- 803 Patient Centered Medical Home – Administrative Burdens
- 804 Centers for Medicare & Medicaid Innovation Projects
- 805 COVID Vaccine Administration Fee
- 806 Healthcare Marketplace Plan Selection
- 807 Medicare Advantage Record Requests
- 808 Reinstatement of Consultation Codes
- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations
- 810 Medicare Drug Pricing and Pharmacy Costs
- 811 Covering Vaccinations for Seniors Through Medicare Part B
- 812 Implant-Associated Anaplastic Large Cell Lymphoma
- 813 Amending Policy on a Public Option to Maximize AMA Advocacy
- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
- 815* Opposition to Debt Litigation Against Patients
- 816* Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes
- 817* Promoting Oral Anticancer Drug Parity
- 818* Pediatric Obesity Treatment Insurance Coverage
- 819* Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA
- 820* Third-Party Pharmacy Benefit Administrators
- 821# PrEP is an Essential Health Benefit
- 822# Monitoring of Alternative Payment Models Within Traditional Medicare
- 823# Health Insurers and Collection of Co-pays and Deductibles
- 824# Enabling and Enhancing the Delivery of Continuity of Care When Physicians Deliver Care Across Diverse Problem Sets
- 826# Leveling the Playing Field

* Contained in the Handbook Addendum

Contained in the Sunday Tote

Reference Committee K

CSAPH Report(s)

- 01 Drug Shortages: 2022 Update
- 02 Climate Change and Human Health

Resolution(s)

- 902 Reducing the Burden of Incarceration on Public Health
- 904 Immigration Status is a Public Health Issue
- 905 Minimal Age of Juvenile Justice Jurisdiction in the United States
- 906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized
- 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury
- 908 Older Adults and the 988 Suicide and Crisis Timeline
- 909 Decreasing Gun Violence and Suicide in Seniors
- 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use
- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies
- 912* Reevaluating the Food and Drug Administration's Citizen Petition Process
- 913* Supporting and Funding Sobering Centers
- 915* Pulse Oximetry in Patients with Pigmented Skin
- 916* Non-Cervical HPV Associated Cancer Prevention
- 917* Care for Children with Obesity
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- 921* Firearm Injury and Death Research and Prevention
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- 923* Physician Education and Intervention to Improve Patient Firearm Safety
- 924* Domestic Production of Personal Protective Equipment
- 926* Limit the Pornography Viewing by Minors Over the Internet
- 927* Off-Label Policy
- 928* Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements
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- 930* Addressing Longitudinal Health Care Needs of Children in Foster Care
- 931* Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs
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- 935* Government Manufacturing of Generic Drugs to Address Market Failures
- 936* Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room
- 937# Indications for Metabolic and Bariatric Surgery
- 938# AMA study of efficacy of requirements for metal detection/weapons interdiction systems in health care facilities

* Contained in the Handbook Addendum

Contained in the Sunday Tote

Not for consideration

Resolutions not for consideration

- 001 Updating Physician Job Description for Disability Insurance
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave
- 010* Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates
- 014* Gender-Neutral Language in AMA Policy
- 204 Elimination of Seasonal Time Change
- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time
- 212 SNAP Expansion for DACA Recipients
- 221* Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
- 225* Drug Policy Reform
- 226* Support for Mental Health Courts
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
- 312* Reporting of Residency Demographic Data
- 603 AMA House of Delegates Resolution Process Review
- 604 Solicitation Using the AMA Brand
- 605* Decreasing Political Advantage Within AMA Elections
- 608* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
- 825# Minimal Sustainable Reimbursement for Community Practices
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
- 903 Supporting Further Study of Kratom
- 914* Greenhouse Gas Emissions from Health Care
- 925* Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA
- 932* Increase Employment Services Funding for People with Disabilities
- 934* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 939# Mattress Safety in the Hospital Setting

* Contained in the Handbook Addendum

Contained in the Sunday Tote

Informational Reports

BOT Report(s)

- 06 Informal Inter-Member Mentoring
- 10 Redefining the AMA's Position on ACA and Healthcare Reform
- 11 2022 AMA Advocacy Efforts
- 13# Structural Urbanism and the Impact on Rural Workforce Disparities

CEJA Opinion(s)

- 01 Amendment to E-9.3.2, “Physician Responsibilities to Colleagues with Illness, Disability or Impairment”

CEJA Report(s)

- 04 Research Handling of De-Identified Patient Information

CMS Report(s)

- 03 Health System Consolidation

* Contained in the Handbook Addendum

Contained in the Sunday Tote

Report of the AMPAC Board of Directors

Presented by: Stephen A. Imbeau, MD
 Chair

On behalf of the AMPAC Board of Directors, I am pleased to present this report to the House of Delegates regarding our activities this election cycle. As the nation continues to recover from the recent COVID-19 pandemic and its effects on health care delivery, our mission remains important as ever, to provide physicians with opportunities to support candidates for federal office who have demonstrated their willingness to work with physicians to strengthen our ability to care for America's patients. In addition, we remain committed to help physician advocates grow their abilities through our political education programs, which include intensive training sessions that provide them with all the tools necessary to successfully take the next step and work on campaigns or run for office themselves.

AMPAC Membership Fundraising

Thank you to the House of Delegate members who gave to AMPAC in 2022, especially those who contributed at the Capitol Club levels. AMPAC fundraising is emerging from the pandemic years with numbers trending in the right direction, with an increase in participation and overall totals. During this midterm election year AMPAC's upward fundraising trend could not be timelier in helping us achieve adequate support for champions and allies of medicine running for federal office.

Thus far AMPAC has raised a combined total of \$1,659,738 in hard and corporate funds for the 2022 election cycle. AMPAC's Capitol Club has 729 members to date, which is up from the prior two years. AMPAC also established a special Election Investor level this year where members contributed \$222 in 2022 and there were 240 members who invested at this level. Currently, HOD State delegation AMPAC participation stands at 68 percent compared to 2021 where the House ended with a 52 percent participation rate.

Due to the logistical challenges of having a speaker in Hawaii, AMPAC is not hosting a Capitol Club luncheon during this meeting. Although AMPAC is not having an official event, all 2022 Capitol Club members should be sure to stop by the AMPAC booth to pick up a special Capitol Club gift. The AMPAC booth is located right outside the House of Delegates meeting room in the Convention Center and will be open for business on Saturday through Tuesday. Of note, AMPAC is accepting contributions for the 2023 membership year.

Finally, as we close the door to 2022, this is a reminder that the next election cycle has already begun. We are only as effective as we are united in our advocacy efforts, and we look forward to the support of our House of Delegate members as we set out to engage in a successful 2023.

Political Action (as of 11/9/22)

In an increasingly toxic political environment, AMPAC once again made an indelible mark on behalf of medicine investing more than \$1.3 million in the 2022 cycle. The job was made more difficult by candidates on the extreme ideological fringe of both parties seemingly more intent on partisan conflict rather than seeking solutions to serious policy challenges. But AMPAC navigated this landscape well with help from the AMA's government affairs team as well as input from state medical society PACs to guide the Board towards those candidates who will work to advance medicine's agenda. This pragmatic strategy paid off by creating access to key decision makers and giving the AMA the ability to shape and ultimately affect the outcome of legislation in critical areas including telehealth, Medicare physician payment and prior authorization.

With close to 60 House and Senate contests still to be determined, the final outcome of the 2022 midterms remains murky. What is clear as of now however, is that neither party was provided a clear mandate and that the

American people will expect bipartisan cooperation from their leaders in Washington, DC to solve the challenges that face our country. This should be a good legislative environment for medicine and one where solutions-oriented candidates backed by AMPAC thrive.

AMPAC's direct contributions to 247 physician-friendly House and Senate candidates from both political parties (62% to Democratic lawmakers and 38% to Republican lawmakers) will continue to ensure that medicine has a place at the table when important health care policy debates take place. Of those races that have been decided, a total of 196 AMPAC supported candidates won election/reelection. The number of physicians in Congress will at least stay at 17 due to Rich McCormick, MD, and his victory in Georgia's sixth district. Currently, there are four other races involving physician candidates that have yet to be called. One is the incumbent in Washington State's eighth district, pediatrician Kim Schrier, MD. Two physician challengers in California and one in Colorado are also waiting for the final vote to be tallied. Once all results are in, the total number of physicians in Congress will be between 17 and 21.

Political Education Programs

After two years of conducting the political education programs virtually, AMPAC is proud to announce that on September 29 – October 2, the 2022 Campaign School was held in-person at the AMA offices in Washington, DC. Physicians, residents, medical students, and physician spouses from across the country participated in the three-day training program. With a hands-on approach our team of veteran campaign trainers walked them through a simulated Congressional campaign, teaching each of them everything they need to know to run a successful race as either a candidate or campaign staff. They also heard from a group of bipartisan political experts on topics including polling, messaging and strategy, digital media, and speech coaching. The program once again received high marks from the participants this year.

Barring any COVID-19 related setbacks, the 2023 AMPAC Candidate Workshop will also return to an in-person format in the spring of 2023. The program will once again offer participants the skills and strategic approach needed to be a winning candidate for office. During the one-and-a-half-day program, participants will learn how and when to make the decision to run, the importance of a disciplined campaign plan and message, the secrets of effective fundraising, the role of spouses and family and much more. Dates for the 2023 Candidate Workshop have not been finalized.

AMPAC is also currently accepting nominations for the 2023 Award for Political Participation. Awarded every two years, the AMPAC Award for Political Participation recognizes an AMA or AMA Alliance member who has made significant personal contributions of time and talent in assisting friends of medicine in their quest for elective office at the federal or state level. These can include volunteer activities in a political campaign or a significant health care related election issue such as a ballot initiative or referendum. The full criteria for the 2023 AMPAC Award for Political Participation including how to submit a nomination can be found on ampaonline.org.

Conclusion

On a final note, James Milam, MD, Anna Yap, MD, Hart Edmonson, and I are completing our terms on the AMPAC Board of Directors. The newly appointed members of the Board will be Bruce MacLeod, MD from Pennsylvania, Sion Roy, MD, from California, resident Victoria Gordon, DO, from Texas, and medical student Juliana Cobb, MS, from Kentucky. We wish them a rewarding and successful experience as they join the returning members of the AMPAC Board to achieve AMPAC's critical mission in support of the AMA's federal advocacy agenda.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Memorial Resolution

F. Douglas Scutchfield, MD, MPH, FACPM

Introduced by the American College of Preventive Medicine

Whereas, F. Douglas “Scutch” Scutchfield, MD, a public health and preventive medicine leader for the world, the nation, and his native Kentucky, died on May 23, 2022; and

Whereas, Dr. Scutchfield, a native of Wheelwright, Kentucky, obtained his medical degree from the University of Kentucky College of Medicine, including an internship at Chicago Wesley Memorial Hospital (currently Northwestern Medical Center) and residency at the University of Kentucky Medical Center; and took additional graduate coursework in health services administration, business administration, economics, epidemiology and biostatistics; and was inducted into several honorary societies, including Omicron Delta Delta, Alpha Omega Alpha, Phi Beta Delta, and Delta Omega, and served as founding president of the Phi Kappa Phi chapter at the University of Kentucky; and

Whereas, Dr. Scutchfield was also awarded two honorary degrees: a Doctor of Science from the Eastern Kentucky University in Richmond in 2004 and a Doctor of Humane Letters from Pikeville College in 2007; and

Whereas, Dr. Scutchfield served in the U.S. Public Health Service as an Epidemic Intelligence Service Officer at the Centers for Disease Control and Prevention in Atlanta, and the U.S. Department of Health and Human Services’ Council on Health Promotion and Disease Prevention; and

Whereas, Dr. Scutchfield held numerous academic and administrative positions in which he taught and mentored students and faculty alike; he was a founder of the College of Community Health Services at the University of Alabama, and the founding director of two schools of public health: the Graduate School of Public Health at San Diego State University and the College of Public Health at the University of Kentucky; and

Whereas, Dr. Scutchfield served as a consultant to numerous health organizations including the National Center for Health Services Research; the National Heart, Lung, and Blood Institute; Project Hope; the Pan American Health Organization; the California Department of Health Services; California Health Care Foundation; United Way; the Good Samaritan Foundation; and Haifa University School of Public Health; and

Whereas, Dr. Scutchfield had an insatiable appetite for the spoken and written word and contributed to the fields of public health and preventive medicine by publishing more than 200 scientific abstracts, papers, and books; in addition, he held several key editorial positions: as *Editor of the American Journal of Preventive Medicine* for 15 years, and Editor-in-Chief of the *Journal of Appalachian Health*, one of his last and proudest editorial accomplishments as it provides the people and communities of Appalachia a resource to secure and ensure their health; in addition, he served on the editorial boards of the *American Journal of Public Health*; served in an editorial capacity for the *Journal of Public Health Management and Practice*, *Annual Review of Public Health*, *California Physician*, *Western Journal of Medicine*, *Journal of Community Health*, *San Diego Physician*, and *Appalachia Medicine*; classic textbooks such as *Scutchfield and Keck’s Principles of Public Health Practice* and many other books, book chapters, and peer-reviewed medical and public health articles; and received the 2022 Henry Clay Public Policy Book Award; and

Whereas, Dr. Scutchfield was a Fellow of the American Academy of Family Physicians, American College of Preventive Medicine, and the Royal Society of Health, and a member of the Fayette County Medical Society, Kentucky Medical Association, American Medical Association, Association of Teachers of Preventive Medicine (now known as APTR), and American Public Health Association; and

Whereas, Dr. Scutchfield served organized medicine in many leadership and consulting roles, notably for his commitment to service for the American Medical Association, where he served as chair of the Section Council on Preventive Medicine and on the Council on Medical Education, among other roles; and the American College of Preventive Medicine. Always willing to assist in some capacity, he gave his time full-heartedly and served in many capacities from representative or delegate to President or Chairman for the American Public Health Association, Association for Prevention Teaching and Research, Public Health Accreditation Board, Association of Schools of Public Health, Residency Review Committee for Preventive Medicine, California Medical Association, Kentucky Medical Association, and multiple accrediting councils and boards; and

Whereas, Dr. Scutchfield had an international reputation and was a consultant to government and nongovernmental organizations in Panama, China, Saudi Arabia, Israel, and Germany; and

Whereas, Dr. Scutchfield received numerous honors, medals, and awards in his lifetime, including the prestigious Sedgwick Medal of the American Public Health Association, the William Beaumont Award and Distinguished Services Award from the American Medical Association, the Honorable Order of Kentucky Colonels, Key to the City of Selma, Alabama, the Commonwealth Award, Duncan Clark Award, University of Kentucky Public Health Hall of Fame, and the University of Kentucky Libraries Medallion for Intellectual Achievement; and

Whereas, Dr. Scutchfield's generous nature was tempered by a deep need for reciprocation, in part what drew him to the work of Thomas Merton, who articulated the need for human contact to bridge the spiritual gulf. Dr. Scutchfield believed strongly in the importance of humanity to those in the healthcare profession and explored his spirituality at the Abbey of Gethsemani, studying Merton's work; and

Whereas, Dr. Scutchfield was the ultimate networker. He seemed to know everyone, and everyone knew him. His legacy will live on through the countless people he took under his wing and mentored. He was a role model to everyone. His easy demeanor made him approachable to all and he made everyone feel as if they were important; and

Whereas, Dr. Scutchfield was an advice contributor and towering figure to the field of public health and preventive medicine and his energy for change, an untiring determination to innovate, move the needle, make phone calls, and get people on board helped shape the course of the advancement and betterment of the field at large and the overall health of the nation; and

Whereas, Dr. Scutchfield will be remembered not only for his stewardship, leadership, and scholarship in medicine but also his giving spirit, warm heart, larger-than-life personality, sacrifice, service, stories, laconic humor, and iconic smile. He never missed an opportunity to praise a colleague, fantasize about the future of public health, or tell an entertaining story about his love of his home state of Kentucky. He never lost touch with his humble beginnings while being able to navigate smoothly between the erudite elites in academic and policy circles and the local folks he served from beginning to end; and

Whereas, Dr. Scutchfield is survived by his beloved wife of greater than 50 years, Phyllis Scutchfield, JD, LLM, of Lexington, Kentucky; his son Alex L. Scutchfield, JD, and daughter-in-law Jennifer of Lexington Kentucky, and his two grandchildren, Cassandra Ann and Ethan Layne; and his brother Scott Scutchfield and Scott's wife Margaret; and touched the lives of so many family members, friends, colleagues, mentees, and patients, leaving this world a better place and living on in the hearts of so many; therefore be it

RESOLVED, That our American Medical Association note with great sadness the passing of F. Douglas "Scutch" Scutchfield, MD, MPH, FACPM with recognition and thanks for his many contributions to our Association and this great nation; and be it further

RESOLVED, That expressions of condolence be forwarded to the Scutchfield family, along with a copy of this memorial resolution.

REPORT 13 OF THE BOARD OF TRUSTEES (I-22)
Structural Urbanism and the Impact on Rural Workforce Disparities

EXECUTIVE SUMMARY

Rural-urban gaps in health outcomes have existed for years, widening in recent decades. Median income and percent of the population in poverty account for about half the rural-urban difference in age-adjusted premature mortality, highlighting the role of chronic disinvestment in rural communities. Another major factor is reduced access to care related to insufficient public transport, poor availability of broadband services, geographically defined health workforce shortages, and growing distance to increasingly consolidated healthcare facilities, including emergency medical services, in rural areas. These phenomena are associated with structural urbanism, defined as a bias toward large population centers. Structural urbanism stems from three factors: a market orientation in health care, necessitating a critical mass of paying customers to make services viable; a public health focus on changing outcomes at the population level, differentially allocating funding toward large population centers; and innate inefficiencies of low-population and remote settings, with equal funding rarely translating into equitable funding.

Cultivating physician leaders uniquely qualified to advocate for rural communities is essential to achieving equitable legislation and regulations. More than 40 medical schools have rural tracks to increase physicians practicing in rural communities. AMA has been steadfast in our support to improve rural health and cultivate a rural physician workforce through sponsorship of medical education initiatives in rural communities and tireless advocacy efforts to support equitable compensation for rural physicians.

When Congress adopted the resource-based relative value scale (RBRVS), it called for geographic adjustments to reflect practice cost differences and one-quarter of the differences in cost-of-living between Medicare payment localities. Three Geographic Practice Cost Indexes (GPCIs) were developed to make these adjustments and have been the subject of controversy. Physicians in rural areas have often argued that the GPCIs do not capture important dimensions of their practice costs and cause their Medicare payment rates to be too low, especially relative to urban areas.

Acknowledging the current limitations of the Medicare physician payment system and the diversity of rural communities in the United States, any interventions to reduce rural physician workforce disparities will need to be localized.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-I-22

Subject: Structural Urbanism and the Impact on Rural Workforce Disparities

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 INTRODUCTION

2
3 This report, presented to the House of Delegates as information, complements Council on Medical
4 Education Report 3-Nov-21, “Rural Health Physician Workforce Disparities” and responds to
5 AMA Policy H-465.981[5], “Enhancing Rural Physician Practices,” which states that the AMA
6 “will undertake a study of structural urbanism, federal payment policies, and the impact on rural
7 workforce disparities.” Accordingly, this report provides an overview of structural urbanism,
8 educational efforts to cultivate the rural physician workforce, advocacy efforts to reduce rural
9 workforce disparities and current challenges with federal payment policies specific to volume,
10 coverage, and access.

11 UNDERSTANDING STRUCTURAL URBANISM AND HEALTH

12
13
14 Structural urbanism in health care is a bias toward large population centers, stemming from three
15 factors: a market orientation in health care, necessitating a critical mass of paying customers to
16 make services viable; a public health focus on changing outcomes at the population level,
17 differentially allocating funding toward large population centers; and the innate inefficiencies of
18 low-population and remote settings, with equal funding rarely translating into equitable funding.
19 Structural urbanism informs policy decisions about where resources are invested, contributing to
20 numerous rural-urban disparities, including within health and medicine. Rural-urban gaps in health
21 outcomes have existed for years, widening in recent decades.¹ Compared to urban areas,
22 individuals in rural areas generally have higher morbidity and mortality rates.²

23
24 While definitions of “rural” tend to be inconsistent many definitions utilize components of the US
25 Census Bureau definition which defines rural as “any population, housing, or territory NOT in an
26 urban area.”³ The US Census definition of rural is closely connected with the definition of urban
27 which initially included incorporated places with populations of 2,500 or more and has since
28 expanded to include urbanized areas and urban clusters. Urbanized areas have population of 50,000
29 or more and urban clusters have populations of at least 2,500 and less than 50,000.⁴

30
31 Within rural areas and as rural diversity has increased over time, people identifying as Native
32 American, Latinx, or Black in these communities have reported worse health and experienced more
33 barriers to care⁵ and higher morbidity and mortality rates than white people.^{6,7} For diabetes,
34 hypertension, heart disease, and stroke, annual age-adjusted mortality rates are higher among Black
35 than white adults in both rural and urban areas, with higher rates across the board for rural
36 compared to urban Black adults.⁸ Indigenous pregnant people in rural areas experience about twice
37 as much severe maternal morbidity and mortality as urban white women, demonstrating
38 compounding effects of intersecting marginalized identities.⁹ Several leading factors are associated
39 with disparate rural-urban outcomes. Median income and percent of the population in poverty
40 account for about half the rural-urban difference in age-adjusted premature mortality,¹⁰

highlighting the role of chronic disinvestment in rural communities. Another major factor is reduced access to care related to insufficient public transport, poor availability of broadband services,¹¹ geographically defined health workforce shortages,¹² and growing distance to increasingly consolidated healthcare facilities, including emergency medical services, in rural areas. Rural-urban insurance coverage gaps historically contributing to disparate mortality¹³ recently narrowed in states expanding Medicaid under the Affordable Care Act,¹⁴ but perinatal care Medicaid coverage disruptions remain much higher for rural-dwelling Black, Indigenous, and people of color than urban white people.¹⁵ Hospital closures are associated with more mortality in rural than urban areas, with worse impact on people of color and people insured by Medicaid.¹⁶ The closure of the sole hospital in a rural community reduces per-capita income by about \$700 (4%) and increases the unemployment rate by 1.6 percentage points.¹⁷

Community hospitals are closing in rural areas at around twice the rate of other areas,¹⁸ reflecting declining profitability in rural compared to increases in urban areas.¹⁹ Rural counties with hospital closures increasingly are in the South, and have more Black and Latinx residents, higher income inequality, lower per capita income, and higher unemployment.²⁰ Among rural hospitals in the country, nearly 200 have closed since the early 2000s²¹ and nearly 900 (40%) are at immediate or high risk of closing in the near future,²² with closures subsequently decreasing the local supply of physicians.²³ Among over 7,000 federally designated health professional shortage areas, 3 of 5 are rural.²⁴ In the U.S., 20% of people live, but only 9% of physicians practice, in rural areas,²⁵ with multiple specialties less available than primary care in rural areas,²⁶ rural physicians aging and delaying retirement,²⁷ and over half of rural counties having no surgeon.²⁸ About 99% of Medicare spending on graduate medical education (GME, i.e., residency) goes to urban areas, with physicians often practicing within 100 miles of where they completed training.²⁹ A long-term decline recently put incoming rural students in U.S. medical schools below 5%, and those from rural areas identifying with underrepresented racial or ethnic groups below 0.5%.³⁰ Comprehensive medical school rural programs and osteopathic programs generate graduates more likely to practice rural primary care, while international medical graduates are more likely to practice primary care in rural persistent poverty locations.^{31,32} Structural urbanism helps to better understand these phenomena. Scholars suggest structural urbanism can be overcome administratively through input from rural residents (including those with additional marginalized or minoritized identities) on regulation and implementation, and legislatively through evidence-based policies that address social drivers through infrastructure investment.^{33,34}

CULTIVATING THE PHYSICIAN WORKFORCE IN RURAL COMMUNITIES

Cultivating physician leaders uniquely qualified to advocate for rural communities is essential to achieving equitable legislation and regulations. Students raised in rural areas, identifying with minoritized racial or ethnic groups, doctors of osteopathic medicine (DO) or international medical graduates (IMG), are most likely to practice in medically underserved areas, including rural communities. Changes in immigration policy can affect the supply of IMGs.³⁵ Board of Trustees Report 11-I-22, “2022 Advocacy Efforts” discusses AMA’s current advocacy efforts to address immigration barriers that may negatively impact efforts to resolve the physician workforce shortage and preserve patient access to care. Fordyce, et al., found that while DOs comprised 4.9% and IMGs 22.2% of the total clinically active workforce, they contributed 10.4% and 19.3%, respectively, to the rural PCP workforce, although their relative representation varied geographically. Additionally, DO PCPs were more likely than allopathic PCPs to practice in rural places (20.5% versus 14.9%, respectively) and IMG PCPs were more likely than other PCPs to practice in rural persistent poverty locations (12.4% versus 9.1%). They also found that the proportion of rural PCP workforce represented by DOs increased with increasing rurality and that of IMGs decreased.³⁶ This finding supports prioritizing these groups as an important recruitment

1 strategy for rural medical school programs to boost the rural physician workforce.^{37,38} While
2 investments in recruiting and retaining students from these groups has been successful in
3 cultivating the rural physician workforce, Rabinowitz, et al., found that it was also necessary to
4 invest in rural medical school programs as these programs have a significant impact on rural family
5 physician and primary care supply. The research suggests that wider adoption of rural programs
6 would substantially increase access to care in rural areas beyond increased reliance on IMGs.³⁹

7
8 Early exposure to careers in medicine and physician role models in the community bolsters
9 students' interest in pursuing careers in medicine and may support increasing the number of rural
10 applicants to medical school. Science and technology enrichment programs in middle school and
11 health professions recruitment and exposure programs in high school can effectively cultivate an
12 interest in careers in medicine for groups historically excluded and underrepresented, including
13 rural students, influencing positive perceptions of achieving a successful career.⁴⁰

14
15 Additionally, physicians practiced longer in a rural environment when they felt better prepared
16 medically and socially and were initially aware of the special characteristics of rural practice.⁴¹
17 Attending a medical school that is osteopathic, has a mission to train rural physicians, or includes
18 rural components such as rural rotations increases the likelihood of choosing rural practice.⁴² More
19 than 40 medical schools have rural tracks to increase physicians practicing in rural communities.

20
21 For example, the University of Washington School of Medicine: Washington, Wyoming, Alaska,
22 Montana, and Idaho (WWAMI) Program developed the Targeted Rural Underserved Track
23 (TRUST) initiative to ensure access to health care in rural and underserved areas. TRUST utilizes
24 an innovative curriculum that matches incoming medical students with a mentor and a community
25 in a rural environment to connect with over four years. TRUST aims to select students with rural
26 and underserved backgrounds who are most likely to return to these areas. Students are also
27 encouraged to choose specialties that serve those areas, generally in primary care.

28
29 AMA is also investing in cultivating the physician workforce in rural communities. The AMA
30 Reimagining Residency grant program awarded Oregon Health & Science University (OHSU) and
31 the University of California, Davis (UC Davis) \$1.8 million to create educational interventions to
32 expand access to quality health care between Sacramento and Portland through a network of mostly
33 rural teaching hospitals and clinics. OHSU and UC Davis partnered to establish a GME
34 collaborative known as the California Oregon Medical Partnership to Address Disparities in Rural
35 Education and Health (COMPADRE). COMPADRE places hundreds of medical students and
36 resident physicians in positions to train with faculty and community physicians at 10 health care
37 systems, 16 hospitals, and a network of Federally Qualified Health Center partners. COMPADRE
38 aims to address health care workforce shortages in rural, tribal, urban, and other communities that
39 lack resources; increase access to physicians; and improve the health of patients from minoritized
40 ethnic and racial groups disproportionately affected by certain health conditions.⁴³

41
42 Additionally, the AMA Reimagining Residency initiative awarded \$1.8 million over five years to
43 the University of North Carolina (UNC) School of Medicine to support the significant expansion of
44 the Fully Integrated Readiness for Service (FIRST) Program to new geographic areas of North
45 Carolina and additional highly needed specialties including family medicine, general surgery,
46 pediatrics, and psychiatry. The FIRST Program was founded in 2015 to link family medicine
47 workforce pathways from medical school to residency and to service in rural/underserved areas.
48 Participating students can complete their medical degree in three years, followed by the
49 opportunity for placement with the Family Medicine Residency program of North Carolina. FIRST
50 scholar graduates commit to three years of service in an underserved area of the state, during which
51 time they receive ongoing support from UNC Family Medicine in partnership with the NC Office

of Rural Health and Community Care, AHEC, Piedmont Health Services, and the North Carolina Academy of Family Physicians.

RELEVANT AMA ADVOCACY TO REDUCE RURAL WORKFORCE DISPARITIES

In addition to sponsoring medical education initiatives in rural communities, AMA remains steadfast in our advocacy efforts to support medical students, residents, and physicians in rural communities. Below are recent advocacy activities related to reducing rural workforce disparities:

- On August 29, 2022, the AMA provided [comments](#) on the Centers for Medicare & Medicaid Services Conditions of Participation for Rural Emergency Hospitals (REH) and Critical Access Hospital (CoP) Updates Proposed Rule. The AMA supports the goals and understands the importance of the Proposed Rule to ensure equitable access to high quality care in rural communities, as rural hospitals continue to close leaving vast care deserts.
- On July 29, 2022, the AMA [provided information](#) regarding the Department of Health and Human Services' (HHS) Initiative To Strengthen Primary Health Care.
- On June 23, 2022, the AMA sent a [letter](#) in support of S. 4330, the "Specialty Physicians Advancing Rural Care (SPARC) Act," which would amend the Public Health Service Act to authorize a loan repayment program to encourage specialty medicine physicians to serve in rural communities experiencing a shortage.
- On February 25, 2022, the AMA sent a [letter](#) to the Centers for Medicare & Medicaid Services (CMS) commenting on the 2022 Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals (IPPS), focused on Graduate Medical Education (GME).
- On January 6, 2022, the AMA supported the Primary Care Physician Reentry Act of 2022, a bill establishing a demonstration program to facilitate physician reentry into clinical practice to provide primary care services.
- In December 2021, the AMA provided verbal support and a press release supporting Rep. Tom Cole's bipartisan S.3497, "Medical Student Education Authorization Act" that would authorize HRSA's Medical Student Education program for five years. The program provides grants to public institutions of higher education to expand or support graduate education for medical students preparing to become physicians in the top quintile of states with a projected primary care provider shortage in 2025. There is a focus on rural, Tribal, and medically underserved communities.
- On September 21, 2021, the AMA [provided information](#) on the Public Service Loan Forgiveness (PSLF) program. Regarding PSLF, the AMA urged the Department of Education to consider the importance of the program for physician borrowers, making the program more widely available to physician borrowers, and providing stronger communication to borrowers to support successful completion of the program.
- On September 1, 2021, the AMA joined a [letter](#) urging Congress to include policies that would increase Medicare support for GME in the budget reconciliation legislation and reinforcing our support for the Resident Physician Shortage Reduction Act of 2021.

- 1 • In September 2021, the AMA provided verbal support for Chairman Richard Neal’s S.
2 3376, “Pathways to Practice Act” which would provide additional funding for the
3 recruitment, education, and training of medical students willing to work in underserved
4 communities.
5
- 6 • On July 1, 2021, the AMA sent a [letter](#) supporting H.R. 4122, the “Resident Education
7 Deferred Interest (REDI) Act,” which would allow borrowers to qualify for interest-free
8 deferment on their student loans while serving in a medical or dental internship or
9 residency program.
10
- 11 • On June 28, 2021, the AMA joined a [letter](#) urging CMS to finalize the Alternative 2
12 methodology in the FY 2022 Inpatient Prospective Payment System (IPPS) proposed rule,
13 with modifications, and increase the number of full time equivalent (FTE) slots awarded
14 per hospital for FY 2023 and all succeeding years.
15
- 16 • On June 28, 2021, the AMA provided [comments](#) about how the new 1,000 GME slots
17 should be distributed.
18
- 19 • On June 23, 2021, the AMA sent a letter ([Senate](#) and [House](#)) voicing our support for the
20 Physician Shortage GME Cap Flex Act of 2021. This legislation would help to address our
21 national physician workforce shortage by providing teaching hospitals an additional five
22 years to set their Medicare Graduate Medical Education (GME) cap if they establish
23 residency training programs in primary care or specialties that are facing shortages.
24
- 25 • On June 10, 2021, the AMA sent a [letter](#) voicing our support for the “Doctors of
26 Community (DOC) Act,” that would permanently authorize the Teaching Health Center
27 Graduate Medical Education (THCGME) program. This legislation is vitally important in
28 ensuring that patients in underserved areas continue to have access to the care they need.
29
- 30 • On May 18, 2021, the AMA signed onto a [letter](#) asking that federal support for physician
31 training be included in upcoming legislative efforts to improve the nation’s infrastructure
32 and reaffirming our support for the Resident Physician Shortage Reduction Act of 2021,
33 which asks for 14,000 additional Medicare-supported GME positions.
34
- 35 • On April 8, 2021, the AMA sent a [letter](#) supporting S. 924, the “Rural America Health
36 Corps Act,” that would establish a demonstration program to provide payments on
37 qualified loans for individuals eligible for but not currently participating in the National
38 Health Service Corps (NHSC) Loan Repayment Program who agree to a five-year period
39 of obligated full-time service in a rural health professional shortage area.
40
- 41 • On March 24, 2021, the AMA joined a [letter](#) supporting the Resident Physician Shortage
42 Reduction Act of 2021, that would gradually raise the number of Medicare-supported
43 GME positions by 2,000 per year for seven years, for a total of 14,000 new slots. A share
44 of these positions would go to hospitals with diverse needs including hospitals in rural
45 areas, hospitals serving patients from health professional shortage areas (HPSAs), hospitals
46 in states with new medical schools or branch campuses, and hospitals already training over
47 their caps. This bipartisan legislation is crucial to expanding the physician workforce and
48 to ensuring that patients across the country are able to access quality care from providers.

- 1 • On February 9, 2021, the AMA wrote a [letter](#) voicing support for S. 54, the “Strengthening
2 America’s Health Care Readiness Act,” that would provide additional funding for the
3 National Health Service Corps (NHSC), the Nurse Corps, and establish a National Health
4 Service Corps Emergency Service demonstration project. The COVID-19 pandemic has
5 highlighted the need for additional emergency capacities and underscored the health
6 workforce shortages and disparities that exist throughout the nation. This bill would bring
7 access to care for patients and welcome relief to the physicians, residents, and nurses who
8 have been on the front lines throughout the pandemic caring for our sickest patients.
9
- 10 • On January 28, 2021, the AMA joined a [letter](#) supporting the Strengthening America’s
11 Health Care Readiness Act, that would support the NHSC and Nurse Corps programs to
12 meet the challenges highlighted by the COVID-19 pandemic, providing a onetime,
13 supplemental appropriation for scholarship and loan forgiveness awards to address health
14 provider shortages and gaps in our health care system, while investing in the pipeline of
15 future health providers. This will help to address longstanding health care shortages and
16 bolster emergency surge capacity when support and providers are desperately needed.
17
- 18 • On January 27, 2021, the AMA joined a [letter](#) thanking the Senate for investing in
19 physician training by adding 1,000 new Medicare-supported graduate medical education
20 (GME) positions in the Consolidated Appropriations Act, 2021.
21
- 22 • On June 24, 2020, the AMA voiced support for the Strengthening America’s Health Care
23 Readiness Act which increases supplemental funding for the NHSC by \$10 billion. This
24 increased funding will be used for additional loan repayment and scholarship programs.
25 Moreover, the bill contains a 40% set aside and provides mentoring and early recruitment
26 for people identifying with historically underrepresented groups in the health care field.
27 Additionally, the bill provides \$50 million for a National Disaster Medical System
28 (NDMS) pilot program which would bolster health emergency surge capacity.
29

30 CURRENT CHALLENGES WITH FEDERAL PAYMENT POLICIES FOR RURAL 31 PHYSICIAN SERVICES 32

33 Understanding of current rural physician workforce disparities includes the physician payment
34 system that limits compensation. From the 1970s to 1992, the basic pattern of Medicare physician
35 payments was frozen based on variously defined “customary, prevailing, and reasonable” charges.
36 Compensation stagnated even as innovations in clinical practice and technology spread beyond
37 urban centers, with very different Medicare payment rates in neighboring regions with similar
38 practice costs for the same services.
39

40 In the late 1980s, Harvard University developed an initial resource-based relative value scale
41 (RBRVS) to move from historical charges to a standardized national payment system grounded in
42 relative differences in the resources needed to deliver physician services. The AMA supported
43 RBRVS and called for national payment amounts to be adjusted to reflect geographic differences in
44 physicians’ practice costs, such as office rent, wages of nonphysician personnel, and professional
45 liability insurance. Congress adopted this policy and also called for geographic adjustments to
46 reflect one-quarter of the differences in cost-of-living between Medicare payment localities. Three
47 Geographic Practice Cost Indexes (GPCIs) were developed to make these adjustments. RBRVS
48 reduced the range of variation in payment rates for the same service in different communities from
49 300 percent or more to within 10 to 15 percent. Physicians in rural areas have continued to face
50 significant challenges with the way Medicare rates are adjusted for geographic differences.⁴⁴

1 The most controversial GPCI is the work GPCI, which adjusts payments based on differences in
2 costs-of-living as measured by differences in earnings of college-educated workers. Although the
3 work GPCI is based on one-quarter of these earnings differences, rural physicians have long
4 believed that it is inappropriate for Medicare payments to reflect these differences at all. To help
5 address these concerns, beginning in 2004, Congress enacted legislation that has been continuously
6 renewed placing a floor of 1.00 on the work GPCI. This floor has the effect of preventing any
7 Medicare payment locality's geographic adjustment for work relative value units from being lower
8 than the national average of 1.00. Geographic adjustments have continued to be the focus of
9 considerable debate. Physicians in rural areas have argued that the GPCIs do not capture important
10 dimensions of their practice costs and cause their Medicare payment rates to be too low, especially
11 relative to urban areas. It is difficult to achieve consensus on significant changes to the GPCIs
12 because, like the other elements of the Medicare payment schedule, the GPCIs are required to be
13 budget neutral from year to year. This means that any GPCI changes that benefit rural areas reduce
14 payments in non-rural areas.

15
16 Another problem has been that patients who live in rural areas have traditionally been more likely
17 to be insured by public programs such as Medicare and Medicaid, which may have lower physician
18 payment rates than commercial insurers. Rural physicians' payer mix may leave them with lower
19 average revenue per patient than in communities with more privately insured patients. Also, total
20 volume of services may be lower due to lower population density as well as increased physician
21 travel time between care facilities making it difficult to cover costs. To help address this, Medicare
22 provides bonus payments on top of the regular Medicare payment amounts for services delivered in
23 primary care and mental health care Health Care Professional Shortage Areas (HPSAs). If the
24 patient resides in a HPSA but receives services from a physician office that is not located in the
25 HPSA, the bonus is not added. In addition, Medicare's Quality Payment Program has a low-volume
26 threshold which allows physicians to be exempt from this quality reporting requirement. There are
27 emerging opportunities to incorporate area-based social risk factors into alternative payment
28 models (e.g., through Medicare Advantage program changes, Innovation Center models in
29 Medicare Advantage or fee-for-service, or Medicaid). These area-based approaches use the
30 sociodemographic data of a geographic area, encompassing the patient's place of residence, to
31 enhance reimbursement to help address health-related social needs, which could be of benefit for
32 rural populations and the physicians serving them. There is no overarching Medicare payment
33 policy aimed at helping rural physicians maintain their practices if they provide a relatively low
34 volume of services.

35
36 The dramatic increase in provision of telehealth services from the start of the COVID-19 pandemic
37 helped patients in rural areas connect with physicians, reducing transportation and distance
38 barriers, but also highlighted a lack of access to the connectivity necessary for audio-visual
39 telehealth services. The AMA played a leading role in aggressively advocating for Medicare to
40 begin covering the CPT codes for telephone visits and provided implementation guides to enable
41 physicians to successfully incorporate telehealth into their practices. Many patients in rural
42 communities, including many who identify as Native American or Black, have neither the
43 connectivity nor the equipment needed for audio-visual telehealth and had to rely on landlines to
44 access health services during the pandemic. The AMA has been advocating for audio-only visits to
45 continue to be available after the COVID-19 Public Health Emergency ends, but to date Medicare
46 has not adopted this policy.

47
48 In addition, prior to the COVID-19 PHE, although Medicare paid for telehealth services when they
49 were provided to patients in rural areas, Medicare's telehealth policies did not provide adequate
50 support for services provided by specialists. During the PHE, AMA advocacy efforts were

1 instrumental in getting about 150 services added to the Medicare telehealth list, including services
2 that are often provided by specialists such as emergency medicine, critical care, home visits,
3 portions of radiation oncology treatment services, eye exams, and telephone visits. In addition,
4 patients were able to get telehealth services in their homes or wherever they were located instead of
5 having to go to a medical facility. It is not yet clear which of these positive changes will become
6 permanent, but the dramatic increase in adoption of telehealth services and the continuing
7 development of hybrid models that combine in-person, telehealth, remote monitoring and other
8 digital services is likely to continue to improve rural patients' access to specialist services when
9 they do not have enough of the needed specialists physically available in their community.

10
11 CONCLUSION

12
13 The AMA remains committed to improving rural health and cultivating the current and future rural
14 physician workforce by advocating for equitable access to high quality care in rural communities
15 and investing in initiatives to expand training opportunities in rural medical schools, teaching
16 hospitals, and clinics.

APPENDIX – Relevant AMA Policy

H-465.981, Enhancing Rural Physician Practices

Our AMA: (1) supports legislation to extend the 10% Medicare payment bonus to physicians practicing in rural counties and other areas where the poverty rate exceeds a certain threshold, regardless of the areas' Health Professional Shortage Area (HPSA) status; (2) encourages federal and state governments to make available low interest loans and other financial assistance to assist physicians with shortage area practices in defraying their costs of compliance with requirements of the Occupational Safety and Health Administration, Americans with Disabilities Act and other national or state regulatory requirements; (3) will explore the feasibility of supporting the legislative and/or regulatory changes necessary to establish a waiver process through which shortage area practices can seek exemption from specific elements of regulatory requirements when improved access, without significant detriment to quality, will result; (4) supports legislation that would allow shortage area physician practices to qualify as Rural Health Clinics without the need to employ one or more physician extenders; and (5) will undertake a study of structural urbanism, federal payment policies, and the impact on rural workforce disparities.

H-465.978, Recognizing and Remedying Payment System Bias As a Factor in Rural Health Disparities

1. Our AMA recognizes that systemic bias in healthcare financing has been one of many factors leading to rural health disparities and will advocate for elimination of these biases through payment policy reform to help reduce the shortage of rural physicians and eliminate health inequities in rural America.
2. Our AMA will, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation.

D-400.989, Equal Pay for Equal Work

Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.

H-200.954, US Physician Shortage

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;

- (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
- (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
- (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
- (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
- (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
- (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
- (12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
- (13) will work to augment the impact of initiatives to address rural physician workforce shortages.

H-465.994, Improving Rural Health

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public. 2. Our AMA will work with other entities and organizations interested in public health to: Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities. Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health. Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities. Advocate for adequate and sustained funding for public health staffing and programs. Policy Timeline Sub. Res. 72, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmed: CEJA Rep. 06, A-18 Appended: Res. 433, A-19 Modified: CSAPH Rep. 2, A-22

H-290.997, Medicaid – Towards Reforming the Program

Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles: (1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors); (2) the creation of basic national standards of uniform minimum adequate benefits; (3) the elimination of the existing categorical requirements; (4) the creation of adequate payment levels to assure broad access to care; and (5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions. Policy Timeline BOT Rep. UU, A-88 Reaffirmed: CMS Rep. G, A-93 Reaffirmation I-96 Reaffirmation

A-00 Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00 Reaffirmation A-05 Reaffirmed: Res. 804, I-09 Reaffirmed: CMS Rep. 01, A-19 Reaffirmed: CMS Rep. 3, A-21.

D-290.979, Medicaid Expansion

Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded. 2. Our AMA will: (a) continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823; and (b) work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. Policy Timeline Res. 809, I-12 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed: CMS Rep. 5, I-20 Reaffirmed: CMS Rep. 3, A-21 Reaffirmed: CMS Rep. 9, A-21 Reaffirmed: CMS Rep. 3, I-21 Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21 Appended: Res. 122, A-22

D-385.952, Alternative Payment Models and Vulnerable Populations

Our AMA: (1) supports alternative payment models (APMs) that link quality measures and payments to outcomes specific to vulnerable and high-risk populations and reductions in health care disparities; (2) will continue to encourage the development and implementation of physician-focused APMs that provide services to improve the health of vulnerable and high-risk populations; and (3) will continue to advocate for appropriate risk adjustment of performance results based on clinical and social determinants of health to avoid penalizing physicians whose performance and aggregated data are impacted by factors outside of the physician's control.

REFERENCES

- ¹ Meit, M., Knudson, A., Gilbert, T. (2014). Rural Health Reform Policy Research Center. [The 2014 update of the rural-urban chartbook](#). Retrieved September 2, 2022
- ² U.S. Food and Drug Administration. (2021, June 22). [Rural Health](#). Retrieved September 2, 2022.
- ³ Bennett, K. J., Borders, T. F., Holmes, G. M., Kozhimannil, K. B., & Ziller, E. (2019). What is rural? Challenges and implications of definitions that inadequately encompass rural people and places. *Health Affairs*, 38(12), 1985-1992.
- ⁴ U.S. Census Bureau, [Urban and Rural Population: 1900-1990](#); [Census 2000 Summary File 1 Table P002](#); [2010 Census Summary File 1 Table P2](#), [A Century of Delineating a Changing Landscape: The Census Bureau's Urban and Rural Classification, 1910 to 2010](#)
- ⁵ James CV, Moonesinghe R, Wilson-Frederick SM, Hall JE, Penman-Aguilar A, Bouye K. Racial/Ethnic Health Disparities Among Rural Adults — United States, 2012–2015. *MMWR Surveill Summ* 2017;66(No. SS-23):1–9.
- ⁶ Warshaw R. Health disparities affect millions in rural U.S. communities. AAMC. 2017 Oct 31. <https://www.aamc.org/news-insights/health-disparities-affect-millions-rural-us-communities>
- ⁷ Kozhimannil KB, Henning-Smith C. Racism and health in rural America. *Journal of health care for the poor and underserved*. 2018;29(1):35-43.
- ⁸ Aggarwal R, Chiu N, Loccoh EC, Kazi DS, Yeh RW, Wadhera RK. Rural-urban disparities: diabetes, hypertension, heart disease, and stroke mortality among black and white adults, 1999-2018. *Journal of the American College of Cardiology*. 2021 Mar 23;77(11):1480-1.
- ⁹ Kozhimannil KB, Interrante JD, Tofte AN, Admon LK. Severe maternal morbidity and mortality among indigenous women in the United States. *Obstetrics and gynecology*. 2020 Feb;135(2):294.
- ¹⁰ Long AS, Hanlon AL, Pellegrin KL. Socioeconomic variables explain rural disparities in US mortality rates: Implications for rural health research and policy. *SSM-Population Health*. 2018 Dec 1;6:72-4.
- ¹¹ Douthit N, Kiv S, Dwolatzky T, Biswas S. Exposing some important barriers to health care access in the rural USA. *Public health*. 2015 Jun 1;129(6):611-20.
- ¹² Rural Health Disparities. Rural Health Information (RHI) Hub. Retrieved September 6, 2022. <https://www.ruralhealthinfo.org/topics/rural-health-disparities>
- ¹³ Gong G, Phillips SG, Hudson C, Curti D, Philips BU. Higher US rural mortality rates linked to socioeconomic status, physician shortages, and lack of health insurance. *Health Affairs*. 2019 Dec 1;38(12):2003-10.
- ¹⁴ Soni A, Hendryx M, Simon K. Medicaid expansion under the Affordable Care Act and insurance coverage in rural and urban areas. *The Journal of Rural Health*. 2017 Apr;33(2):217-26.
- ¹⁵ Kozhimannil KB, Interrante JD, Basile Ibrahim B, Chastain P, Millette MJ, Daw J, Admon LK. Racial/Ethnic Disparities in Postpartum Health Insurance Coverage Among Rural and Urban US Residents. *Journal of Women's Health*. 2022 Aug 30.
- ¹⁶ Gujral K, Basu A. Impact of rural and urban hospital closures on inpatient mortality. *National Bureau of Economic Research*; 2019 Aug 26.
- ¹⁷ Holmes GM, Slifkin RT, Randolph RK, Poley S. The effect of rural hospital closures on community economic health. *Health services research*. 2006 Apr;41(2):467-85. Holmes GM, Slifkin RT, Randolph RK, Poley S. The effect of rural hospital closures on community economic health. *Health services research*. 2006 Apr;41(2):467-85.
- ¹⁸ American Hospital Association. Fast Facts: U.S. Rural Hospitals. 2021. Retrieved October 4, 2022. <https://www.aha.org/system/files/media/file/2021/05/infographic-rural-data-final.pdf>
- ¹⁹ Thomas SR, Holmes GM, Pink GH. 2012-14 Profitability of Urban and Rural Hospitals by Medicare Payment Classification.
- ²⁰ Planey AM, Perry JR, Kent EE, Thomas SR, Friedman H, Randolph RK, Homes GM. Since 1990, rural hospital closures have increasingly occurred in counties that Are More urbanized, diverse and economically unequal. NC Rural Health Research Program, UNC Sheps Center. 2022 Feb.
- ²¹ University of North Carolina at Chapel Hill. The Cecil. G. Sheps Center for Health Services Research. Rural Hospital Closures. Retrieved September 2, 2022.
- ²² Ellison, A. (2022). Beckers Hospital Review. 892 hospitals at risk of closure, state by state. Retrieved September 2, 2022.

-
- ²³ Germack HD, Kandrack R, Martsolf GR. When rural hospitals close, the physician workforce goes. *Health Affairs*. 2019 Dec 1;38(12):2086-94.
- ²⁴ National Rural Health Association. [About Rural Health](#). Retrieved September 2, 2022.
- ²⁵ Bureau of Health Professions. *Rural Health Professions Facts: Supply and Distribution of Health Professions in Rural America*. Rockville, MD: Health Resources and Services Administration; 1992.
- ²⁶ Barreto T, Jetty A, Eden AR, Petterson S, Bazemore A, Peterson LE. Distribution of physician specialties by rurality. *The Journal of Rural Health*. 2021 Sep;37(4):714-22.
- ²⁷ Cohen AJ, Ndoye M, Fergus KB, Lindsey J, Butler C, Patino G, Anger JT, Breyer BN. Forecasting limited access to urology in rural communities: Analysis of the American Urological Association Census. *The Journal of Rural Health*. 2020 Jun;36(3):300-6.
- ²⁸ Cohen C, Baird M, Koirola N, Kandrack R, Martsolf G. The Surgical and Anesthesia Workforce and Provision of Surgical Services in Rural Communities: A Mixed-Methods Examination. *The Journal of Rural Health*. 2021 Jan;37(1):45-54.
- ²⁹ Hawes EM, Fraher E, Crane S, Weidner A, Wittenberg H, Pauwels J, Longenecker R, Chen F, Page CP. Rural residency training as a strategy to address rural health disparities: Barriers to expansion and possible solutions. *Journal of Graduate Medical Education*. 2021 Aug;13(4):461-5.
- ³⁰ Shipman SA, Wendling A, Jones KC, Kovar-Gough I, Orlowski JM, Phillips J. The decline in rural medical students: a growing gap in geographic diversity threatens the rural physician workforce. *Health Affairs*. 2019 Dec 1;38(12):2011-8.
- ³¹ Rabinowitz HK, Petterson S, Boulger JG, Hunsaker ML, Diamond JJ, Markham FW, Bazemore A, Phillips RL. Medical school rural programs: a comparison with international medical graduates in addressing state-level rural family physician and primary care supply. *Academic Medicine*. 2012 Apr 1;87(4):488-92.
- ³² Fordyce MA, Doescher MP, Chen FM, Gary Hart L. Osteopathic physicians and international medical graduates in the rural primary care physician workforce. *Family Medicine-Kansas City*. 2012 Jun 1;44(6):396.
- ³³ Kozhimannil KB, Henning-Smith C. Improving health among rural residents in the US. *Jama*. 2021 Mar 16;325(11):1033-4.
- ³⁴ Kozhimannil KB. Indigenous maternal health—a crisis demanding attention. In *JAMA Health Forum* 2020 May 1 (Vol. 1, No. 5, pp. e200517-e200517). American Medical Association.
- ³⁵ Boulet JR, Duvivier RJ, Pinsky WW. Prevalence of international medical graduates from Muslim-majority nations in the US physician workforce from 2009 to 2019. *JAMA Network Open*. 2020 Jul 1;3(7):e209418.
- ³⁶ Fordyce, M. A., Doescher, M. P., Chen, F. M., & Gary Hart, L. (2012). Osteopathic physicians and international medical graduates in the rural primary care physician workforce. *Family Medicine-Kansas City*, 44(6), 396.
- ³⁷ MacQueen, I.T., Maggard-Gibbons, M., Capra, G., Raaen, L., Ulloa, J.G., Shekelle, P.G., Miake-Lye, I., Beroes, J.M. and Hempel, S., 2018. Recruiting Rural Healthcare Providers Today: a Systematic Review of Training Program Success and Determinants of Geographic Choices. *Journal of General Internal Medicine*, 33(2), p.191.
- ³⁸ Komaromy, M., Grumbach, K., Drake, M., Vranizan, K., Lurie, N., Keane, D., & Bindman, A. B. (1996). The role of black and Hispanic physicians in providing health care for underserved populations. *New England Journal of Medicine*, 334(20), 1305-1310.
- ³⁹ Rabinowitz, H. K., Petterson, S., Boulger, J. G., Hunsaker, M. L., Diamond, J. J., Markham, F. W., ... & Phillips, R. L. (2012). Medical school rural programs: a comparison with international medical graduates in addressing state-level rural family physician and primary care supply. *Academic Medicine*, 87(4), 488-492.
- ⁴⁰ Hughes, A. (2018). Barriers to entering higher education: rural students' perspective. *JITLL*, 1, 22-7.
- ⁴¹ Pathman, D. E., Steiner, B. D., Jones, B. D., & Konrad, T. R. 1999. Preparing and retaining rural physicians through medical education. *Academic medicine: journal of the Association of American Medical Colleges*, 74(7), 810-820.
- ⁴² LaRavia, D., Calvert, J., Zavala, J., Smith, O.D., Talley, S., Gingrich, D., Polk, D., Granholm, M. and Lawson, N., 2002. Keeping physicians in rural practice. *American Academy of Family Physicians Rural Recruitment and Retention Position Paper*.
- ⁴³ Oregon Health & Science University. June 5, 2019. COMPADRE: Five-year, \$1.8M Award Aims to Transform Health Care in Rural California and Oregon. <https://research.ucdavis.edu/compadre-five-year-1-8m-award-aims-to-transform-health-care-in-rural-california-and-oregon/>.
- ⁴⁴ Medicare RBRVS 2021: The Physicians' Guide, American Medical Association, Chicago, Illinois.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-I-22

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

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

The Board of Trustees (BOT) has completed its review of the specialty organizations seated in the House of Delegates (HOD) required to submit information and materials for the 2022 American Medical Association (AMA) Interim Meeting in compliance with the five-year review process established by the House of Delegates in Policy G-600.020, "Summary of Guidelines for Admission to the House of Delegates for Specialty Societies," and AMA Bylaw 8.5, "Periodic Review Process."

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

The following organizations were reviewed for the 2022 Interim Meeting:

- American Association of Neuromuscular & Electrodiagnostic Medicine
- American College of Rheumatology
- American Society for Dermatologic Surgery Association
- American Society for Radiation Oncology
- American Society for Surgery of the Hand
- American Society of Maxillofacial Surgeons
- Association for Clinical Oncology
- Radiological Society of North America
- Society for Vascular Surgeons
- Society of American Gastrointestinal Endoscopic Surgeons
- Society of Nuclear Medicine and Molecular Imaging
- Society of Thoracic Surgeons

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

1 The materials submitted indicate that: the American Association of Neuromuscular &
2 Electrodiagnostic Medicine, American College of Rheumatology, American Society for
3 Dermatologic Surgery Association, American Society for Radiation Oncology, American Society
4 for Surgery of the Hand, American Society of Maxillofacial Surgeons, Association for Clinical
5 Oncology, Radiological Society of North America, Society for Vascular Surgeons, Society of
6 American Gastrointestinal Endoscopic Surgeons, and the Society of Thoracic Surgeons meet all
7 guidelines and are in compliance with the five-year review requirements of specialty organizations
8 represented in the HOD.

9
10 The materials submitted also indicate that the Society of Nuclear Medicine and Molecular Imaging
11 did not meet all guidelines and is not in compliance with the five-year review requirements of
12 specialty organizations represented in the HOD.

13 14 RECOMMENDATIONS

15
16 The Board of Trustees recommends that the following be adopted, and the remainder of this report
17 be filed:

- 18
19 1. The American Association of Neuromuscular and Electrodiagnostic Medicine, American
20 College of Rheumatology, American Society for Dermatologic Surgery Association,
21 American Society for Radiation Oncology, American Society for Surgery of the Hand,
22 American Society of Maxillofacial Surgeons, Association for Clinical Oncology,
23 Radiological Society of North America, Society for Vascular Surgeons, Society of
24 American Gastrointestinal Endoscopic Surgeons, and the Society of Thoracic Surgeons
25 retain representation in the American Medical Association House of Delegates. (Directive
26 to Take Action)
- 27
28 2. Having failed to meet the requirements for continued representation in the AMA House of
29 Delegates as set forth in AMA Bylaw B-8.5 the Society of Nuclear Medicine and
30 Molecular Imaging be placed on probation and be given one year to work with AMA
31 membership staff to increase their AMA membership. (Directive to Take Action)

Fiscal Note: Less than \$500

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

| Organization | AMA Membership of Organization's Total Eligible Membership |
|---|---|
| American Association of Neuromuscular & Electrodiagnostic Medicine | 545 of 2,614 (21%) |
| American College of Rheumatology | 957 of 4,753 (20%) |
| American Society for Dermatologic Surgery Association | 1,921 of 5,863 (33%) |
| American Society for Radiation Oncology | 860 of 3,890 (22%) |
| American Society for Surgery of the Hand | 488 of 2,292 (21%) |
| American Society of Maxillofacial Surgeons | 56 of 217 (26%) |
| Association for Clinical Oncology | 3,907 of 18,400 (21%) |
| Radiological Society of North America | 1,741 of 13,989 (12%) |
| Society for Vascular Surgery | 562 of 2,738 (20%) |
| Society of American Gastrointestinal Endoscopic Surgeons | 862 of 4,282 (20%) |
| Society of Nuclear Medicine and Molecular Imaging | 211 of 1,285 (16%) |
| Society of Thoracic Surgeons | 1,101 of 5,373 (20%) |

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

Policy G-600.020

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

Exhibit C

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

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

Exhibit D – AMA Bylaws on Specialty Society Periodic Review

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

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

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

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 016
(I-22)

Introduced by: Academic Physicians Section

Subject: Increasing Female Representation in Oncology Clinical Trials

Referred to: Reference Committee on Amendments to Constitution & Bylaws

1 Whereas, Females have historically been underrepresented in biomedical research, including in
2 oncology clinical trials; and¹⁻⁵

3
4 Whereas, Previous studies have found that females comprised only 34.7-38.6% of participants
5 in cancer prevention and treatment trials from 1990-2010, a proportion far less than the actual
6 incidence of cancers among females; and⁶⁻⁷

7
8 Whereas, More recent literature relating to this topic documents that females remain
9 underrepresented, especially as compared to the magnitude and proportion of their disease
10 burden in surgical and other invasive oncology trials, and anal canal, bladder, bone/joint,
11 esophageal, head/neck, kidney, stomach, and thyroid cancer trials; and⁸⁻⁹

12
13 Whereas, The resulting generalizability of cancer clinical trial findings remains hindered by the
14 persistent failure to proportionally enroll female participants relative to their disease burden, a
15 factor which continues to limit women's access to novel therapeutics and potentially improved
16 survival through trial participation; and

17
18 Whereas, Current research also shows that industry-funded oncology clinical trials had greater
19 odds of proportional female representation than U.S. government and academic-funded
20 oncology trials,⁸⁻¹⁰ suggesting success of the Food and Drug Administration (FDA) exploratory
21 committees investigating female participation (for nearly all industry-funded trials) over simple
22 mandates for female participation as put forth by the National Institutes of Health (NIH) (for most
23 government and academic-funded trials not overseen by the FDA); and¹¹⁻¹³

24
25 Whereas, Existing AMA policy encourages increased outreach and education only for *minority*
26 *and female physicians* to promote minority and female patient recruitment in clinical trials,
27 despite this being an issue that impacts *all physicians and their patients*; therefore, be it

1 RESOLVED, That our American Medical Association amend H-460.911, "Increasing Minority
2 Participation in Clinical Research," by addition as follows:

3
4 **Increasing Minority and Female Participation in Clinical Research H-460.911**
5

6 1. Our AMA advocates that:

7 a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct
8 annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of
9 pediatric and elderly populations, to determine if proportionate representation of women and
10 minorities is maintained in terms of enrollment and retention. This surveillance effort should be
11 modeled after National Institute of Health guidelines on the inclusion of women and minority
12 populations.

13 b. The FDA have a page on its web site that details the prevalence of minorities and women in
14 its clinical trials and its efforts to increase their enrollment and participation in this research; and

15 c. Resources be provided to community level agencies that work with those minorities and
16 females who are not proportionately represented in clinical trials to address issues of lack of
17 access, distrust, and lack of patient awareness of the benefits of trials in their health care.

18 These minorities include Blacks/African Americans, Hispanics, Asians/Pacific Islanders/Native
19 Hawaiians, and Native Americans.

20
21 2. Our AMA recommends the following activities to the FDA in order to ensure proportionate
22 representation of minorities and females in clinical trials:

23 a. Increased fiscal support for community outreach programs; e.g., culturally relevant
24 community education, community leaders' support, and listening to community's needs;

25 b. Increased outreach to ~~female~~ all physicians to encourage recruitment of minority and female
26 patients in clinical trials;

27 c. Continued ~~minority physician~~ education for all physicians and physicians-in-training on clinical
28 trials, subject recruitment, subject safety, and possible expense reimbursements, and that this
29 education encompass discussion of barriers that currently constrain appropriate female and
30 minority subject recruitment and methods for increasing trial accessibility for patients such as
31 community partnerships, optimized patient-centered locations for accessing trials, and the ready
32 availability of transportation to and from trial locations and child care services;

33 d. Support for the involvement of minority physicians in the development of partnerships
34 between minority communities and research institutions; and

35 e. Fiscal support for minority and female recruitment efforts and increasing trial accessibility
36 through optimized patient-centered locations for accessing trials, the ready availability of
37 transportation to and from trial locations, child care services, and transportation, child care,
38 reimbursements, and location.

39
40 3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-
41 FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including
42 consideration of pediatric and elderly populations; and that these results are included in
43 publication and/or freely distributed, whether or not subgroup differences exist. (Modify Current
44 HOD Policy)

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

Received: 11/11/22

REFERENCES:

1. Lawrence SC, Bendixen K. His and hers: Male and female anatomy in anatomy texts for U.S. medical students, 1890–1989. *Soc Sci Med*. 1992;35(7):925-934. doi:10.1016/0277-9536(92)90107-2
2. Murciano-Goroff YR. Differences in the percentage of illustrations showing males versus females in general medicine and general surgery textbooks. *Med Sci Educ*. 2015;25(2):123-126. doi:10.1007/s40670-015-0116-8
3. Hawkes S, Haseen F, Aounallah-Skhiri H. Measurement and meaning: reporting sex in health research. *Lancet*. 2019;393(10171):497-499. doi:10.1016/S0140-6736(19)30283-1
4. van der Graaf R, van der Zande ISE, den Ruijter HM, et al. Fair inclusion of pregnant women in clinical trials: an integrated scientific and ethical approach. *Trials*. 2018;19(1):78. doi:10.1186/s13063-017-2402-9
5. Mazure CM, Jones DP. Twenty years and still counting: including women as participants and studying sex and gender in biomedical research. *BMC Womens Health*. 2015;15:94. doi:10.1186/s12905-015-0251-9
6. Swanson GM, Bailar JC, 3rd. Selection and description of cancer clinical trials participants--science or happenstance? *Cancer*. 2002;95(5):950-959. doi:10.1002/cncr.10785
7. Kwiatkowski K, Coe K, Bailar JC, Swanson GM. Inclusion of minorities and women in cancer clinical trials, a decade later: Have we improved? *Cancer*. 2013;119(16):2956-2963. doi:10.1002/cncr.28168.
8. Perera ND, Bellomo TR, Litt HK, et al. Female participation in U.S. oncology clinical trials registered on ClinicalTrials.gov from 2008 to 2020. *Journal of Clinical Oncology* 39, no. 28, suppl (October 01, 2021) 85-85. doi:10.1200/JCO.2020.39.28_suppl.85
9. Perera ND, Schmidt WM, Bellomo TR, et al. Nationwide trends in female representation in oncology clinical trials: a cross-sectional study of ClinicalTrials.gov from 2008-2020. Poster presented at: American College of Physicians (ACP) National Meeting; 2022 April 29-30, Chicago, IL
10. Perera ND, Bellomo TR, Schmidt WM, et al. Analysis of Female Representation in Registered Oncology Clinical Trials in the United States (U.S.) from 2008 to 2020. Manuscript under review as of 2022 September 23 by *The Oncologist*
11. U.S. Food and Drug Administration. Investigational new drug applications and new drug applications. Fed Regist. 1998;63(28):6854-62.
12. National Institutes of Health: Department of Health and Human Services. Monitoring Adherence To The NIH Policy On The Inclusion Of Women And Minorities As Subjects In Clinical Research Fiscal Year 2009-2010. <http://orwh.od.nih.gov/research/inclusion/pdf/Inclusion-ComprehensiveReport-FY-2009-2010.pdf>. Accessed October 8, 2021.
13. U.S. Code Title 42. Public Health and Welfare: U.S. Code 289a-2 - Inclusion of women and minorities in clinical research. <https://www.govinfo.gov/content/pkg/USCODE-2011-title42/pdf/USCODE-2011-title42-chap6A-subchapIII-partH-sec289a-2.pdf>. Accessed February 16, 2022.

RELEVANT AMA POLICY

Increasing Minority Participation in Clinical Research H-460.911

1. Our AMA advocates that:

- a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
- b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
- c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:

- a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;
- b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
- c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
- d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
- e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.

3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.

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

Viability of Clinical Research Coverages and Reimbursement H-460.965

Our AMA believes that:

- (1) legislation and regulatory reform should be pursued to mandate third party payer coverage of patient care costs (including co-pays/co-insurance/deductibles) of nationally approved (e.g., NIH, VA, ADAMHA, FDA), scientifically based research protocols or those scientifically based protocols approved by nationally recognized peer review mechanisms;
 - (2) third party payers should formally integrate the concept of risk/benefit analysis and the criterion of availability of effective alternative therapies into their decision making processes;
 - (3) third party payers should be particularly sensitive to the difficulty and complexity of treatment decisions regarding the seriously ill and provide flexible, informed and expeditious case management when indicated;
 - (4) its efforts to identify and evaluate promising new technologies and potentially obsolete technologies should be enhanced;
 - (5) its current efforts to identify unproven or fraudulent technologies should be enhanced;
 - (6) sponsors (e.g., NIH, pharmaceutical firms) of clinical research should finance fully the incremental costs added by research activities (e.g., data collection, investigators' salaries, data analysis) associated with the clinical trial. Investigators should help to identify such incremental costs of research;
 - (7) supports monitoring present studies and demonstration projects, particularly as they relate to the magnitude (if any) of the differential costs of patient care associated with clinical trials and with general practice;
 - (8) results of all trials should be communicated as soon as possible to the practicing medical community maintaining the peer reviewed process of publication in recognized medical journals as the preferred means of evaluation and communication of research results;
 - (9) funding of biomedical research by the federal government should reflect the present opportunities and the proven benefits of such research to the health and economic well-being of the American people;
 - (10) the practicing medical community, the clinical research community, patient advocacy groups and third party payers should continue their ongoing dialogue regarding issues in payment for technologies that benefit seriously ill patients and evaluative efforts that will enhance the effectiveness and efficiency of our nation's health care system; and
 - (11) legislation and regulatory reform should be supported that establish program integrity/fraud and abuse safe harbors that permit sponsors to cover co-pays/coinsurance/ deductibles, otherwise not covered clinical care, and non-clinical ancillary costs in the context of nationally approved clinical trials.
- Citation: CSA Rep. F, I-89; Reaffirmed: Joint CMS/CSA Rep., I-92; Reaffirmed: BOT Rep.40, I-93; Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 4, A-02; Reaffirmed: CMS Rep. 4, A-12; BOT Action in response to referred for decision: Res. 813, I-15; BOT Action in response to referred for decision: Res. 823, I-15; Reaffirmation: I-18; Modified: Res. 226, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 017
(I-22)

Introduced by: Organized Medical Staff Section

Subject: Supervision of Non-Physician Providers by Physicians

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, A primary concern of our American Medical Association is both the improvement of
2 medical care and public health, as well as the satisfaction of the physician in the practice of
3 medicine; and
4

5 Whereas, Our American Medical Association has concerns about the expanding scope of
6 practice of non-physician practitioners; and
7

8 Whereas, Our AMA has policy on the supervision of physicians by physicians (AMA Policy H-
9 375.967) with the purpose of assuring the greatest quality and safety of patients under medical
10 care; and
11

12 Whereas, Our AMA has policy that states, "The hospital governing authority should depend
13 primarily on the medical staff to recommend the extent of functions which may be delegated to,
14 and services which may be provided by, members of these emerging or expanding health
15 professions." As this policy suggests guidelines that should be included in medical staff bylaws
16 but is incomplete in defining the extent and limitations of physician supervision of non-physician
17 practitioners (AMA Policy H-35.996); therefore be it
18

19 RESOLVED, That our American Medical Association advocate to relevant entities with a goal to
20 ensure physicians on staff receive written notification when their license is being used to
21 document "supervision" of non-physician practitioners. Physician supervision should be explicitly
22 defined and mutually agreed upon (Directive to Take Action); and be it further
23

24 RESOLVED, That our AMA advocate for advanced notice and disclosure to the physician
25 before they are hired or as soon as practicably known by provider organizations and institutions
26 that anticipate physician supervision of non-physician practitioners as a condition for physician
27 employment (Directive to Take Action); and be it further
28

29 RESOLVED, That our AMA advocate that organizations, institutions, and medical staffs that
30 have physicians who participate in supervisory duties for non-physician practitioners have
31 processes and procedures in place that have been developed with appropriate clinical physician
32 input. These should be adequate to assure patient safety and appropriate clinical care and are
33 fully disclosed to physicians (Directive to Take Action); and be it further
34

35 RESOLVED, That our AMA advocate that physicians be able to report professional concerns
36 about care provided by the non-physician practitioners to the appropriate leadership with
37 protections so as not to be retaliated against by the physician's employer in any way. (Directive
38 to Take Action)

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

Received: 11/11/22

RELEVANT AMA POLICY

Supervision and Proctoring by Facility Medical Staff H-375.967

Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:

- (1) Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.
- (2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
- (3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.
- (4) The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.
- (5) The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.
- (6) The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.
- (7) Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.
- (8) Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcribed by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.
- (9) Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports.

Citation: CMS Rep. 3, A-99; Reaffirmed: CLRPD Rep. 1, A-09; Reaffirmed: CMS Rep. 01, A-19

Status and Utilization of New or Expanding Health Professionals in Hospitals H-35.996

(1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff. Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role.

(2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work

closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions.

Citation: BOT Rep. G, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00;

Modified: CMS Rep. 6, A-10; Reaffirmation A-12; Reaffirmed: CMS Rep. 1, A-22

Practicing Medicine by Non-Physicians H-160.949

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).

Citation: Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99;

Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00;

Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21

Support for Physician Led, Team Based Care D-35.985

Our AMA:

1. Reaffirms, will proactively advance at the federal and state level, and will encourage state and national medical specialty societies to promote policies H-35.970, H-35.973, H-35.974, H-35.988, H-35.989, H-35.992, H-35.993, H-160.919, H-160.929, H-160.947, H-160.949, H-160.950, H-360.987, H 405.969 and D-35.988.

2. Will identify and review available data to analyze the effects on patients? access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.

3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.

4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation's primary care workforce needs.

5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.

6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.

7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

Citation: BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 6, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(I-22)

Introduced by: Academic Physicians Section

Subject: Requirements for Physician Self-reporting of Outpatient Mental Health Services, Treatments or Medications to Credentialing Agencies and Insurers

Referred to: Reference Committee B

1 Whereas, All human beings, including all physicians, eventually become afflicted by medical
2 conditions meriting evaluation, management and treatment by a clinician; and
3

4 Whereas, Such medical conditions may accrue while a physician is engaged in the active
5 practice of medicine; and
6

7 Whereas, some of these medical conditions include mental health conditions; and
8

9 Whereas, Actively practicing physicians are at higher risk for mental illness that can be treated
10 on an outpatient basis than members of other professions, and
11

12 Whereas, Burnout, a condition believed to afflict up to 50 percent or more of physicians in some
13 specialties, is a condition that can predispose to the mental health disease of depression, a
14 treatable disease that merits ongoing management and treatment by a mental health
15 professional; and
16

17 Whereas, Physicians who suffer untreated depression are at increased risk for suicide, with
18 more than 300 physicians dying by suicide in a typical year, at a rate that exceeds those for
19 most other professions and occupations; and
20

21 Whereas, Physician suicides are not only tragic but also a terrible waste of human capital; and
22

23 Whereas, Mental health conditions under outpatient medical management by another licensed
24 professional are less likely to impair a physician's ability to discharge their clinical duties in an
25 ethical and competent fashion than unmanaged mental health conditions; and
26

27 Whereas, Physicians applying for re-licensure or insurance, hospital organization, or medical
28 specialty board recredentialing typically are asked to reveal mental health conditions under
29 treatment, even if such treatments are limited to an outpatient setting, as a condition for re-
30 licensure or re-credentialing; and
31

32 Whereas, An untreated or unmanaged mental or psychological condition or disease should elicit
33 more concern for the clinician's competence and fitness to practice medicine than a mental
34 health condition under active outpatient management; and
35

36 Whereas, It is a form of discrimination to single out mental illness matters as a condition that
37 must be revealed during re-licensure and re-credentialing, because evidence is lacking that
38 physicians who are receiving effective outpatient mental health counseling or medications are
39 typically unable to competently practice medicine; and

Whereas, It is self-evident that any physician currently receiving inpatient care for any disease, including mental health diseases, is temporarily unable to discharge their clinical duties, and

Whereas, Our American Medical Association has recently taken actions and adopted policies aimed at minimizing or eliminating discrimination against minoritized populations, such as African Americans, Native Americans, individuals from the LGBTQ community, and those who dress or wear hair styles or hair coverings in a manner that delineates them as a member of a particular ethnic or cultural group; and

Whereas, To single out physicians receiving effective outpatient mental health services as being somehow unable or unfit to practice medicine is also a form of discrimination to be avoided; and

Whereas, Federal legislation aimed at decreasing the burdens that can result in physician suicide have been enacted by the Congress in 2022 as H.R. 1667, the Lorna Breen Health Care Provider Protection Act³, an act which was subsequently signed into law, demonstrating that the American people demonstrably have a clear interest in the health of physicians that exceeds that previously demonstrated by many of the organizations involved in the licensure and credentialing of physicians; and

Whereas, Our American Medical Association has previously enacted Policy H-295.858, "Access to Confidential Health Services for Medical Students and Physicians," which states in part that accessing such services should not be required to be disclosed to state licensure boards (but which is silent as regards disclosure to hospital and insurer credentialing agencies and medical specialty boards); and

Whereas, Our AMA has previously enacted Policy H-275.945, "Self-Incriminating Questions on Applications for Licensure and Specialty Boards," advocating that provisions of the Americans with Disabilities Act must apply to physicians whose "disability" is not sufficiently severe to impair their ability to practice medicine; and

Whereas, The authors of a 2022 article in *Academic Medicine* recommended that state medical boards review and refine licensure applications' health history questions regarding mental health disclosure in ways that strategically address concerns related to stigma, bias, and unwarranted scrutiny, and called for research to examine the impact of such question changes on applicant response accuracy, help-seeking behaviors, and mental health outcomes and stigma, while also recommending that medical schools offer and promote access to mental health services, encourage faculty to normalize help-seeking behaviors, and provide students with information about state licensure processes; therefore be it

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 it 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

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

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

Received: 11/12/22

RELEVANT AMA POLICY

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

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.

H-275.945, "Self-Incriminating Questions on Applications for Licensure and Specialty Boards"

The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 229
(I-22)

Introduced by: Medical Student Section

Subject: Coverage and Reimbursement for Abortion Services

Referred to: Reference Committee B

Whereas, At the Annual 2022 Meeting of the House of Delegates, the American Medical Association recognized that “healthcare, including reproductive services like contraception and abortion, is a human right”; and

Whereas, Access to abortion services has significantly decreased across the country due to the overturning of *Roe v. Wade* (1973) by *Dobbs v Jackson Women’s Health Organization* (2022); and

Whereas, The cost of abortion services in 2020 ranged from \$489 to \$873, \$493 to \$1191, and around \$1068 for first-trimester medication abortions, first-trimester aspiration abortions, and second-trimester abortions respectively¹; and

Whereas, Most patients in the United States must pay out-of-pocket for abortion care due to state restrictions prohibiting abortion coverage in insurance plans, and many report delaying abortion due to insufficient income to cover out-of-pocket expenses²⁻⁶; and

Whereas, Half of patients seeking abortion care in the US have incomes below the federal poverty line and are eligible for Medicaid in the majority of states²; and

Whereas, The Hyde Amendment, passed in 1977, bans state use of federal Medicaid dollars to pay for abortions with exceptions only for rape, incest, and life of the pregnant person⁶; and

Whereas, People of color are more likely to be impacted by the Hyde Amendment, with 29% of Black women and 25% of Hispanic women receiving Medicaid compared to 15% of white women aged 18-49^{4,7}; and

Whereas, Medicaid programs in 35 states and the District of Columbia only cover abortion services in the case of rape, incest, or danger to life of the pregnant person⁶; and

Whereas, Nearly 30% of Medicaid-eligible pregnant patients in Louisiana who would have sought an abortion if covered under Medicaid instead gave birth⁸; and

Whereas, Twenty-five states have laws restricting abortion coverage in insurance plans offered through the Affordable Care Act marketplace⁴; and

Whereas, The Equal Access to Abortion Coverage in Health Insurance (EACH) Act was introduced in the US Senate in 2021 and guarantees abortion coverage in Medicaid, CHIP, Medicare, the IHS, TRICARE, and other federally funded coverage⁹; and

Whereas, AMA Policy 5.998 states that our AMA would oppose the use of federal and state funding mechanisms that deny abortion to patients, such as bans resulting from the Hyde Amendment, but does not state that our AMA will explicitly advocate for abortion coverage; therefore be it

RESOLVED, That our American Medical Association 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 (Directive to Take Action); 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 (Directive to Take Action); 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 (Directive to Take Action); 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. (New HOD Policy)

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

Date Received: 11/11/2022

References:

1. Upadhyay U, Ahlback C, Kaller S, Cook C, Munoz I. Trends in self-pay costs and insurance acceptance for abortion across the United States, 2017 to 2020. *Contraception*. 2021;103(5):375. doi:10.1016/j.contraception.2021.03.011
2. Jerman J, Jones RK, Onda T. Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008. <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>. Published online May 10, 2016. Accessed August 31, 2022.
3. An Overview of Abortion Laws. Guttmacher Institute. <https://www.guttmacher.org/state-policy/explore/overview-abortion-laws>. Published March 9, 2016. Accessed November 9, 2022.
4. Jones RK, Jerman J. Characteristics and Circumstances of U.S. Women Who Obtain Very Early and Second-Trimester Abortions. *PLOS ONE*. 2017;12(1):e0169969. doi:10.1371/journal.pone.0169969
5. Regulating Insurance Coverage of Abortion. Guttmacher Institute. <https://www.guttmacher.org/state-policy/explore/regulating-insurance-coverage-abortion>. Published March 14, 2016. Accessed November 8, 2022
6. Roberts SCM, Gould H, Kimport K, Weitz TA, Foster DG. Out-of-Pocket Costs and Insurance Coverage for Abortion in the United States. *Women's Health Issues*. 2014;24(2):e211-e218. doi:10.1016/j.whi.2014.01.003
7. State Funding of Abortions Under Medicaid. KFF. <https://www.kff.org/medicaid/state-indicator/abortion-under-medicaid>. Published May 13, 2022. Accessed August 31, 2022.
8. Roberts SCM, Johns NE, Williams V, Wingo E, Upadhyay UD. Estimating the proportion of Medicaid-eligible pregnant women in Louisiana who do not get abortions when Medicaid does not cover abortion. *BMC Women's Health*. 2019;19(1):78. doi:10.1186/s12905-019-0775-5
9. Duckworth T. S.1021 - EACH Act of 2021. 117th Congress (2021-2022). <https://www.congress.gov/bills/117th-congress/senate-bill/1021/text>. Published March 25, 2021. Accessed November 9, 2022.

RELEVANT AMA POLICY

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. Res. 028, A-22

Public Funding of Abortion Services H-5.998

The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 12, A-05'

Reaffirmed: CMS Rep. 1, A-15

Support for Access to Preventive and Reproductive Health Services H-425.969

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Sub. Res. 224, I-15; Reaffirmation: I-17

Reproductive Parity H-185.937

Our AMA supports legislation and policies that require any health insurance products offering maternity services to include all choices in the management of reproductive medical care.

Res. 4, I-13

Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act H-185.925

1. Our AMA supports improvements to the essential health benefits benchmark plan selection process to ensure limits and exclusions do not impede access to health care and coverage.
2. Our AMA encourages federal regulators to develop policy to prohibit essential health benefits substitutions that do not exist in a state's benchmark plan and the selective use of exclusions or arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage.
3. Our AMA encourages federal regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to Office for Civil Rights. Res. 814, I-16

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing

information to patients about medical care and procedures or which interfere with the physician-patient relationship;

(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and

(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13

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

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.

2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:

a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;

b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;

c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;

d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and

g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications. Res. 621, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 230
(I-22)

Introduced by: Medical Student Section

Subject: Increased Health Privacy on Mobile Apps in Light of Roe v. Wade

Referred to: Reference Committee B

Whereas, In June 2022, the U.S. Supreme Court ruling in Dobbs v. Jackson Women's Health Organization overturned previous precedent regarding abortion access established by both Roe v. Wade and Planned Parenthood v. Casey, meaning that patients receiving abortions and physicians providing abortions may now be prosecuted by some states for this treatment even in the case of medical necessity¹; and

Whereas, MHealth apps are defined as mobile wireless technologies for public health, which have been shown to increase access to health information, services and skills, as well as promote positive changes in health behaviors to prevent the onset of acute and chronic diseases²; and

Whereas, Many mobile apps and devices, including period-tracking apps, are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), allowing the entities owning them to sell health information and personally identifiable information to third-parties^{3,4}; and

Whereas, Information, such as location data, IP addresses, and fingerprint or face identification can be acquired by apps and used to identify an individual or their activities, which could be used for prosecution of abortion or discrimination of protected groups⁵⁻⁸; and

Whereas, Companies such as Kochava and Weight Watchers have attempted to collect and/or sell the personally identifiable information of at least 125 million people, including children as young as age 8^{5,9}; and

Whereas, Companies such as Flo Health have sold information from period tracking apps to third parties, like marketing companies, Facebook, and Google, without permission from their users¹⁰; and

Whereas, A 2021 review of 20,911 apps in the medical, health, and fitness categories in the Google play store found that 28% offered no privacy policies and 88% included code that could potentially collect user data¹¹; and

Whereas, A woman in Nebraska was prosecuted for having an abortion by using information obtained from Facebook via warrant as evidence that she had an abortion, indicating that information collected by mobile apps can be and already has been used to prosecute those receiving abortions¹²; and

Whereas, Companies selling user data have offered heatmaps and other information identifying specific individuals who go to abortion clinics, and sometimes offer this data for free, providing a

1 way to obtain data usable to prosecute those receiving abortions without a need for a
2 warrant^{5,13}; and
3

4 Whereas, The Federal Trade Commission (FTC) has recently filed a complaint against a
5 company selling location information that would allow for the identification of individuals
6 receiving an abortion, indicating that the federal government believes that the prosecution of
7 abortions via sold data is indeed a real possibility and danger^{5,14}; and
8

9 Whereas, The FTC is currently hindered in its enforcement capabilities by an inability to force
10 penalties for first-time offenses of the FTC Act, therefore incentivizing companies to sell
11 sensitive health information or personally-identifying information without repercussion^{14,15}; and
12

13 Whereas, This sale of information could also be used to identify and possibly prosecute
14 healthcare providers who provide abortions even in medically necessary scenarios¹³; and
15

16 Whereas, AMA policy H-480.943 calls for increased privacy, security, and patient education
17 surrounding the use of mobile health applications, but does not consider these actions regarding
18 mobile applications that are not health-related; and
19

20 Whereas, Although D-315.968 seeks to enact our AMA Privacy Principles through legislation
21 regarding health apps and tools, it does not ask our AMA to extend these principles via
22 legislation to non-health software, such as non-health apps that can track location; therefore be
23 it
24

25 RESOLVED, That American Medical Association policy D-315.968, Supporting Improvement to
26 Patient Data Privacy,” be amended by addition to read as follows:
27

28 Supporting Improvement to Patient Data Privacy D-315.968

29 Our AMA will (1) strengthen patient and physician data privacy protections by advocating
30 for legislation that reflects the AMA’s Privacy Principles with particular focus on mobile
31 health apps and other digital health tools, in addition to non-health apps and software
32 capable of generating patient data and (2) will work with appropriate stakeholders to
33 oppose using any personally identifiable data to identify patients, potential patients who
34 have yet to seek care, physicians, and any other healthcare providers who are providing
35 or receiving healthcare that may be criminalized in a given jurisdiction. (Modify HOD
36 Policy)

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

Date Received: 11/11/2022

References:

1. *Dobbs v. Jackson Women’s Health Organization*
2. MHealth: Use of Mobile Wireless Technologies for Public Health. https://apps.who.int/gb/ebwha/pdf_files/EB139/B139_8-en.pdf.
3. Banerjee S, Hemphill T, Longstreet P. Wearable devices and healthcare: Data Sharing and Privacy. *The Information Society*. 2017;34(1):49-57. doi:10.1080/01972243.2017.1391912
4. Belfort R, Bernstein WS, Dworkowitz A, Pawlak B, Yi P. June 2020 a shared responsibility - ehealth initiative. EHIDC. <https://www.ehdc.org/sites/default/files/resources/files/RWJFConsumerHealth.pdf>. Published June 2020. Accessed March 16, 2022.
5. FTC Sues Kochava for Selling Data that Tracks People at Reproductive Health Clinics, Places of Worship, and Other Sensitive Locations. Federal Trade Commission. Published August 29, 2022. Accessed September 1, 2022. <https://www.ftc.gov/news->

- events/news/press-releases/2022/08/ftc-sues-kochava-selling-data-tracks-people-reproductive-health-clinics-places-worship-other
6. Staff the PNO, Staff DPIPand CTO. Cohen K, et al. Location, health, and other sensitive information: FTC committed to fully enforcing the law against illegal use and sharing of highly sensitive data. Federal Trade Commission. <https://www.ftc.gov/business-guidance/blog/2022/07/location-health-and-other-sensitive-information-ftc-committed-fully-enforcing-law-against-illegal>. Published September 6, 2022.
 7. FTC Explores Rules Cracking Down on Commercial Surveillance and Lax Data Security Practices. Federal Trade Commission. Published August 10, 2022. Accessed September 1, 2022. <https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-explores-rules-cracking-down-commercial-surveillance-lax-data-security-practices>
 8. Washington D, Slaughter R. *UNITED STATES of AMERICA Federal Trade Commission Regarding the Commercial Surveillance and Data Security Advance Notice of Proposed Rulemaking.*; 2022. Accessed September 1, 2022. https://www.ftc.gov/system/files/ftc_gov/pdf/RKS%20ANPR%20Statement%2008112022.pdf
 9. Staff the PNO, Staff DPIPand CTO. FTC takes action against company formerly known as Weight Watchers for illegally collecting kids' sensitive health data. Federal Trade Commission. <https://www.ftc.gov/news-events/news/press-releases/2022/03/ftc-takes-action-against-company-formerly-known-weight-watchers-illegally-collecting-kids-sensitive>. Published March 17, 2022.
 10. Staff the PNO, Staff DPIPand CTO. FTC finalizes order with Flo Health, a fertility-tracking app that shared sensitive health data with Facebook, Google, and others. Federal Trade Commission. <https://www.ftc.gov/news-events/news/press-releases/2021/06/ftc-finalizes-order-flo-health-fertility-tracking-app-shared-sensitive-health-data-facebook-google>. Published June 22, 2021.
 11. Tangari G, Ikram M, Ijaz K, Kaafar MA, Berkovsky S. Mobile Health and Privacy: Cross Sectional Study. The BMJ. <https://www.bmj.com/content/373/bmj.n1248>. Published June 17, 2021.
 12. Kaste M. Nebraska cops used facebook messages to investigate an alleged illegal abortion. NPR. <https://www.npr.org/2022/08/12/1117092169/nebraska-cops-used-facebook-messages-to-investigate-an-alleged-illegal-abortion>. Published August 12, 2022.
 13. Location Data Firm Provides Heat Maps of Where Abortion Clinic Visitors Live. <https://www.vice.com/en/article/g5qag3/location-data-firm-heat-maps-planned-parenthood-abortion-clinics-placer-ai>.
 14. FTC v Kochava, Inc. Federal Trade Commission. Published August 29, 2022. Accessed September 1, 2022. <https://www.ftc.gov/legal-library/browse/cases-proceedings/ftc-v-kochava-inc>
 15. Washington D. *UNITED STATES of AMERICA Federal Trade Commission Statement of Chair Lina M. Khan Regarding the Commercial Surveillance and Data Security Advance Notice of Proposed Rulemaking Commission File No. R111004.*; 2022. Accessed September 1, 2022. https://www.ftc.gov/system/files/ftc_gov/pdf/Statement%20of%20Chair%20Lina%20M.%20Khan%20on%20Commercial%20Surveillance%20ANPR%2008112022.pdf

RELEVANT AMA POLICY

Supporting Improvements to Patient Data Privacy D-315.968

Our AMA will strengthen patient 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.

Res. 227, A-22

Integration of Mobile Health Applications and Devices into Practice H-480.943

1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services

as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.

2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.

4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.

6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks

7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.

8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

CMS Rep. 06, I-16; Reaffirmation: A-17

Police, Payer, and Government Access to Patient Health Information H-315.975

(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmed: BOT Rep. 16, I-21

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:

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

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

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

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

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

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

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

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.
9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

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

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

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

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99;

Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed:

Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01;

Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04;

Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07;

Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-1; 2Reaffirmed: BOT Rep. 17,

A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res.

232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21;

Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(I-22)

Introduced by: Medical Student Section

Subject: Expanding Support for Access to Abortion Care

Referred to: Reference Committee B

1 Whereas, The *Dobbs v Jackson Women's Health Organization* (2022) decision overturned the
2 federal right to abortion as established in *Roe v. Wade* (1973)¹; and

3
4 Whereas, After the overturning of *Roe v. Wade*, abortion is now banned or severely restricted in
5 twenty-six states and three U.S. territories²⁻⁶; and

6
7 Whereas, The states with the most restrictive abortion laws also have the worst maternal and
8 child health outcomes⁷⁻⁹; and

9
10 Whereas, Research indicates the number of maternal deaths will increase 13% in the first year
11 after a nationwide abortion ban, and 24% in subsequent years, and for Black women, these
12 numbers increase to 18% and 39% respectively, proving the urgent need for action¹⁰; and

13
14 Whereas, Pregnant people who are denied access to abortion care are more likely to remain in
15 contact with and less likely to leave physically and emotionally abusive partners, which is of
16 particular importance as intimate partner violence during pregnancy and the post-partum period
17 is a leading cause of pregnancy-associated deaths^{11,12}; and

18
19 Whereas, The inability to access abortion care has negative socioeconomic consequences for
20 both the pregnant person and their families, as people who gave birth after denial of abortion
21 are four times more likely to live in poverty for at least four years after childbirth than those who
22 received abortions^{13,14}; and

23
24 Whereas, Inequities in abortion access disproportionately impact low-income people and people
25 of color, and worsen existing disparities in maternal and infant mortality and rates of pre-term
26 and low birthweight births^{15,16}; and

27
28 Whereas, Half of patients seeking abortion care in the US have incomes below the federal
29 poverty line¹⁷; and

30
31 Whereas, The Hyde Amendment, passed in 1977, bans the use of federal Medicaid dollars to
32 pay for abortions with exceptions only for rape, incest, and the life of the pregnant person^{18,19};
33 and

34
35 Whereas, Nearly 1 in 5 (19%) women of reproductive age in the United States receive
36 healthcare coverage through Medicaid²⁰; and

37
38 Whereas, People of color are more likely to be impacted by the Hyde Amendment, with 29% of
39 Black women and 25% of Hispanic women receiving Medicaid compared to 15% of white
40 women aged 18-49²¹; and

1 Whereas, The Turnaway Study found that women who were unable to afford pregnancy
2 termination and subsequently had a child as a result were more likely than women who received
3 an abortion to be unemployed, receive public assistance, and live below the poverty line one
4 year post clinic visit despite no economic differences between the groups the year prior²²⁻²⁴; and
5

6 Whereas, A study recently published in the American Journal of Public Health found states with
7 restrictions on Medicaid coverage of abortion care had a 29% higher total maternal mortality
8 than states without Medicaid coverage restrictions²⁵; and
9

10 Whereas, Restrictions on the funding of abortion care through federally funded insurance
11 programs lead to higher rates of unintended birth and furthers economic hardship on low
12 income pregnant people^{26,27}; and
13

14 Whereas, The American College of Obstetricians and Gynecologists (ACOG) recommends that
15 the Hyde Amendment and other federal and state restrictions on insurance coverage of abortion
16 be eliminated²⁸; and
17

18 Whereas, At the June 2022 Annual Meeting of the House of Delegates, the American Medical
19 Association recognized that “healthcare, including reproductive services like contraception and
20 abortion, is a human right”; however, the overturning of Roe v. Wade necessitates urgent action
21 by the AMA to address the heightened threat to public health posed by the recent onslaught of
22 abortion bans introduced at the state and federal level²⁹⁻³¹; and
23

24 Whereas, Our AMA issued a statement on June 24, 2022 in response to the Dobbs v. Jackson
25 Supreme Court ruling, stating, “we will oppose any law or regulation that compromises or
26 criminalizes patient access to safe, evidence-based medical care, including abortion”; however,
27 there has been no explicit condemnation of the Hyde Amendment by the AMA³²; and
28

29 Whereas, Laws restricting abortion in many states, including Texas, define “fetal heartbeat” as
30 “cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the
31 gestational sac”³³; and
32

33 Whereas, ACOG reports that while electronic impulses indicating cardiac activity may be
34 audible in early pregnancy (around 6 weeks of gestation), this cannot be considered a
35 “heartbeat” until the chambers of the heart have been developed (around 17-20 weeks of
36 gestation)³⁴; and
37

38 Whereas, Laws restricting abortion access oppose existing AMA policies D-5.999, H-5.989, and
39 H-160.946 by compromising a physician’s ability to use his or her medical judgment in regards
40 to which treatment is in the best interest of the patient, discouraging shared decision making,
41 and criminalizing physicians for performing medical abortions in accordance with best medical
42 practice; therefore it be
43

44 RESOLVED, That our American Medical Association recognize that policies and legislation that
45 limit access to abortion care are serious threats to public health (New HOD Policy); and be it
46 further
47

48 RESOLVED, That our AMA advocate for the explicit codification of protections for abortion care
49 consistent with AMA policy into federal law (Directive to Take Action); and be it further
50

51 RESOLVED, That our AMA oppose efforts to exclude provisions from spending bills which limit
52 federal funds from being used for abortion care (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA collaborate with relevant stakeholders including state medical
2 societies to encourage amendments to existing state laws so that a “fetal heartbeat” is not
3 inaccurately stated as synonymous with the first evidence of embryonic cardiac activity.
4 (Directive to Take Action)

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

Received: 11/12/22

References:

1. Supreme Court of the United States. 19-1392 Dobbs v. Jackson Women's Health Organization (06/24/2022). Published online 2022:213.
2. Abortion Laws by State. Center for Reproductive Rights. Accessed August 31, 2022. <https://reproductiverights.org/maps/abortion-laws-by-state/>
3. State Bans on Abortion Throughout Pregnancy. Guttmacher Institute. Published March 14, 2016. Accessed August 31, 2022. <https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions>
4. Times TNY. Tracking the States Where Abortion Is Now Banned. *The New York Times*. <https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html>. Published May 24, 2022. Accessed August 31, 2022.
5. Sidik SM. The effects of overturning Roe v. Wade in seven simple charts. *Nature*. 2022;608(7922):254-257. doi:10.1038/d41586-022-02139-3
6. 60 Days After Dobbs: State Legal Developments on Abortion | Brennan Center for Justice. Accessed September 22, 2022. <https://www.brennancenter.org/our-work/research-reports/60-days-after-dobbs-state-legal-developments-abortion>
7. Addante AN, Eisenberg DL, Valentine MC, Leonard J, Maddox KEJ, Hoofnagle MH. The association between state-level abortion restrictions and maternal mortality in the United States, 1995-2017. *Contraception*. 2021;104(5):496-501. doi:10.1016/j.contraception.2021.03.018
8. Pabayo R, Ehnholt A, Cook DM, Reynolds M, Muennig P, Liu SY. Laws Restricting Access to Abortion Services and Infant Mortality Risk in the United States. *Int J Environ Res Public Health*. 2020;17(11):E3773. doi:10.3390/ijerph17113773
9. Wilkinson TA, Maslowsky J, Berlan ED. The Pediatrician in the Post-Roe Landscape. *JAMA Pediatr*. Published online August 15, 2022. doi:10.1001/jamapediatrics.2022.2868
10. Stevenson AJ, Root L, Menken J. The maternal mortality consequences of losing abortion access. Published online June 29, 2022. doi:10.31235/osf.io/7g29k
11. Campbell J, Matoff-Stepp S, Velez ML, Cox HH, Laughon K. Pregnancy-Associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence. *J Womens Health*. 2021;30(2):236-244. doi:10.1089/jwh.2020.8875
12. Roberts SC, Biggs MA, Chibber KS, Gould H, Rocca CH, Foster DG. Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. *BMC Med*. 2014;12(1):144. doi:10.1186/s12916-014-0144-z
13. Jones K, Bernstein A. The Economic Effects of Abortion Access: A Review of the Evidence (Fact Sheet). Institute for Women's Policy Research. Published July 22, 2019. Accessed February 22, 2020. <https://iwpr.org/iwpr-issues/reproductive-health/the-economic-effects-of-abortion-access-a-review-of-the-evidence/>
14. Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States | AJPH | Vol. 108 Issue 3. Accessed June 9, 2022. <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304247>
15. Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014 | AJPH | Vol. 112 Issue 9. Accessed August 31, 2022. <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042>
16. Redd SK, Rice WS, Aswani MS, et al. Racial/ethnic and educational inequities in restrictive abortion policy variation and adverse birth outcomes in the United States. *BMC Health Serv Res*. 2021;21(1):1139. doi:10.1186/s12913-021-07165-x
17. Jerman J, Jones RK, Onda T. Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008. Published online May 10, 2016. Accessed August 31, 2022. <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>
18. State Funding of Abortions Under Medicaid. KFF. Published May 13, 2022. Accessed August 31, 2022. <https://www.kff.org/medicaid/state-indicator/abortion-under-medicaid/>
19. S.142 - 113th Congress (2013-2014): Hyde Amendment Codification Act. Published January 24, 2013. Accessed August 31, 2022. <http://www.congress.gov/>
20. Health Insurance Coverage of Women Ages 15-49. KFF. Published October 23, 2020. Accessed September 21, 2022. <https://www.kff.org/other/state-indicator/health-insurance-coverage-of-women-ages-15-49/>
21. The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion. Guttmacher Institute. Published April 23, 2021. Accessed September 21, 2022. <https://www.guttmacher.org/fact-sheet/hyde-amendment>
22. Advancing New Standards in Reproductive Health, University of California San Francisco. The Turnaway Study. ANSIRH. Accessed August 31, 2022. <https://www.ansirh.org/research/ongoing/turnaway-study>
23. Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters. Guttmacher Institute. Published July 12, 2016. Accessed August 31, 2022. <https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters>
24. Miller S, Wherry L, Foster DG. *The Economic Consequences of Being Denied an Abortion*. National Bureau of Economic Research; 2020:w26662. doi:10.3386/w26662
25. State Abortion Policies and Maternal Death in the United States, 2015–2018 | AJPH | Vol. 111 Issue 9. Accessed August 31, 2022. https://ajph.aphapublications.org/doi/10.2105/AJPH.2021.306396?url_ver=Z39.88-2003&rft_id=ori%3Arid%3Aacrossref.org&rft_dat=cr_pub++0pubmed
26. Research brief: The impact of Medicaid coverage restrictions on abortion. Ibis Reproductive Health. Published October 7, 2014. Accessed August 31, 2022. <https://www.ibisreproductivehealth.org/publications/research-brief-impact-medicaid-coverage-restrictions-abortion>

27. Upadhyay UD, McCook AA, Bennett AH, Cartwright AF, Roberts SCM. State abortion policies and Medicaid coverage of abortion are associated with pregnancy outcomes among individuals seeking abortion recruited using Google Ads: A national cohort study. *Soc Sci Med*. 2021;274:113747. doi:10.1016/j.socscimed.2021.113747
28. The American College of Obstetrics and Gynecology. Increasing Access to Abortion. 2020;136(6):9.
29. 29. American Medical Association House of Delegates Resolution 028 Preserving Access to Reproductive Health Services Pg. 97-102. Published online June 10, 2022. <https://www.ama-assn.org/system/files/a22-saturday-tote.pdf>
30. Texas State Law Library. Texas Abortion "Trigger" Law Effective August 25th, 2022. Published July 7, 2022. Accessed September 21, 2022. <https://www.sll.texas.gov/spotlight/2022/07/texas-abortion-trigger-law-effective-august-25th-2022/>
31. Graham L. Protecting Pain-Capable Unborn Children from Late-Term Abortions Act. Published online September 13, 2022:27.
32. Ruling an egregious allowance of government intrusion into medicine. American Medical Association. Accessed August 31, 2022. <https://www.ama-assn.org/press-center/press-releases/ruling-egregious-allowance-government-intrusion-medicine>
33. 86(R) HB 1501 - enrolled version - capitol.texas.gov. <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB01501F.pdf>. Accessed August 30, 2022. (10)
34. ACOG Guide to language and Abortion. ACOG. <https://www.acog.org/contact/media-center/abortion-language-guide>. Accessed August 30, 2022. (9)

RELEVANT AMA POLICY

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.

Res. 028, A-22

Right to Privacy in Termination of Pregnancy H-5.993

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;

(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and

(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13

Protecting the Patient-Physician Relationship H-165.837

Our AMA: (1) supports protecting the patient-physician relationship by continuing to advocate for: the obligation of physicians to be patient advocates; the ability of patients and physicians to privately contract; the viability of the patient-centered medical home; the use of value-based decision-making and shared decision-making tools; the use of consumer-directed health care alternatives; the obligation of physicians to prioritize patient care above financial interests; and the importance of financial transparency for all involved parties in cost-sharing arrangements; and (2) will continue to advocate protecting the patient-physician relationship in the context of bundled payment methodologies, comparative effectiveness research and physician profiling.

CMS Rep. 4, A-10; Reaffirmed: CMS Rep. 01, A-20

Government Interference in Patient Counseling H-373.995

1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
 - A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
 - B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
 - C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
 - D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
 - E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
 - F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
 - G. Is there a process for appeal to accommodate individual patients' circumstances?
6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19

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

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

Health, In All Its Dimensions, Is a Basic Right H-65.960

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Res. 021, A-19; Reaffirmed: Res. 234, A-22

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.

Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(I-22)

Introduced by: Organized Medical Staff Section

Subject: Obtaining Professional Recognition for Medical Service Professionals

Referred to: Reference Committee B

1 Whereas, Medical service professionals are gatekeepers for patient safety through
2 implementation of a stringent credentialing process that ensures quality patient care, medical
3 service professionals are highly trained professionals with specific expertise in credentialing
4 processes and regulatory compliance¹; and

5
6 Whereas, Medical service professionals have the responsibility for coordinating the activities of
7 the organized staff. These activities may include all aspects of the services provided by the
8 department, including accreditation compliance, credentials verification, medical staff committee
9 support, policy and procedure, and bylaws development²; and

10
11 Whereas, National Association Medical Staff Services (NAMSS) was first formed in California in
12 1978 and has grown to include over 5,500 medical staff professionals from all 50 states and
13 abroad³; and

14
15 Whereas, Included in the NAMSS' 2021 – 2024 Strategic Plan is a critical imperative to obtain a
16 standard occupational classification (SOC) from the U.S. Bureau of Labor Statistics (BLS) for
17 medical service professionals (MSPs); currently the BLS does not recognize the medical service
18 professional profession and instead classified MSPs as human resource (HR) professionals;
19 this designation is incorrect—and from the medical staff standpoint, egregious⁴; and

20
21 Whereas, SOC code is the gold standard for workforce data, serving to establish a profession
22 by definition and scope and make a case for hiring, retaining, and promoting within a
23 profession⁵; and

24
25 Whereas, Medical service professionals petitioned for a unique SOC code in 2010 and 2018⁶;
26 and

27
28 Whereas, BLS denied both petitions stating medical service professionals fall under Human
29 Resources and are “sufficiently covered in existing Human Resources and compliance
30 operations⁷,” and

¹ <https://www.bellevuehospital.com/services/medical-staff-services>

² https://samples.jbpub.com/9780763784416/84416_CH01_Gassiot.pdf

³ <https://www.namss.org/About/NAMSS-Timeline>

⁴ NAMSS, Synergy, Q1, 2022

⁵ National Association Medical Staff Services Webinar, Obtaining Professional Recognition for MSPs: Standard Occupational Classification (SOC), August 15, 2022.

⁶ *ibid*

⁷ *ibid*

Whereas, An SOC code is critical for the growth and independence of a profession; without a designated SOC code, government entities cannot formally collect and analyze a profession's data. A lack of systematic data on a profession, especially one that continues to evolve, will prevent it from growing and make it susceptible to scope creep from other professions⁸; therefore be it

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)

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

Received: 11/11/22

RELEVANT AMA POLICY

Medicare Payment Schedule Conversion Factor H-400.966

(1) The AMA will aggressively promote the compilation of accurate data on all components of physician practice costs and the changes in such costs over time, as the basis for informed and effective advocacy with Congress and the Administration concerning physician payment under Medicare. (2) The AMA will work aggressively with CMS, the Bureau of Labor Statistics, and other appropriate federal agencies to improve the accuracy of such indices of market activity as the Medicare Economic Index and the medical component of the Consumer Price Index.

Citation: CMS Rep. B, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 6, I-08; Reaffirmed: CMS Rep. 1, I-11; Reaffirmation: I-12; Reaffirmed in lieu of Res. 113, A-13; Reaffirmation I-13; Reaffirmed: CMS Rep. 3, A-14; Reaffirmed: CMS Rep. 04, I-18; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19

Revisions to AMA Policy on the Physician Workforce H-200.955

It is AMA policy that:

- (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
- (2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
- (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
- (4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
- (5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
- (6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
- (7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.

⁸ NAMSS, Synergy, Q1,2022

(8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.

(9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

Citation: CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10;
Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(I-22)

Introduced by: Congress of Neurological Surgeons, American Association of Neurological Surgeons

Subject: Recognizing Specialty Certifications for Physicians

Referred to: Reference Committee C

1 Whereas, Specialty certification is a critical component of our system of physician self-regulation
2 and is essential to serve the public and the medical profession by improving the quality of health
3 care through setting professional standards for lifelong certification; and
4

5 Whereas, The Institute for Credentialing Excellence defines a professional certification program
6 as one that provides an independent assessment of the knowledge, skills, and/or competencies
7 required for competent performance of a professional role or specific work-related tasks and
8 responsibilities; and
9

10 Whereas, The Institute for Credentialing Excellence further states that certification is also
11 intended to measure continued competence through recertification or renewal requirements;
12 and
13

14 Whereas, Only the entity that initially certifies an individual should recertify the individual's
15 certificate thereafter; and
16

17 Whereas, According to policy H-275.926, "Medical Specialty Board Certification Standards," our
18 AMA opposes any action, regardless of intent, that appears likely to confuse the public about
19 the unique credentials of the American Board of Medical Specialties (ABMS) or American
20 Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board-certified
21 physicians in any medical specialty, or take advantage of the prestige of any medical specialty
22 for purposes contrary to the public good and safety; and
23

24 Whereas, There are many legitimate certifying boards beyond the ABMS and AOA-BOS (e.g.,
25 American Board of Oral and Maxillofacial Surgery, American Board of Obesity Medicine, and
26 American Board of Physician Specialties) that curate knowledge and set standards for required
27 knowledge in a medical specialty and grant physicians certification who successfully meet their
28 independent assessments of knowledge and skills; and
29

30 Whereas, According to policy H-275.926, "Medical Specialty Board Certification Standards," our
31 AMA advocates for nomenclature to better distinguish those physicians who are in the board
32 certification pathway from those who are not; and
33

34 Whereas, Efforts by organizations that do not meet the basic standards for initial and continuing
35 certification to gain recognition by state legislatures and national organizations are ongoing and
36 will be confusing to the public and other health care stakeholders; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-275.926, "Medical
2 Specialty Board Certification Standards," by addition to read as follows:

3
4 Our AMA:

- 5 (1) Opposes any action, regardless of intent, that appears likely to confuse the public
6 about the unique credentials of American Board of Medical Specialties (ABMS) or
7 American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS)
8 board certified physicians in any medical specialty, or take advantage of the prestige
9 of any medical specialty for purposes contrary to the public good and safety.
- 10 (2) Opposes any action, regardless of intent, by organizations providing board
11 certification for non-physicians that appears likely to confuse the public about the
12 unique credentials of medical specialty board certification or take advantage of the
13 prestige of medical specialty board certification for purposes contrary to the public
14 good and safety.
- 15 (3) Continues to work with other medical organizations to educate the profession and
16 the public about the ABMS and AOA-BOS board certification process. It is AMA
17 policy that when the equivalency of board certification must be determined, the
18 certification program must first meet industry standards for certification that include
19 both 1) a process for defining specialty-specific standards for knowledge and skills
20 and 2) offer an independent, external assessment of knowledge and skills for both
21 initial certification and recertification in the medical specialty. In addition, accepted
22 standards, such as those adopted by state medical boards or the Essentials for
23 Approval of Examining Boards in Medical Specialties, will be utilized for that
24 determination.
- 25 (4) Opposes discrimination against physicians based solely on lack of ABMS or
26 equivalent AOA-BOS board certification, or where board certification is one of the
27 criteria considered for purposes of measuring quality of care, determining eligibility to
28 contract with managed care entities, eligibility to receive hospital staff or other clinical
29 privileges, ascertaining competence to practice medicine, or for other purposes. Our
30 AMA also opposes discrimination that may occur against physicians involved in the
31 board certification process, including those who are in a clinical practice period for
32 the specified minimum period of time that must be completed prior to taking the
33 board certifying examination.
- 34 (5) Advocates for nomenclature to better distinguish those physicians who are in the
35 board certification pathway from those who are not.
- 36 (6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the
37 financial burden on residents related to specialty board fees and fee procedures,
38 including shorter preregistration periods, lower fees and easier payment terms.
39 (Modify Current HOD Policy); and be it further
40

41 RESOLVED, That our AMA advocate for federal and state legislatures, federal and state
42 regulators, physician credentialing organizations, hospitals, other health care stakeholders and
43 the public to define physician board certification as establishing specialty-specific standards for
44 knowledge and skills, using an independent assessment process to determine the acquisition of
45 knowledge and skills for initial certification and recertification. (Directive to Take Action)

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

Received: 10/19/22

REFERENCES:

1. Institute for Credentialing Excellence. Definition of Certification, at <https://www.credentialingexcellence.org/About>, accessed 19 October 2022

RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926

Our AMA:

- (1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
- (2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
- (3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
- (4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
- (5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
- (6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

Citation: Res. 318, A-07; Reaffirmation A-11; Modified: CME Rep. 2, I-15; Modified: Res. 215, I-19

Continuing Board Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its

member boards that are consistent with this principle.

11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.

13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.

14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.

15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.

16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.

17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.

18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.

19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.

20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.

21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.

22. Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.

23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.

24. Continue to assist physicians in practice performance improvement.

25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.

29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.
34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.
35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.
36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.
37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.
38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.
39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.
- Citation: CME Rep. 2, I-15; Appended: Res. 911, I-15; Appended: Res. 309, A-16; Appended: CME Rep. 02, A-16; Appended: Res. 307, I-16; Appended: Res. 310, I-16; Modified: CME Rep. 02, A-17; Reaffirmed: Res. 316, A-17; Reaffirmed in lieu of: Res. 322, A-17; Appended: CME Rep. 02, A-18; Appended: Res. 320, A-18; Appended: Res. 957, I-18; Reaffirmation: A-19; Modified: CME Rep. 02, A-19; Appended: CME Rep. 1, I-20; Appended: Res. 310, A-21; Modified: CME Rep. 2, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(I-22)

Introduced by: Resident and Fellow Section

Subject: Support for GME Training in Reproductive Services

Referred to: Reference Committee C

1 Whereas, Abortion is considered a safe and effective medical procedure with many indications,
2 including rape, incest, intimate partner violence, fetal anomalies, illness during pregnancy,
3 exposure to teratogenic medications, and contraceptive failure¹⁻³; and
4

5 Whereas, Abortion is additionally medically critical for pregnancy complications, such as ectopic
6 pregnancy, placental abruption, bleeding from placenta previa, preeclampsia or eclampsia, and
7 cardiac or renal conditions which may be so severe that abortion is the only measure to
8 preserve a pregnant person's health or save their life¹⁻³; and
9

10 Whereas, In *Dobbs v. Jackson Women's Health Organization* decision, issued June 24, 2022,
11 the majority opinion held that abortion is not a constitutional right, thereby overturning *Roe v.*
12 *Wade* (1973) and *Planned Parenthood v. Casey* (1992)⁴; and
13

14 Whereas, At the June 2022 Annual Meeting, our House of Delegates passed "Preserving
15 Access to Reproductive Health Services" D-5.999, thereby codifying our stance on opposition to
16 criminalization of supporting reproductive health services, including abortion; and
17

18 Whereas, As of 9/26/22, 44 states prohibit abortion to some degree after a certain point in
19 pregnancy, with 9 states completely banning abortion, 4 states banning abortion at 6 weeks, 1
20 state at 15 weeks, 1 state at 20 weeks, 9 states at 22 weeks, 4 states at 24 weeks, 16 states at
21 viability, and 1 state in the third trimester^{5,6}; and
22

23 Whereas, The share of reported abortions performed on women outside their state of residence
24 was much higher before the 1973 *Roe* decision that stopped states from banning abortion. In
25 1972, 41% of all abortions in D.C. or the 20 states that provided this information to the CDC that
26 year were performed on women outside their state of residence. In 1973, the corresponding
27 figure was 21% in D.C. and the 41 states that provided this information, and in 1974 it was 11%
28 in D.C. and the 43 states that provided data⁷; and
29

30 Whereas, As of 2019, 39% of women aged 15-44 live in counties that do not have an abortion
31 provider, and that number is expected to grow largely with the *Dobbs v. Jackson Women's*
32 *Health Organization* decision^{6,8}; and
33

34 Whereas, Without training in basic medication and procedural abortion training, obstetricians &
35 gynecologists ("OB/GYN physicians") and family medicine physicians are unable to perform
36 safe and quality care for pregnancy loss and complications of pregnancy as detailed above; and

1 Whereas, While the Accreditation Council for Graduate Medical Education (ACGME) requires
2 access to abortion training for all obstetrics and gynecology residencies, 44.8% of accredited
3 programs are located in states that have or are likely to ban abortion, and a 2020 study found
4 that nearly one-tenth of OB/GYN residents report no training in abortion care^{9,10}; and
5

6 Whereas, Trainees seeking positions in OB/GYN and Family Medicine are limited by available
7 training programs and the National Resident Matching Program (NRMP) matching system with
8 regards to their ability to train at institutions that can provide adequate abortion training, and not
9 all students will have the personal or financial flexibility to pursue additional abortion training
10 elsewhere; and
11

12 Whereas, In 2022, the American College of Obstetricians and Gynecologists (ACOG) reaffirmed
13 its support for opposition to “legislative restrictions that impede access to abortion and increase
14 difficulty in abortion provision and training, including restrictions on public funding of abortion
15 education and training”¹¹; and
16

17 Whereas, In light of *Dobbs*, ACGME revised its program requirements for GME in obstetrics and
18 gynecology to include that “Programs must provide clinical experience or access to clinical
19 experience in the provision of abortions as part of the planned curriculum. If a program is within
20 a jurisdiction that legally restricts this clinical experience, the program must provide access to
21 this clinical experience in a jurisdiction where no such legal restriction is present.”¹²; and
22

23 Whereas, In 2022, the American Academy of Family Physicians (AAFP) reaffirmed its position
24 that “all medical students and family medicine residents receive comprehensive training in
25 reproductive decision making. Curricula and training should include but are not limited to:
26 abortion, pregnancy termination, contraception, and surgical and non-surgical management of
27 ectopic pregnancy, medication abortion and contraceptive management in-person and via
28 telehealth, options counseling, miscarriage management, opt-out abortion training, and referral
29 services”¹³; therefore be it

1 RESOLVED, That our American Medical Association policy H-295.923, “Medical Training and
2 Termination of Pregnancy,” be amended by addition and deletion to read as follows:

3
4 **Medical Training and Termination of Pregnancy**

5 1. Our AMA supports the education of medical students, residents and young physicians
6 about the need for physicians who provide termination of pregnancy services, the
7 medical and public health importance of access to safe termination of pregnancy, and
8 the medical, ethical, legal and psychological principles associated with termination of
9 pregnancy.

10 2. Our AMA ~~supports~~ will advocate for the availability of abortion education and hands-
11 on exposure to medication and procedural abortion procedures for termination of
12 pregnancy, including medication abortions, for medical students and resident/fellow
13 physicians and opposes efforts to interfere with or restrict the availability of this
14 education and training.

15 3. In the event that medication and procedural abortion are limited or illegal in a home
16 institution, our AMA supports pathways, including cost subsidization, to ensure trainees
17 traveling to another program have hands-on training in medication and procedural
18 abortion, and will advocate for legal protections for both trainees who cross state lines to
19 receive education on reproductive health services, including medication and procedural
20 abortion, as well as the institutions facilitating these opportunities.

21 34. Our AMA encourages the Accreditation Council for Graduate Medical Education to
22 consistently enforce compliance with the standardization of abortion training
23 opportunities as per the requirements set forth by the relevant Residency Review
24 Committees Review Committee for Obstetrics and Gynecology and the American
25 College of Obstetricians and Gynecologists’ recommendations (Modify Current HOD
26 Policy); and be it further
27

28 RESOLVED, That our AMA reaffirm policies H-100.948 “Supporting Access to Mifepristone
29 (Mifeprex)” and H-425.969 “Support for Access to Preventive and Reproductive Health
30 Services.” (Reaffirm HOD Policy)

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

Received: 11/11/22

REFERENCES:

1. Facts are Important: Abortion is Healthcare. Washington D.C.: American College of Obstetricians and Gynecologists, 2022, <https://www.acog.org/advocacy/facts-are-important/abortion-is-healthcare>.
2. National Academies of Sciences E, Medicine. The Safety and Quality of Abortion Care in the United States. Washington, DC: The National Academies Press; 2018.
3. Cameron S. Recent advances in improving the effectiveness and reducing the complications of abortion. F1000Res. 2018;7:F1000 Faculty Rev-1881. Published 2018 Dec 2. doi:10.12688/f1000research.15441.1
4. *DOBBS, STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, ET AL. v. JACKSON WOMEN'S HEALTH ORGANIZATION ET AL.* [2022] 597 U.S. 19-1392 (Supreme Court of the United States), p.9.
5. Guttmacher Institute. 2022. *State Bans on Abortion Throughout Pregnancy*. [online] Available at: <https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions> [Accessed 26 September 2022].
6. Power to Decide, ed. State-by-State Guide. Abortion Finder. <https://www.abortionfinder.org/abortion-guides-by-state>. Accessed September 26, 2022.
7. Kortsmit K, Mandel MG, Reeves JA, et al. Abortion Surveillance — United States, 2019. MMWR Surveill Summ 2021;70(No. SS-9):1–29. DOI: <http://dx.doi.org/10.15585/mmwr.ss7009a1>
8. Welsh J. A Verywell report: Abortion access ranked by State. Verywell Health. <https://www.verywellhealth.com/abortion-access-ranking-states-5202659>. Published September 27, 2021. Accessed September 26, 2022.
9. Vinekar K, Karlapudi A, Nathan L, Turk J, Rible R, Steinauer J. Projected Implications of Overturning Roe v Wade on Abortion Training in U.S. Obstetrics and Gynecology Residency Programs. Obstetrics & Gynecology. 2022 Apr 27. doi: 10.1097/AOG.0000000000004832
10. Horvath, Sarah MD, MS; Zite, Nikki MD, MPH; Turk, Jema MBA, PhD; Ogburn, Tony MD; Steinauer, Jody MD, PhD. Resident Abortion Care Training and Satisfaction: Results from the 2020 Council on Resident Education in Obstetrics and Gynecology

In-Training Examination Survey. Obstetrics & Gynecology: September 2021 - Volume 138 - Issue 3 - p 472-474, doi: 10.1097/AOG.0000000000004512

11. Abortion training and education. Committee Opinion No. 612. American College of Obstetricians and Gynecologists. Obstet Gynecol 2014;124:1055-9.
12. The Accreditation Council for Graduate Medical Education. ACGME Program Requirements for Graduate Medical Education in Obstetrics and Gynecology Summary and Impact of Interim Requirement Revisions, Requirement #: IV.C.7.- IV.C.7.e).(3). 2022. https://www.acgme.org/globalassets/pfassets/reviewandcomment/220_obstetricsandgynecology_2022-06-24_impact.pdf
13. American Academy of Family Physicians. Reproductive Decisions, Training In. July 2022. <https://www.aafp.org/about/policies/all/reproductive-decisions-training.html>

RELEVANT AMA POLICY

Medical Training and Termination of Pregnancy H-295.923

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA supports the availability of abortion education and exposure to procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.
3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.

Citation: Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17; Modified: Res. 309, I-21

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.

Citation: Res. 028, A-22;

Support for Access to Preventive and Reproductive Health Services H-425.969

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Citation: Sub. Res. 224, I-15; Reaffirmation: I-17

Training in Reproductive Health Topics as a Requirement for Accreditation of Family Residencies D-310.954

Our AMA: (1) will work with the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health including training in contraceptive counseling, family planning, and counseling for unintended pregnancy; and (2) encourages the ACGME to ensure greater clarity when making revisions to the educational requirements and expectations of family medicine residents in comprehensive women's health topics.

Citation: (Res. 317, A-13)

Supporting Access to Mifepristone (Mifeprex) H-100.948

Our AMA will support mifepristone availability for reproductive health indications, including via telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and Drug Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.

Citation: Res. 504, A-18; Modified: Res. 027, A-22

Access to Emergency Contraception D-75.997

1. Our AMA will: (a) intensify efforts to improve awareness and understanding about the availability of emergency contraception in the general public; and (b) support and monitor the application process of manufacturers filing for over-the-counter approval of emergency contraception pills with the Food and Drug Administration (FDA).

2. Our AMA: (a) will work in collaboration with other stakeholders (such as American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American College of Preventive Medicine) to communicate with the National Association of Chain Drug Stores and the National Community Pharmacists Association, and request that pharmacies utilize their web site or other means to signify whether they stock and dispense emergency contraception, and if not, where it can be obtained in their region, either with or without a prescription; and (b) urges that established emergency contraception regimens be approved for over-the-counter access to women of reproductive age, as recommended by the relevant medical specialty societies and the US Food and Drug Administration's own expert panel.

Citation: CMS Rep. 1, A-00; Appended: Res. 506, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 821
(I-22)

Introduced by: Integrated Physician Practice Section

Subject: PrEP is an Essential Health Benefit

Referred to: Reference Committee J

Whereas, The annual incidence of Human Immunodeficiency Virus (HIV) globally is still more than 1.5 million cases in 2022 and the United States continues to experience more than 34,000 new infections annually which disproportionately affect communities of color; and

Whereas, Pre-Exposure Prophylaxis (PrEP) is an evidence-based intervention that is 99 percent effective in preventing HIV transmission in sexual encounters and 74 percent effective in preventing HIV transmission in injection drug use according to the Centers for Disease Control and Prevention¹; and

Whereas, PrEP is critical to ending the HIV epidemic in the United States but only 25 percent of the approximately one million Americans who are most at risk for HIV infection are using this prevention; and

Whereas, Reducing barriers to care is essential to the effort to reduce HIV infection; and

Whereas, A recent ruling² by the United States District Court for the Northern District of Texas held that the Patient Protection and Affordable Care Act's inclusion coverage for PrEP cannot be mandated because it runs afoul of the Religious Freedom Restoration Act, thereby reducing access to this critical intervention and placing other mandated essential health benefits at risk; and

Whereas, The limiting of access to tested and proven preventive care removes a valuable tool from integrated, physician-led care teams and thus introduces an unnecessary weakness in the overall integrated care model of healthcare delivery; therefore be it

RESOLVED, That our American Medical Association support the continued inclusion of Pre-Exposure Prophylaxis (PrEP) for Human Immunodeficiency Virus (HIV) as an Essential Health Benefit under the Patient Protection and Affordable Care Act (Directive to Take Action); and be it further

RESOLVED, That our AMA support and join legal efforts to overturn the judgment rendered in *Braidwood v. Becerra* in the U.S. District Court for the Northern District of Texas. (Directive to Take Action).

Fiscal Note: Minimal: Less than \$1,000 to implement.

Received: 11/11/22

¹ Centers for Disease Control and Prevention. PrEP Effectiveness. <https://www.cdc.gov/hiv/basics/prep/prep-effectiveness.html> Accessed 9/26/2022

² *Braidwood Management Inc. et al. v. Xavier Becerra et al.* 4:20-cv-00283-0. (N.D. TX. 2022). <https://caselaw.findlaw.com/us-dis-crt-n-d-tex-for-wor-div/1911374.html> Accessed 9/26/2022.

RELEVANT AMA POLICY

Pre-Exposure Prophylaxis (PrEP) for HIV (H-20.895)

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

Citation: Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

Support of a National HIV/AIDS Strategy (H-20.896)

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

Citation: Sub. Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 822
(I-22)

Introduced by: Medical Student Section

Subject: Monitoring of Alternative Payment Models within Traditional Medicare

Referred to: Reference Committee J

1 Whereas, Under the Trump administration, the Center for Medicare and Medicaid Innovation
2 created a pilot project called Global and Professional Direct Contracting (GPDC) Model, which
3 allowed designated for-profit healthcare entities, better known as Direct Contracting Entities
4 (DCEs), to enter into a relationship with Medicare¹; and

5
6 Whereas, The Biden administration continued the project, changing the name to Accountable
7 Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) in response
8 to concerns raised about for-profit entities in Traditional Medicare²; and

9
10 Whereas, ACO-REACH, scheduled to begin in January of 2023, would move seniors enrolled in
11 Traditional Medicare into a novel reimbursement model without their consent by allowing CMS
12 to automatically search two years of seniors' claims history — without their consent or
13 knowledge — to find any visits with a participating DCE provider as the basis for aligning them
14 with that DCE¹⁻³; and

15
16 Whereas, Searching patients' claim history is a violation of AMA policy (D-315.992) regarding
17 patient privacy and moving seniors into a health plan they did not select is a violation of AMA
18 policy (H-373.998) regarding patient choice; and

19
20 Whereas, DCEs through ACO-REACH are allowed to keep up to 40% of the dollars dedicated
21 to patients in their care as profit, which exceeds the maximum medical loss ratio of 20% set by
22 the Affordable Care Act (also known as the 80/20 rule), and therefore giving them a dangerous
23 financial incentive to restrict seniors' care^{4,5}; and

24
25 Whereas, Patients do not choose to enroll in DCEs/ACO-REACH, but are automatically enrolled
26 if their primary care physician is in one, forcing patients to change their physician if they desire
27 to withdraw from the model^{1,2}; and

28
29 Whereas, Physicians may not necessarily choose to be part of DCEs/ACO-REACH, but can find
30 themselves in one if their group practice is acquired by another non-medical entity such as a
31 private equity firm, and then find their patients having to choose between staying with them or
32 leaving the DCEs/ACO-REACH^{1,2,5}; and

33
34 Whereas, Traditional Medicare limits the risk to the patient and burden on the physician by
35 generally not requiring pre-approval for treatment and offering free choice of doctors and
36 hospitals^{1,2}; and

37
38 Whereas, While Traditional Medicare is beholden to taxpayers, for-profit health insurance
39 companies have a fiduciary responsibility to maximize profit for their shareholders, which can be
40 aided through narrow networks and denial of care⁶⁻⁷; and

Whereas, Patient and physician choice is one of the highest priorities of our AMA (H-415.988, H-330.988); therefore be it

RESOLVED, That our American Medical Association monitor the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) program for its impacts on patients and physicians in Traditional Medicare, including the quality and cost of healthcare and patient/provider choice, and report back to the House of Delegates on the impact of the ACO-REACH demonstration program annually until its conclusion (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate against any Medicare demonstration project that denies or limits coverage or benefits that beneficiaries would otherwise receive in Traditional Medicare (Directive to Take Action); and be it further

RESOLVED, That our AMA develop educational materials for physicians regarding the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) program to help physicians understand the implications of their or their employer's participation in this program and to help physicians determine whether participation in the program is in the best interests of themselves and their patients. (Directive to Take Action)

Fiscal Note: Estimated cost to implement resolution is \$25,000

Received: 11/12/22

REFERENCES:

1. Global and Professional Direct Contracting (GPDC) Model (Center for Medicare and Medicaid Innovation, 2021). <https://innovation.cms.gov/innovation-models/gpdc-model>
2. Fact Sheet: Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model. Centers for Medicaid & Medicare Services. <https://www.cms.gov/newsroom/fact-sheets/accountable-care-organization-aco-realizing-equity-access-and-community-health-reach-model>. Published February 24, 2022. Accessed November 12, 2022.
3. RTI International. Global and Professional Direct Contracting Model Financial Operating Guide: Overview. 2021. <https://innovation.cms.gov/media/document/dc-financial-op-guide-overview>
4. Gilfillan, Richard, and Donald M. Berwick. "Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game." *Health Affairs*, 29 Sept. 2021, <https://www.healthaffairs.org/pitt.idm.oclc.org/doi/10.1377/forefront.20210927.6239>
5. Gilfillan, Richard, and Donald M. Berwick. "Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 2: Building On The ACO Model." *Health Affairs*, 30 Sept. 2021, <https://www.healthaffairs.org/pitt.idm.oclc.org/doi/10.1377/forefront.20210928.795755>
6. Geruso, M., & Layton, T. (2020). Upcoding: evidence from Medicare on squishy risk adjustment. *Journal of Political Economy*, 128(3), 984-1026.
7. Schwartz, A. L., Chen, Y., Jagmin, C. L., Verbrugge, D. J., Brennan, T. A., Groeneveld, P. W., & Newhouse, J. P. (2022). Coverage Denials: Government And Private Insurer Policies For Medical Necessity In Medicare: Study examines medical necessity coverage denials in Medicare and private insurers. *Health Affairs*, 41(1), 120-128.

RELEVANT AMA POLICY

Health Insurance Market Regulation H-165.856

Our AMA supports the following principles for health insurance market regulation:

- (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan;
- (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection;
- (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges;

- (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium;
 - (5) Insured individuals should be protected by guaranteed renewability;
 - (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices;
 - (7) Guaranteed issue regulations should be rescinded;
 - (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
 - (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and
 - (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:
 - (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed;
 - (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and
 - (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.
- CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Appended: Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed in lieu of Res. 125, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation: A-17; Reaffirmed: Res. 518, A-17; Reaffirmed: Res. 105, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
 - a. Health insurance coverage for all Americans
 - b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
 - c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
 - d. Investments and incentives for quality improvement and prevention and wellness initiatives
 - e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
 - f. Implementation of medical liability reforms to reduce the cost of defensive medicine
 - g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

- a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
 - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
 - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
 - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
 - e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
 - f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
- Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22

Educating the American People About Health System Reform H-165.844

Our AMA reaffirms support of pluralism, freedom of enterprise, and strong opposition to a single payer system.

Res. 717, I-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: CMS Rep. 2, A-22

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Res. 412, A-06; Appended: Res. 907, I-12; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmed: Res. 425, A-22

Adequacy of Health Insurance Coverage Options H-165.846

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:

- A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
- B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
- C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
- D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.

2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.

3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.

CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

- A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
- B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
- C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
- D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
- E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
- F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
- G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
- H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for

the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients

Res. 130, I-93; Res. 316, I-93Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep. 1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

Opposition to Nationalized Health Care H-165.985

Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:

(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.

(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services.

(Reaffirmed: BOT Rep. I-93-25; Reaffirmed: CMS Rep. I-93-5)

(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.

(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.

(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.

(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.

(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.

(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.

BOT Rep. U, I-88; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 110, A-94; Reaffirmed: CMS Rep. 7, I-97; Reaffirmed by CMS Rep. 9, A-98; Reaffirmed: CMS Rep. 4, A-99; Reaffirmation I-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 112, A-09; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Modified: Speakers Rep., A-14; Reaffirmed: CMS Rep. 09, A-19

Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974

Our AMA supports parity of coverage for mental illness, alcoholism and substance use.

Res. 212, A-96; Reaffirmation A-97; Reaffirmed: Res. 215, I-98; Reaffirmation A-99; Reaffirmed: BOT Action in response to referred for decision Res. 612, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmation A-02; Reaffirmation I-03; Modified: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmation A-15; Modified: Res. 113, A-16

Nondiscrimination in Health Care Benefits H-185.986

Our AMA reaffirms its opposition to discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans, and opposes discrimination in any proposed plans for national health care coverage or universal access for the people who are uninsured. Res. 58, A-91; Reaffirmation A-97; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Ending Medicare Advantage Auto-Enrollment H-285.905

Our AMA will work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of "auto-enrollment" of individuals into Medicare Advantage Plans. Res. 216, I-16; Reaffirmation: A-22

Medicare Advantage Policies H-285.913

Our AMA will: 1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty; 2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and 3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

Patient Information and Choice H-373.998

Our AMA supports the following principles:

1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.
2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.
3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.
4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.
5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.
6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: Sub. Res. 701, A-93; Sub. Res. 125, A-93; Reaffirmation A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: Sub. Res. 107,

I-93; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; BOT Rep. 36 - I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed by Sub. Res. 107, I-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-96; Reaffirmation I-96; Reaffirmation A-97; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 9, A-98; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 4, A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, A-15; Reaffirmation: A-17; Reaffirmed: Res. 108, A-17; Reaffirmation: A-19; Reaffirmed in lieu of: Res. 112, A-19

Prevent Medicare Advantage Plans from Limiting Care D-285.959

Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions.

Res. 706, A-21

Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans H-330.870

Our AMA will: (1) advocate for provision of transparent print and audio/video patient educational resources to patients and families in multiple languages from health care systems and from Medicare - directly accessible - by consumers and families, explaining clearly the different benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications under Medicare, Medicare Supplemental and Medicare Advantage plans; (2) advocate for printed and audio/video patient educational resources regarding personal costs, changes in benefits and provider panels that may be incurred when switching (voluntarily or otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans, including additional information regarding federal and state health insurance assistance programs that patients and consumers could access directly; and (3) advocate for increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of and access to such programs.

Res. 817, I-19; Modified: Res. 125, A-22

Legislation for Assuring Equitable Participation of Physicians in Medicare Advantage H-330.916

Our AMA seeks to have the CMS, while contracting with Medicare Advantage organizations for Medicare services, require the following guarantees to assure quality patient care to medical beneficiaries: (1) a Medicare Advantage patient shall have the right to see a duly licensed physician of the appropriate training and specialty; (2) if CMS decertifies a Medicare Advantage plan, enrollees in that plan who are undergoing a course of treatment by a physician at the time of such termination shall continue to receive care from their treating physician until an appropriate transfer is accomplished; and (3) any Medicare Advantage plan deselection of participating physicians may occur only after the physician has been given the opportunity to appeal the deselection decision to an Independent Review Body.

Res. 707, I-98; Reaffirmed: BOT Rep. 23, A-09; Modified: CMS Rep. 01, A-19

Police, Payer and Government Access to Patient Health Information D-315.992

Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act "privacy" rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician's concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians.

Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed: BOT Rep. 7, A-21; Reaffirmation: A-22

Standardization of Advance Beneficiary Notification of Non-Coverage Forms for Medicare Advantage Plans and Original Fee-For-Service Medicare D-70.950

1. Our AMA will request the Centers for Medicare & Medicaid Services provide a standardized Advance Beneficiary Notice of Non-coverage (ABN) that will be sufficient notification to inform all Medicare Advantage Plan and Original (Fee-For-Service) Medicare beneficiaries when Medicare may deny payment for an item or service.
2. Our AMA will advocate that Medicare Advantage Plan requirements for carrier specific advance beneficiary notice of non-coverage and similar forms be eliminated.

Res. 109, A-14; Reaffirmation: I-18

Elimination of Subsidies to Medicare Advantage Plans D-390.967

1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services.
2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.

Res. 229, A-07; Modified: CMS Rep. 01, A-17

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19

Medicare Advantage Plans D-330.923

Our AMA encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs only to those health plans that meet all of the following criteria: (1) an 85% or higher medical loss ratio; (2) physician payment rates are no less than Medicare Fee for Service rates; and (3) use enforceable contracts that prohibit unilateral changes in physician payment rates.

Res. 837, I-08; Reaffirmed: Res. 116, A-17; Reaffirmation: I-18

Medicare Advantage Policies H-330.878

Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.

Res. 116, A-17; Reaffirmation: I-18

Medicare Advantage Opt Out Rules H-330.913

Our AMA: (1) opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who can't must choose new doctors; (2) supports current proposals to extend the 30 day waiting period that limits when Medicare recipients may opt out of managed care plans, if such proposals can be amended to create an exemption to protect patients whenever a plan alters benefits or whenever a patient's physician leaves the plan; and (3) supports changes in CMS regulations which would require Medicare Advantage plans to immediately notify patients, whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and to give affected patients a reasonable opportunity to switch plans.

Res. 707, A-99; Reaffirmed: CMS Rep. 5, A-09; Modified: CMS Rep. 01, A-19

Medicare Advantage Step Therapy D-320.984

Our AMA will continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019.

Res. 810, I-18; Reaffirmation: A-22

Prior Authorization Relief in Medicare Advantage Plans H-320.938

Our AMA supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- a. List services and prescription medications that require a PA on a website and ensure that patient informational materials include full disclosure of any PA requirements.
- b. Notify providers of any changes to PA requirements at least 45 days prior to change.
- c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.
- d. Standardize a PA request form.
- e. Minimize PA requirements as much as possible within each plan and eliminate the application of PA to services and prescription medications that are routinely approved.
- f. Pay for services and prescription medications for which PA has been approved unless fraudulently obtained.
- g. Allow continuation of medications already being administered or prescribed when a patient changes health plans, and only change such medications with the approval of the ordering physician.
- h. Make an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.
- i. Define a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans.

Res. 814, I-18; Reaffirmation: A-22

Strengthening Medicare Through Competitive Bidding H-330.886

1. Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program:

- a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries.
- b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks.
- c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses.
- d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region.
- e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area.
- f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums.
- g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans.

2. Our AMA supports using a competitive bidding process to determine federal payments to Medicare Advantage plans.

CMS Rep. 7, I-13

Managed Medicare Reimbursement H-330.928

The AMA advocates that Medicare managed care plans (e.g., Medicare Advantage, etc.) that use the RBRVS do so in a manner that maintains the relativity of the RBRVS utilized in the traditional Medicare program.

Sub. Res. 819, I-97; Reaffirmation I-05; Modified: CMS Rep. 1, A-15

Medicare Cost-Sharing D-330.951

Our AMA will urge the Centers for Medicare and Medicaid Services to require companies that participate in the Medicare Advantage program to provide enrollees and potential enrollees timely information in a comparable, standardized, and clearly-written format that details enrollment restrictions, as well as all coverage restrictions and beneficiary cost-sharing requirements for all services.

CMS Rep. 2, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 823
(I-22)

Introduced by: Private Practice Physicians Section

Subject: Health Insurers and Collection of Co-pays and Deductibles

Referred to: Reference Committee J

1 Whereas, Insurers contract with physicians to provide medical care to patients at an agreed
2 upon rate; and
3

4 Whereas, Insurers contract with patients to receive medical care from physicians at an agreed
5 upon rate, subject to co-pay and deductible amounts; and
6

7 Whereas, Despite the contract between patient and insurer, the patient's physician must collect
8 the co-pay and deductible from the patient; and
9

10 Whereas, At times, this practice is misunderstood by patients; they believe their physician is
11 attempting to gain additional payment for care; and
12

13 Whereas, To honor the respective contractual obligations between insurer and physician, and
14 insurer and patient, insurers should be required to collect co-pays and deductibles from
15 patients; therefore be it
16

17 RESOLVED, That our American Medical Association advocate for legislation and/or regulations
18 to require insurers to collect co-pays and deductibles in fee-for-service arrangements directly
19 from patients with whom the insurers are contractually engaged and pay physicians the full
20 contracted rate unless physicians opt out to collect on their own. (Directive to Take Action)

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

Received: 11/11/22

RELEVANT AMA POLICY

Payment by Health Insurance Plans of Medicare Deductibles and Copayments D-390.984

Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; and (2) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary.

Citation: Res. 105 and 106, A-03; Reaffirmed: BOT Rep. 28, A-13; Modified: CCB/CLRPD Rep. 2, A-14

Price of Medicine H-110.991

Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to

prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.

Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmed: A-19; Appended: Res. 126, A-19

Patient's Out-of-Pocket Contributions to Private Health Insurance H-185.983

(1) The AMA takes the position that the practice of basing copayments on a different basis than the third party reimbursement should be condemned. (2) If physicians learn that their patients' copayments are being computed on a different basis than the third party's reimbursement, they should inform their patients and, when appropriate, help them make fully informed, cost-conscious alternative choices about their insurance coverage. (3) If physicians suspect that copayments are being set unfairly, they should bring these matters to the attention of the state insurance commissioner or other state regulator and ask for assistance from their state medical society.

Citation: BOT Rep. D, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13

Managed Care Secondary Payers H-385.950

Our AMA:

- (1) will seek regulatory changes that require all payers of secondary Medicare insurance to reimburse the co-insurance and applicable deductible obligations of Medicare beneficiaries;
- (2) will require that these co-insurance and deductible obligations cannot be waived contractually;
- (3) will consider the development of draft federal legislation to require Medicare to recognize the total coinsurance and deductible amounts facing Medicare beneficiaries in instances where Medicare provides secondary insurance coverage;
- (4) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan (not a Medigap policy) as their secondary carrier should be entitled to receive payment in full from their secondary carriers for all Medicare patient deductible and copayments without regard to the amount of the Medicare payment for the service;
- (5) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan as secondary should be entitled to receive payment in full from their secondary plans for all Medicare patient deductibles and copayments without regard to any requirement that there be prior authorization by the secondary plan for medical care and treatment that is medically necessary under Medicare, by imposing limits on the amount, type or frequency of services covered, and by thereby seeking to "manage" the Medicare benefit, as if the secondary carrier were the primary carrier; and
- (6) in its advocacy efforts, will address and seek to solve (by negotiation, regulation, or legislation) the problem wherein a secondary insurance company does not reimburse the patient for, nor pay the physician for, the remainder/balance of the allowable amount on the original claim filed with the patient's primary insurance carrier, regardless of the maximum allowed by the secondary insurance payer.

Citation: BOT Rep. 33, A-96; Appended: Res. 122, A-98; Reaffirmed: Res. 105, A-00; Sub. Res. 104, A-01; Reaffirmed: I-01; Appended: Res. 105 and 106, A-03; Appended: Res. 821, I-11; Modified: BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 824
(I-22)

Introduced by: Private Practice Physicians Section

Subject: Enabling and Enhancing the Delivery of Continuity of Care When Physicians Deliver Care Across Diverse Problem Sets

Referred to: Reference Committee J

1 Whereas, The American Medical Association has advocated strongly for fair rates of pay for
2 physicians regarding services rendered; and
3

4 Whereas, The CPT documentation coding changes for 2021 regarding office-based evaluation
5 and management (E&M) services has had success in limiting our documentation and has
6 placed a better focus on the value of the actual work physicians perform; and
7

8 Whereas, The current reimbursement system has placed a value on performing an E&M service
9 regarding one or two problems that are new or chronic at each patient encounter; and
10

11 Whereas, Patients will frequently have more requests within a given visit than is currently
12 designed to account for and it is recognized that being able to address more than one to two
13 problems in a visit represents good patient care, good customer service, good continuity of care,
14 and good medical care; and
15

16 Whereas, Proceduralists are currently allowed and encouraged to account for each individually
17 recognized service that is performed for a patient at each encounter and this has been accepted
18 by the whole of the AMA; and
19

20 Whereas, Those physicians who attempt to address more than one to two problems during a
21 patient encounter as a result of a patient request or need, either by addressing those additional
22 problems at that visit or by attempting to delay a subset of the additional problems to a future
23 visit, are at risk of either delivering patient care at a value that is less than what is currently
24 designed for by the AMA or is at risk of a patient gaining a perception that the physician has
25 delivered a poor customer service experience for that patient at that encounter; and
26

27 Whereas, The perception of an excellent customer service experience has become ever more
28 important with increasingly utilized star ratings as promulgated by common internet search
29 companies and patient-centric medical rating services, and that the value of these star ratings
30 strongly reflects upon the success of a medical practice; and
31

32 Whereas, being encouraged by patients, health plans, IPAs, and Medicare to perform more
33 services in a visit than is currently designed and accounted for has the effect of decreasing the
34 perceived value of these additional services within the eyes of the patient and below the value
35 as designed by the AMA; and
36

37 Whereas, Office-based physicians who are exposed to such requests from patients and are
38 able and wish to perform such additional services currently are continually placed in a position
39 of not being fairly reimbursed for their services which in turn results in medical practices that

1) are not being able to offer a competitive rate pay to their staff; 2) are strongly encouraged by patients, health plans, IPAs, and Medicare to deliver their services at a lower than intended rate of remuneration; 3) are not able to present and utilize adequate resources for patients for the sake of quality patient care; 4) continually place their own wellbeing at risk due to a greater workload at a lower rate of pay; 5) are faced with higher rates of stress and burnout; and 6) are forced to sacrifice time that should be spent with family and friends and place the very success of the practice at risk; therefore be it

RESOLVED, That our American Medical Association recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for appropriate payment for multiple services (two or more) to be performed during a single patient encounter. (New HOD Policy)

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

Received: 11/11/22

RELEVANT AMA POLICY

Evaluation and Management (H-70.961)

Our AMA will work with the CMS to continue to refine evaluation and management coding.

Citation: Res. 804, A-96; Reaffirmed: I-00; Reaffirmed: CMS Rep. 06, A-10; Modified: CMS Rep. 01, A-20

Medicare Guidelines for Evaluation and Management Codes (H-70.952)

Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; and (6) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.

Citation: Sub. Res. 801, I-97; Reaffirmed: I-00; Reaffirmed: CMS Rep. 06, A-10; Modified: CMS Rep. 01, A-20

Preservation of Five Levels of Evaluation and Management Services (D-70.979)

Our AMA will communicate to the Centers for Medicare and Medicaid Services and to private payers that the current levels of Evaluation and Management services should be maintained and not compressed, with appropriate payment for each level.

Citation: Sub. Res. 801, I-01; Reaffirmed: A-06; Reaffirmed in lieu of: Res. 823, I-06; Modified: CMS Rep. 01, A-16

Update on Revision of CPT E&M Codes and Development of Clinical Examples (H-70.921)

Our AMA policy is that future efforts to substantially revise Evaluation and Management (E&M) codes should only occur under the auspices of the CPT Editorial Panel and then through a broadly inclusive process that provides for significant and meaningful input from state medical associations, medical specialty societies and public and private payers.

Citation: BOT Rep. 26, I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: Res. 816, I-19

Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services (H-385.952)

Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed.

Citation: Res. 118, I-95; Reaffirmed: A-00; Reaffirmed: A-02; Reaffirmed: A-06; Reaffirmed: A-09;
Reaffirmed: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 825
(I-22)

Introduced by: Private Practice Physicians Section

Subject: Minimal Sustainable Reimbursement for Community Practices

Referred to: Reference Committee J

1 Whereas, Community-based private practices accept insurance reimbursement to provide
2 access to affordable service for people in need; and
3

4 Whereas, Small private practices provide neighborhood-based care, often in communities facing
5 health disparities, that may not be readily available elsewhere; and
6

7 Whereas, Medicare rates are collaboratively (by the AMA, government agencies, and industry)
8 based on the source-based relative values scale, created by Harvard University in 1985 and
9 published in the *Journal of the American Medical Association* in 1988¹, which incorporates
10 physician work, practice expense, professional liability costs, and geographic variations, with
11 extensive input from physicians and specialty societies; and
12

13 Whereas, There are currently no lower limits regarding the reimbursement rates insurers pay to
14 medical practices and no legal requirements that insurers negotiate with practices, provide fair
15 reimbursement, or consider the needs of patients served by community practices; and
16

17 Whereas, Reimbursement from private insurers to small practices is often well below Medicare
18 rates and below the level required to cover fixed costs and accompanied by a dramatic increase
19 in required reporting by physician offices; and
20

21 Whereas, Payers may refuse to negotiate appropriate reimbursement rates with small private
22 practices; and
23

24 Whereas, AMA policy supports a pluralistic approach to health care utilization to include small,
25 solo, and medium-sized practices. Despite the well documented outcome-based evidence of the
26 benefit of these treatment options, third-party insurers are forcing market consolidation with
27 unsustainable reimbursement models that are below Medicare reimbursement rates; and
28

29 Whereas, Private practices are prohibited from collaborating with each other to request fair
30 reimbursement due to prior antitrust legal interpretations; and
31

32 Whereas, Private practices are rapidly disappearing, either going out of business or being
33 absorbed by large institutional practices that are able to negotiate with payers (as of January
34 2021², nearly 70 percent of U.S. physicians reportedly worked for hospitals or corporate
35 entities); and

¹ Janower ML. The Resource-Based Relative Value Scale. JAMA. 1988 Mar 4;259(9):1329. PMID: 3339834

² Physician Advocacy Institute. COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment 2019-2020. Accessed 9/22/2022: http://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/Revised-6-8-21_PA-Physician-Employment-Study-2021-FINAL.pdf?ver=K6dyoekRSC_c59U8QD1V-A%3d%3d

Whereas, The future of health care is trending towards the concepts of population health management, outcome evidence-based care, and value-based purchasing of health care. These models favor large groups and hospitals, once again excluding private practice physicians in small and medium-sized groups, thus action is needed now to establish both access to patients and appropriate floors for reimbursement which will address these health care models and their potentially deleterious effects on private practice physicians in small and medium-sized groups going forward; and

Whereas, In the same way individuals are protected through the Fair Labor Standards Act of 1938 (29 USC § 203), which set a minimum wage, and states and municipalities have enacted similar measures, governments have the authority to establish minimum levels of reimbursement for medical practices; therefore be it

RESOLVED, That our American Medical Association study small practices in the country to better understand reimbursement rates from major insurers and how these practices experience them (Directive to Take Action); and be it further

RESOLVED, That our AMA study and report back on appropriate remedies for reimbursement rates for physician practices (Directive to Take Action); and be it further

RESOLVED, That our AMA study the impacts of concepts of population health management, outcome evidence-based care, and value-based purchasing of health care on small and medium-sized physician practices (Directive to Take Action).

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

Received: 11/11/22

RELEVANT AMA POLICY

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors (D-400.990)

Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.

Citation: Res. 137, A-02; Reaffirmed: CCB/CLRPD Rep. 4, A-12; Appended: Res. 103, A-13; Reaffirmed: A-19

National Mandatory Fee Schedule (H-385.986)

The AMA opposes any type of national mandatory fee schedule.

Citation: Res. 27, A-85; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CLRPD Rep. 2, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of: Res 127, A-10; Reaffirmed: A-15

Definition of "Usual, Customary and Reasonable" (UCR) (H-385.923)

1. Our AMA adopts as policy the following definitions:

(a) "usual; fee means that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee);

(b) a fee is 'customary' when it is within the range of usual fees currently charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area; and

(c) a fee is 'reasonable' when it meets the above two criteria and is justifiable, considering the special circumstances of the particular case in question, without regard to payments that have been discounted under governmental or private plans.

2. Our AMA takes the position that there is no relationship between the Medicare fee schedule and Usual, Customary and Reasonable Fees.

Citation: Res. 109, A-07; Appended: Res. 107, A-13

Physician Choice of Practice (H-385.926)

Our AMA: (1) encourages the growth and development of the physician/patient contract; (2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.); (3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and (4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance.

Citation: BOT Rep. QQ, I-91; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: Ref. Cmte. A, A-93; Reaffirmed: BOT Rep. UU, A-93; Reaffirmed: CMS Rep. G, A-93; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: Sub. Res. 701, A-93; Reaffirmed: A-93; Reaffirmed: BOT Rep. 25, I-93; Reaffirmed: CMS Rep. 5, I-93; Reaffirmed: CMS Rep. 10, I-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 107, I-93 Res. 124, I-93; Reaffirmed: Sub. Res. 127, A-94; Reaffirmed: BOT Rep. 46, A-94; Reaffirmed: Sub. Res. 132, A-94; Reaffirmed: BOT Rep. 16, I-94; Reaffirmed: CMS Rep. 8, A-95; Reaffirmed: Sub. Res. 109, A-95; Reaffirmed: Sub. Res. 125, A-95; Reaffirmed: Sub. Res. 109, I-95; Reaffirmed: A-96; Reaffirmed: I-96; Reaffirmed: A-97; Reaffirmed: I-98; Reaffirmed: A-99; Appended: Res. 127, A-98; Reaffirmed: CMS Rep. 6, A-99; reaffirmed: A-00; Reaffirmed: Sub Res. 116, I-00; reaffirmed: Res. 217, A-01; Reaffirmed: A-04; Consolidated and Renumbered: CMS Rep. 7, I-05; Reaffirmed: A-07; Reaffirmed: A-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: I-13; Reaffirmed: A-15; Reaffirmed: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 09, A-16; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 6, A-21; Reaffirmed: CMS Rep. 2, A-22

Payment for Physicians Services (H-385.989)

Our AMA: (1) supports a pluralistic approach to third party payment methodology under fee-for-service, and does not support a preference for "usual and customary or reasonable" (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public.

Citation: CMS Rep. A, A-84; Reaffirmed: CLRPD Rep. 3, A-94; Reaffirmed: Sub Res. 716, A-00; Reaffirmed: A-02; Reaffirmed: A-07; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: I-13; Reaffirmed: A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 826
(I-22)

Introduced by: Private Practice Physicians Section

Subject: Leveling the Playing Field

Referred to: Reference Committee J

1 Whereas, The AMA has entertained resolutions, created reports, and authored letters and
2 comments on Medicare site-of-service differential for more than 30 years; and
3

4 Whereas, On October 1, 2022, the Centers for Medicare & Medicaid Services' final rule dictating
5 the fee schedule for inpatient prospective payment systems (IPPS) and long-term care hospital
6 (LTCH) payment systems for the federal 2023 fiscal year went into effect with an increase in
7 payments for inpatient services of 4.3 percent and an additional estimated aggregate IPPS
8 LTCH payment increase of 2.4 percent; and
9

10 Whereas, Inflation and rising payroll costs are just as detrimental factors for outpatient Part B
11 services as to inpatient services; and
12

13 Whereas, It is an injustice not to provide for increases in the outpatient Part B fee schedule,
14 particularly in light of the national emphasis on health equity; and
15

16 Whereas, The Supporting Medicare Providers Act, introduced in both the U.S. House of
17 Representatives and the U.S. Senate during the 117th Congress, seeks to address looming cuts
18 in Medicare; and
19

20 Whereas, A huge health care system in which contractors and physicians are annually under
21 threat of cuts that may seem small but are destabilizing is not an acceptable method of
22 operating a system with such permanency as Medicare; and
23

24 Whereas, Patients have been paying into this system throughout their working lives and
25 deserve stability in the Medicare Part B program; and
26

27 Whereas, The federal government as a duty to maintain stability in the US healthcare economy
28 which contributes to stability in the US economy as a whole; therefore be it
29

30 RESOLVED, That our American Medical Association produce a graphic report illustrating the
31 fiscal losses and inequities that practices without facility fees have endured for decades as a
32 result of the site of service differential factoring in inflation. (Directive to Take Action).

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

Received: 11/11/22

RELEVANT AMA POLICY

The Site-of-Service Differential (D-330.902)

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

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

Payment Variations Across Outpatient Sites of Service (D-240.994)

Our AMA will work with states to advocate that third party payers be required to: a. Assess equal or lower facility coinsurance for lower-cost sites of service (hospital outpatient department, ambulatory surgical center, or office-based facility); b. Publish and routinely update pertinent information related to patient cost-sharing; and c. Allow their plan's participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient.

Citation: CMS Rep. 3, A-13; Reaffirmed: I-17

Managed Care (H-285.998)

(1) Introduction The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing.

(2) Definition "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population.

(3) Techniques Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees.

(4) Case Management Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings.

With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role.

The primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the

patient's care.

Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payers should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed.

A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field.

A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan.

All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient.

When inordinate amounts of time or effort are involved in providing case management services required by a third party payer which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payer or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage."

Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians.

In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process.

Citation: Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, A-96; Modified: CMS Rep. 4, I-96; Reaffirmed: A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed; CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmed: A-00; Reaffirmed: A-02; Reaffirmed: I-04; Reaffirmed in lieu of Res. 839, I-08; Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Reaffirmed: I-10; Reaffirmed; A-11; Reaffirmed; Res. 709, A-12; Reaffirmed: CMS Rep. 07, A-16; Reaffirmed; CMS Rep. 08, A-17; Reaffirmed; CMS Rep. 04, A-18; Reaffirmed: A-19; Reaffirmed: CMS Rep. 4, A-21; Reaffirmed: A-22

Appropriate Payment Level Difference by Place and Type of Service (H-330.925)

Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery.

Citation: Sub. Res. 104, A-98; Reaffirmed: I-98; Appended: CMS Rep. 7, A-99; Reaffirmed: A-00; Reaffirmed: A-11; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed: Sub Res 104, A-14; Reaffirmed: Res. 116, A-14; Modified: CMS Rep. 3, A-14; Reaffirmed; A-14; Reaffirmed: A-15; Reaffirmed: A-17

Appropriate Payment Level Differences by Place and Type of Service (D-330.997)

1. Our AMA encourages CMS to: (A) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (B) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers.

2. Our AMA will continue to encourage the CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments.

Citation: CMS Rep. 7, A-99; Reaffirmed: I-03; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed; Sub. Res. 104, A-14; Reaffirmed: A-14; Reaffirmed: A-15; Reaffirmed: I-17; Reaffirmed: CMS Rep. 4, I-18; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 937
(I-22)

Introduced by: American Society for Metabolic and Bariatric Surgery, Society of American
Gastrointestinal and Endoscopic Surgeons

Subject: Indications for Metabolic and Bariatric Surgery

Referred to: Reference Committee K

1 Whereas, Obesity is the most common chronic disease in adulthood; and

2
3 Whereas, Untreated adult obesity leads to significant morbidity, premature mortality, and an
4 enormous financial burden to society from health care costs and lost productivity; and

5
6 Whereas, Effective treatment of the disease obesity requires a comprehensive multi-disciplinary
7 approach delivered chronically including lifestyle therapy, anti-obesity medications, and
8 metabolic and bariatric surgery; and

9
10 Whereas, In 1991, the National Institutes of Health (NIH) convened a Consensus Development
11 Conference that established the baseline criteria for the indications for the practice of bariatric
12 surgery based on the available scientific evidence of that time period; and

13
14 Whereas, Since this Consensus Development Conference, providers, hospitals, policy makers
15 and insurers have used these guidelines as a universal threshold for access to metabolic and
16 bariatric surgery services, regardless of individualized patient concerns; and

17
18 Whereas, Since the publication of the 1991 NIH Guidelines, hundreds of scientific papers have
19 been published that challenge the absolute weight-based restrictions that have prevented
20 patients with the disease of obesity and associated comorbidity from obtaining life-altering
21 metabolic surgery services. In addition, the NIH itself indicated in 1996 that the Guidelines
22 should no longer be used for policy decisions; and

23
24 Whereas, The American Society for Metabolic and Bariatric Surgery (ASMBS) and International
25 Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) published a new
26 consensus document that provides updates and replaces the 1991 NIH Guidelines. These
27 updates include revising and broadening the indications for surgery based upon the most
28 current scientific evidence; and

29
30 Whereas, The new ASMBS and IFSO indications for surgery is highlighted by the indication of
31 metabolic and bariatric surgery (MBS) for individuals with a body mass index (BMI) of ≥ 35 ,
32 regardless of the presence of comorbidities related to obesity; for individuals with metabolic
33 disease with a BMI between 30-35; and for individuals in the Asian population with a BMI \geq
34 27.5; and

35
36 Whereas, The 2022 ASMBS and IFSO: Indications for Metabolic and Bariatric Surgery have
37 been approved by the governing boards of both organizations and were released to the public
38 on October 21, 2022; and

1 Whereas, Many health insurance plans, public and private, continue to utilize the outdated and
2 now obsolete 1991 NIH guidelines for surgery and this presents a significant barrier to patients
3 seeking definitive surgical care for the disease of obesity, resulting in progressive weight gain,
4 worsening obesity, and weight-related co-morbidities; and
5

6 Whereas, Recent American Medical Association policy D-440.954, "Addressing Obesity,"
7 establishes the AMA as working to improve national understanding of the obesity epidemic and
8 address gaps in medical obesity education and health disparities, and the lack of insurance
9 coverage for obesity treatment; therefore be it
10

11 RESOLVED, That our American Medical Association acknowledge and accept the new
12 American Society for Metabolic and Bariatric Surgery and International Federation for the
13 Surgery of Obesity and Metabolic Disorders indications for metabolic and bariatric surgery (New
14 HOD Policy); and be it further
15

16 RESOLVED That our AMA immediately call for full acceptance of these guidelines by insurance
17 providers, hospital systems, policy makers, and government healthcare delivery entities
18 (Directive to Take Action); and be it further
19

20 RESOLVED, That our AMA work with all interested parties to lobby the legislative and executive
21 branches of government to affect public health insurance coverage to ensure alignment with
22 these new guidelines. (Directive to Take Action)

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

Received: 11/03/22

RELEVANT AMA POLICY

Addressing Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.

2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

3. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 938
(I-22)

Introduced by: Academic Physicians Section

Subject: AMA Study of Efficacy of Requirements for Metal Detection/Weapons
Interdiction Systems in Health Care Facilities

Referred to: Reference Committee K

1 Whereas, Incidents of armed violence committed upon medical personnel continue at an
2 unacceptable rate; and
3

4 Whereas, Such an incident in Tulsa, Oklahoma in June 2022 resulted in the deaths of
5 Drs. Preston Phillips and Stephanie Husen, as well as hospital employee Amanda Glenn and
6 patient visitor William Love (a military veteran who sacrificed his life by confronting the gunman,
7 to enable others present to escape from harm)^{1,2}; and
8

9 Whereas, Another incident of armed violence in a hospital occurred in a Dallas, Texas labor and
10 delivery ward in October 2022, resulting in the deaths of nurse Jacqueline Pokuaa and social
11 worker Katie Flowers, was inflicted by an armed parolee wearing an electronic monitoring
12 device³; and
13

14 Whereas, Violent acts committed upon emergency department personnel during 2022 have
15 included at least two in Los Angeles County, California in June⁴ and September⁵ 2022, and at
16 least one in St. Louis County, Missouri during June 2022⁶, with each act causing non-fatal
17 injuries that necessitated surgical procedures followed by hospitalization of the injured
18 individuals; and
19

20 Whereas, These violent acts committed upon medical personnel or visitors were all inflicted by
21 metallic weapons; and
22

23 Whereas, The matter of patient- or visitor-perpetrated violence against health care personnel
24 who are on duty or going off duty is a problem that has existed for at least four decades, and
25 includes an incident in which a nurse and psychiatry resident were murdered by shotgun at the
26 University of Kansas Emergency Department in March 1981⁷; and
27

28 Whereas, A significant number of other shootings have occurred in emergency departments
29 between 1981 and 2022, illustrating the ongoing nature of the problem; and
30

31 Whereas, Hospitals, and especially their Emergency Departments, Maternity Units and
32 Intensive Care Units, are locations at which patients and/or their families are highly likely to
33 receive unexpected bad news, which in some individuals perpetrates a motive to seek revenge
34 by violent means against members of the health care team; and
35

36 Whereas, Other locations exist on hospital campuses at which a disgruntled patient or family
37 member may wish to seek revenge through use of a metallic weapon for perceived poor
38 treatment; and

Whereas, Hospital maternity/labor and delivery units presently typically deploy security procedures designed to preclude infant abductions and to preclude those not welcomed by the mother-to-be from being in their vicinity; and

Whereas, Americans have become accustomed to the deployment and use of metal detection systems at commercial sites such as airports, stadiums, and schools to deter those who might commit armed mayhem, as best exemplified by the rollout of metal detectors at airports after the terrorist attacks of September 11, 2001 and the upgrading of security processes at schools after the 1999 Columbine school shootings; and

Whereas, Few if any Americans perceive these deployments of metal detection systems as stigmatizing or as signaling that these locations are inherently dangerous, an argument against metal detector use proffered by some hospital system executives⁸; and

Whereas, The access by armed patients or visitors to hospitals varies markedly between the various states due to the existence of or lack of “open carry” laws, which enable citizens to lawfully bear weapons in public places in states in which such laws have been enacted; and

Whereas, Despite the existence of these open carry laws in certain of the United States, airports in all states and territories of the United States enforce policies that prohibit the possession of any weapons beyond the entrance area of airports; therefore be it

RESOLVED, That our American Medical Association Council on Science and Public Health study the issues of 1) workplace violence as it impacts health care workers, patients, and visitors, and 2) anticipated positive impacts of weapons detection and interdiction systems toward reduction of workplace violence, so that our AMA can develop learned and data-based recommendations and accompanying advocacy regarding proposed new requirements for the deployment of these systems in health care settings, and share these recommendations with accrediting bodies such as The Joint Commission, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other relevant stakeholders, including the American Hospital Association. (Directive to Take Action)

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

Received: 11/12/22

REFERENCES:

1. Ebrahimji A *et al.* (CNN). A patient who sacrificed his life, 2 gifted doctors, a beloved receptionist. These are the people killed in the Tulsa hospital shooting. <https://www.cnn.com/2022/06/02/us/tulsa-shooting-victims-what-we-know/index.html> Accessed November 8, 2022
2. Bella T, Knowles H, Bever L and Kornfield M. Tulsa gunman angry over pain after back surgery, police say. Washington Post. June 2, 2022. <https://www.washingtonpost.com/nation/2022/06/02/tulsa-shooting-news-medical-center/> Accessed October 25, 2022
3. M, Hutchinson B. 2 health care workers killed in Dallas maternity ward shooting identified. <https://abcnews.go.com/US/dead-gunman-opens-fire-dallas-hospital-officials/story?id=91917260> Accessed October 25, 2022
4. Associated Press. Doctor, nurses stabbed at California hospital; man arrested. <https://www.usnews.com/news/us/articles/2022-06-03/man-stabs-3-medical-staffers-at-southern-california-hospital> Accessed October 21, 2022
5. Cabrera L. Southern California nurse stabbed outside of emergency room. Wswnews.org. <https://www.wsws.org/en/articles/2022/10/01/occy-o01.html> Accessed October 19, 2022
6. Kull K. Nurse, paramedic stabbed at SSM Health DePaul Hospital in Bridgeton. St. Louis Today, July 11, 2022. https://www.stltoday.com/news/local/crime-and-courts/nurse-paramedic-stabbed-at-ssm-health-depaul-hospital-in-bridgeton/article_6d0dfb09-94b0-55c1-9962-0ef99915089c.html Accessed October 25, 2022
7. <https://www.nytimes.com/1981/03/22/us/2-killed-by-gunman-in-hospital.html> Accessed October 26, 2022
8. Gorman A. LA County removing metal detectors from some hospital facilities. Los Angeles Times, February 3, 2013. <https://www.latimes.com/health/la-xpm-2013-feb-03-la-me-metal-detectors-20130203-story.html> Accessed October 25, 2022

RELEVANT AMA POLICY

Firearm Safety Counseling in Physician-Led Health Care Teams H-145.976

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.
2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.
3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.
4. Our AMA supports the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate.

Guns in Hospitals H-215.977

1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:
 - A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.
 - B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.
 - C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.
 - D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.
 - E. Policies should undergo periodic reassessment and evaluation.
 - F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.
2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present.
3. Our AMA will: (a) advocate that physicians not be required to carry or use weapons in correctional facilities where they provide clinical care; and (b) work with appropriate stakeholders to make evidence-based recommendations regarding the presence of weapons in correctional healthcare facilities.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 939
(I-22)

Introduced by: Organized Medical Staff Section

Subject: Mattress Safety in the Hospital Setting

Referred to: Reference Committee K

1 Whereas, It is the responsibility of the organized medical staff to oversee the safety of patients
2 in the hospital setting; and
3

4 Whereas, Covering hospital safety includes working to mitigate and overall decrease infections;
5 and
6

7 Whereas, Materials in the patients' room such as the hospital bed and matters can be a
8 causative agent of infection spread; and
9

10 Whereas, Proper care of the hospital bed and mattress comes under the purview of the
11 organized medical staff as well as accrediting bodies; and
12

13 Whereas, The U.S. Food and Drug Administration and hospital bed/mattress manufacturers
14 have specific instructions on the care and maintenance of hospital beds and mattresses;
15 therefore be it
16

17 RESOLVED, That our American Medical Association work with the accrediting bodies and
18 interested stakeholders to make sure all possible appropriate care and maintenance measures
19 be undertaken to mitigate infection related to hospital bed and mattress use. (Directive to Take
20 Action)

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

Received: 11/11/22

RELEVANT AMA POLICY

Responsibility for Infection Control H-235.969

AMA policy states that: (1) the hospital medical staff should have a multidisciplinary committee to oversee the surveillance, prevention and control of infection; (2) the infection control committee should report to the hospital medical staff executive committee; and (3) the medical staff's role, responsibility and authority in the infection control activities should be included in the medical staff bylaws.

Citation: (Sub. Res. 802, A-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease H-440.856

Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAIs; (3) all clinicians to assume "antimicrobial stewardship," i.e., adherence to evidence-based solutions and best practices to reduce of HAIs and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care. Citation: BOT Rep. 3, A-10; Reaffirmation A-15

RESOLUTIONS - BY SPONSOR (I-22)

Academic Physicians Section

- 016# Increasing Female Representation in Oncology Clinical Trials
 - 228# Requirements for Physician Self-reporting of Outpatient Mental Health Services, Treatments or Medications to Credentialing Agencies and Insurers
 - 938# AMA study of efficacy of requirements for metal detection/weapons interdiction systems in health care facilities
-

American Academy of Pediatrics

- 818* Pediatric Obesity Treatment Insurance Coverage
 - 921* Firearm Injury and Death Research and Prevention
 - 922* Firearm Safety and Technology
 - 923* Physician Education and Intervention to Improve Patient Firearm Safety
-

American Academy of Physical Medicine and Rehabilitation

- 603 AMA House of Delegates Resolution Process Review
 - 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury
-

American Association of Clinical Urologists

- 201 Physician Reimbursement for Interpreter Services
-

American College of Cardiology

- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
-

American College of Preventive Medicine

- 819* Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA
 - 925* Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA
-

American College of Radiology

- 308 Paid Family/Medical Leave in Medicine
-

American College of Rheumatology

- 820* Third-Party Pharmacy Benefit Administrators
-

American Society for Metabolic and Bariatric Surgery

- 937# Indications for Metabolic and Bariatric Surgery
-

American Society of Addiction Medicine

- 216* Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare
-

Arkansas

- 307 Fair Compensation of Residents and Fellows

Association for Clinical Oncology

- 223* Criminalization of Pregnancy Loss as the Result of Cancer Treatment
 - 224* Fertility Preservation
 - 924* Domestic Production of Personal Protective Equipment
-

Colorado

- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era
-

Congress of Neurological Surgeons

- 316# Recognizing Specialty Certification for Physicians
-

Garretson, Delegate

- 605* Decreasing Political Advantage Within AMA Elections
-

Georgia

- 214 Universal Good Samaritan Statute
 - 806 Healthcare Marketplace Plan Selection
 - 807 Medicare Advantage Record Requests
 - 808 Reinstatement of Consultation Codes
-

Illinois

- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups
 - 905 Minimal Age of Juvenile Justice Jurisdiction in the United States
-

Integrated Physician Practice Session

- 821# PrEP is an Essential Health Benefit
-

International Medical Graduate Section

- 007 Consent for Sexual and Reproductive Healthcare
 - 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies
 - 904 Immigration Status is a Public Health Issue
-

Louisiana

- 601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity

Medical Student Section

- 003 Indigenous Data Sovereignty
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave
- 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants
- 006 Assessing the Humanitarian Impact of Sanctions
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** contained in the Handbook Addendum*

contained in the Sunday Tote