DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2023 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-23)

Report of Reference Committee B

Peter C. Amadio, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Board of Trustees Report 06 – Universal Good Samaritan Statute
2. Board of Trustees Report 07 – Obtaining Professional Recognition for Medical Service Professionals
3. Resolution 205 – Cannabis Product Safety
4. Resolution 225 – Antipsychotic Medication Use for Hospice Patients
5. Resolution 234 – Pharmacy Benefit Manager (PBM) Control of Treating Disease States
6. Resolution 235 – Preventing Imminent Payment Cuts and Ensuring the Sustainability of the Medicare Program

RECOMMENDED FOR ADOPTION AS AMENDED

7. Resolution 201 – Opposition to the Restriction and Criminalization of Appropriate Use of Psychotropics in Long Term Care
8. Resolution 204 – Improving PrEP & PEP Access
9. Resolution 216 – Saving Traditional Medicare
10. Resolution 218 – Youth Residential Treatment Program Regulation
11. Resolution 219 – Improving Access to Post-Acute Medical Care for Patients with Substance Use Disorder (SUD)
12. Resolution 223 – Initial Consultation for Clinical Trials Under Medicare Advantage

RECOMMENDED FOR ADOPTION IN LIEU OF

13. Resolution 203 – Anti-Discrimination Protections for Housing Vouchers
14. Resolution 222 – Expansion of Remote Digital Laboratory Access Under CLIA
15. Resolution 224 – ERISA Preemption of State Laws Regulating Pharmacy Benefit Managers

RECOMMENDED FOR REFERRAL

16. Resolution 206 – The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice
17. Resolution 207 – On-Site Physician Requirements for Emergency Departments

18. Resolution 215 – A Public Health-Centered Criminal Justice System
19. Resolution 217 – Addressing Work Requirements for J-1 Visa Waiver Physicians
20. Resolution 227 – Reforming Stark Law's Blanket Self-Referral Ban
21. Resolution 233 – Corporate Practice of Medicine Prohibition

RECOMMENDED FOR REFERRAL FOR DECISION

22. Resolution 226 – Delay Imminent Proposed Changes to U.S. Census Questions Regarding Disability
23. Resolution 229 – Facilitating Appropriate Reimbursement of Diagnostic Radiopharmaceuticals

RECOMMENDED FOR NOT ADOPTION

24. Resolution 220 – Merit-Based Process for the Selection of all Federal Administrative Law Judges

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

25. Resolution 202 – Protecting the Health of Patients Incarcerated in For-Profit Prisons
26. Resolution 208 – Non-Physician Practitioners Oversight and Training
27. Resolution 210 – Immigration Status in Medicaid and CHIP
28. Resolution 213 – Health Technology Accessibility for Aging Patients

Amendments

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

RECOMMENDED FOR ADOPTION

(1) BOT 6 - UNIVERSAL GOOD SAMARITAN STATUTE

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 6 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 6 adopted and the remainder of the Report filed.

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 214-I-22 and that the remainder of the report be filed.

That Policy H-130.937, Delivery of Health Care by Good Samaritans be amended by addition:

5. Our AMA will develop model principles on Good Samaritan protections for physicians under state and federal laws that would encourage the prompt rendering of emergency care. (Modify Current HOD Policy)

Your Reference Committee heard unanimous support for Board of Trustees Report 6. Your Reference Committee agrees that more needs to be done to support strong protections of physicians responding as Good Samaritans, regardless of location within the United States and regardless of the type of medical emergency they are called upon to address. Your Reference Committee appreciates that our colleagues from across the Federation of Medicine have worked assiduously to support protection from liability for physicians acting as Good Samaritans who meet the specified standard of conduct and act in good faith. Your Reference Committee heard that the protections already enshrined in AMA policy and promoted through advocacy efforts to shield physician Good Samaritans from liability while rendering treatment responsive to the Covid-19 public health emergency, the opioid overdose epidemic, and in-flight medical emergencies, should extend, by means of a national Good Samaritan Statute, to all such physician-rendered care without regard to type of medical emergency or in which state it occurs. Therefore, your Reference Committee recommends that Board of Trustees Report 6 be adopted, and the remainder of the report be filed.

(2) BOT 7 - OBTAINING PROFESSIONAL RECOGNITION FOR MEDICAL SERVICE PROFESSIONALS

RECOMMENDATION:

Your Reference Committee recommends that Board of Trustees Report 7 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 7 adopted and the remainder of the Report filed.

The Board of Trustees recommends that Alternate Resolution 232-I-22 be adopted to read as follows, and the remainder of the report be filed:

RESOLVED, That our American Medical Association support a unique standard occupational classification from the U.S. Bureau of Labor Statistics for medical services professionals. (New HOD Policy)

Your Reference Committee heard testimony unanimously supporting Board of Trustees Report 7 and recognizing the support that medical service professionals (MSPs) give to medical staff by performing core functions such as credentialing. Your Reference Committee heard that the duties performed by MSPs are more unique than what can be captured under U.S. Bureau of Labor Statistics (BLS) Standard Occupational Classifications (SOC) for human resources. Therefore, your Reference Committee recommends that Board of Trustees Report 7 be adopted, and the remainder of the report be filed.

(3) RESOLUTION 205 - CANNABIS PRODUCT SAFETY

RECOMMENDATION:

Your Reference Committee recommends that Resolution 205 be <u>adopted</u>.

HOD ACTION: Resolution 205 <u>adopted</u>.

RESOLVED, that our American Medical Association draft state model legislation to help states implement the provisions of AMA policies H-95.924, Cannabis Legalization for Adult Use and H-95.936, Cannabis Warnings for Pregnant and Breastfeeding Women that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding. (Directive to Take Action)

Your Reference Committee heard supportive comments for this resolution. Your Reference Committee heard that our AMA policy already provides clear support for advocating that states include warnings for pregnant and breastfeeding women against using cannabis. Your Reference Committee heard testimony that numerous scientific and medical organizations, including the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Services Administration, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists discourage pregnant and breastfeeding women from using cannabis. Testimony highlighted that our AMA can use current policy to draft model state legislation that accomplishes the intent of this Resolution. Your Reference Committee heard that any model legislation that our AMA creates should encompasses our AMA policies on cannabis that address the dangers associated with the use of cannabis (whether edibles, vapes or other forms) by children, young adults, those who are pregnant, and others covered by AMA policies. Your Reference Committee appreciates the testimony from multiple public health and specialty organizations detailing unique concerns relating to cannabis use and encourages our AMA to take those into account when drafting the model legislation. Moreover, your Reference Committee heard that our AMA may not require any state to adopt a model bill but instead works collaboratively with state medical societies to support state legislative efforts. Your

Reference Committee encourages states that have effective cannabis-related regulation and warning labels to share such information with our AMA to help inform the model bill drafting process. Therefore, your Reference Committee recommends that resolution 205 be adopted.

(4) RESOLUTION 225 - ANTIPSYCHOTIC MEDICATION USE FOR HOSPICE PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 225 be adopted.

HOD ACTION: Resolution 225 adopted.

RESOLVED, that our American Medical Association seek legislation or regulatory changes that exempt hospice patients from limitations on the use of antipsychotic medications for behavioral changes.

Your Reference Committee heard strong support for this resolution and ensuring access to medication for patients in skilled nursing facilities, including for patients enrolled in hospice. Your Reference Committee heard testimony expressing concern for patients prescribed antipsychotic and other medication as inappropriate sedation. Your Reference Committee heard testimony that was supportive of efforts to ensure antipsychotic and other medications are prescribed for legitimate medical purposes, including for patients enrolled in hospice care. Your Reference Committee is concerned by testimony indicating that patients enrolled in hospice have lost access to medications as a result of overly broad and misapplied policies. Testimony noted that our AMA can play a helpful role and take appropriate action to ensure that physicians' judgment takes precedence over broad policies that may be harmful to patients, including legislative or regulatory action. Therefore, your Reference Committee recommends that resolution 225 be adopted.

(5) RESOLUTION 234 - PHARMACY BENEFIT MANAGER (PBM) CONTROL OF TREATING DISEASE STATES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 234 be adopted.

HOD ACTION: Resolution 234 adopted.

Resolved, That our American Medical Association take a strong public stance against allowing payors and pharmacy benefit managers to divert patients to their own care teams for medical care and medication prescribing (New HOD Policy); and be it further

Resolved, That our AMA take immediate action (which may include legal or policy action) to assess and pursue appropriate measures designed to prevent payors and pharmacy benefit managers from diverting patients to their own care teams for medical care and medication prescribing (Directive to Take Action).

Your Reference Committee heard testimony in support of Resolution 234. Testimony reflected the frustration with pharmacy benefit managers (PBMs) ability to manipulate and effectively interfere with patient's preferred care plan. Substantial testimony was given supporting an amendment to existing policy that would essentially maintain the language of this resolution while reaffirming our AMA's existing position on prohibiting pharmacy actions that are unilateral medical decisions. Additionally, testimony reflected the active advocacy efforts aimed at PBM transparency that are ongoing. Therefore, your Reference Committee recommends that resolution 234 be adopted.

(6) RESOLUTION 235 - PREVENTING IMMINENT PAYMENT CUTS AND ENSURING THE SUSTAINABILITY OF THE MEDICARE PROGRAM

RECOMMENDATION:

Your Reference Committee recommends that Resolution 235 be <u>adopted</u>.

HOD ACTION: Resolution 235 <u>adopted</u>.

RESOLVED, that our American Medical Association prioritize preventing the imminent 3.4% Medicare payment cut from taking effect by any means available (Directive to Take Action); and be it further

RESOLVED, that our AMA continue to prioritize reforming the Medicare payment system to ensure the continued economic viability of medical practice (New HOD Policy); and be it further

RESOLVED, that our AMA shall work towards achieving the highest sustainable annual Medicare payment increases possible, whether tied to the MEI, the CPI, or some other relevant measure of inflation that is sufficient to ensure that Medicare beneficiaries can receive robust access to care and that medical practices do not continue to encounter economic challenges as a result of insufficient payment updates (Directive to Take Action); and be it further

RESOLVED, that our AMA immediately create and disseminate, in major news outlets, a press release outlining the current problems within the Medicare system and how it will affect access to care with a call to action to help those with Medicare keep their physicians and the high-quality care they deserve. (Directive to Take Action)

Your Reference Committee heard strong unanimous testimony in support of resolution 235. However, your Reference Committee wishes to note that the American College of Physicians was incorrectly listed as a sponsor of this resolution. Your Reference Committee heard that Medicare payment reform is a clear and immediate necessity, and it is the focal point of our AMA's 2023 Recovery Plan. Your Reference Committee heard that there has been a substantial decline in Medicare physician payment rates, undermining the stability of physician practices and the health care system at large. Your Reference Committee heard that in response to these cuts, our AMA supported the introduction of H.R. 2474, the Strengthening Medicare for Patients and Providers Act, which proposes annual payment updates aligned with the Medicare Economic Index (MEI). Testimony highlighted that our

AMA's advocacy extends beyond legislation to include a robust grassroots campaign encouraging stakeholders to support H.R. 2474, complemented by draft bills aimed at reforming budget neutrality policies. Testimony noted the urgency, underscored by the final rule for the 2024 Medicare physician fee schedule that includes a 3.4 percent payment cut, far below and not in accord with the MEI of 4.6 percent. Your Reference Committee heard at the 2023 Annual Meeting our AMA swiftly responded to our members' concerns regarding Medicare payment reform by reaffirming Policy Advocacy and Action for a Sustainable Medical Care System D-385.945. Our members have voiced that the absence of inflation-adjusted payment updates is unsustainable and threatens the closure of private practices and our AMA has taken swift action, including a significant increase in funding for advocacy, creating a sustained media strategy, and enhancing grassroots efforts to engage physicians and patients. Your Reference Committee heard that these actions reflect our AMA's commitment to achieving permanent physician payment reform. Furthermore, testimony stated that our AMA launched the Fix Medicare Now campaign, a substantial effort to raise awareness and advocacy, highlighted by the relaunch of the FixMedicareNow.org website. Testimony noted that the Senate Finance Committee's recent legislation to alleviate part of the 2024 payment cut acknowledges the issue and provides a temporary solution. Your Reference Committee heard that our AMA has initiated the Physician Practice Information survey to gather updated cost data from over 10,000 practices, which will inform the RBRVS and the MEI. Your Reference Committee heard that these concerted efforts demonstrate our AMA's multifaceted approach to addressing Medicare payment reform, indicating a strong commitment to achieving a reformed and equitable payment system. There was strong support for our AMA's current strategies and efforts, as well as a noted desire for continued and expanded engagement at both the legislative and grassroots levels to ensure the success of Medicare payment reforms. Additional testimony emphasized the importance of involving more physicians in discussions with their patients about Medicare issues. Your Reference Committee heard that this approach is seen as vital for gaining support from seniors, who are key stakeholders in this matter. There was a call for continued and urgent pressure to convert our AMA policies into actual legislation. Your Reference Committee heard that this step is crucial for making tangible changes in the Medicare payment system. Testimony noted that engaging the patient population, especially at the local level, is seen as an essential part of this strategy. Your Reference Committee heard that this engagement ensures that patient voices are heard and considered in the reform process. Therefore, your Reference Committee recommends that resolution 235 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(7) RESOLUTION 201 - OPPOSITION TO THE RESTRICTION AND CRIMINALIZATION OF APPROPRIATE USE OF PSYCHOTROPICS IN LONG TERM CARE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 201 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association work with key partners to advocate that CMS revise the existing measure for psychotropic prescribing in nursing homes to ensure nursing home residents have access to all medically appropriate care (Directive to Take Action); and be it further

RESOLVED, that our AMA ~~amend~~ reaffirm policy H-160.954. ~~by insertion as follows: (1) Our AMA continues to take all reasonable and necessary steps to ensure that errors in medical decision making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal, state, and local government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Modify Current HOD Policy)~~

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 201 be adopted as amended.

RECOMMENDATION C:

Your Reference Committee recommends that the title of Resolution 201 be changed to read as follows:

MEDICALLY APPROPRIATE PSYCHOTROPIC USE IN LONG TERM CARE FACILITIES

HOD ACTION: Resolution 201 adopted as amended with a change of title.

MEDICALLY APPROPRIATE PSYCHOTROPIC USE IN LONG TERM CARE FACILITIES

RESOLVED, that our American Medical Association work with key partners to advocate that CMS revise the existing measure for psychotropic prescribing in nursing homes to ensure nursing home residents have access to all medically appropriate care (Directive to Take Action); and be it further

RESOLVED, that our AMA amend policy H-160.954 by insertion as follows: (1) Our AMA continues to take all reasonable and necessary steps to ensure that errors in medical decision making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal, state, and local government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Modify Current HOD Policy)

Your Reference Committee heard supportive testimony on resolution 201. Your Reference Committee heard testimony that patients in long-term care facilities have suffered inappropriate tapering of psychotropic and other medication therapies as well as inappropriate diagnoses. Your Reference Committee agrees that medical care should not be second guessed by government policies that do not account for individualized patient care decision-making. Additional testimony detailed how nursing homes feel like they cannot provide psychotropic medicine because of fears resulting from current policies.

Your Reference Committee also heard strong support opposing the criminalization of medicine. Further testimony noted that this issue affects physicians and patients in multiple specialties across multiple states for a wide variety of medical issues. Your Reference Committee heard further testimony concerning ways in which our AMA has demonstrated its ability to stand up for physicians across the nation at the federal and state levels in multiple settings—including for reproductive rights, pain care, mental illness, and substance use disorders. Moreover, your Reference Committee heard that our AMA has multiple policies on opposing the criminalization of medical practice, including Policy D-5.999, “Preserving Access to Reproductive Health Services,” which is specific to—among other things—opposing “criminal and civil penalties or other retaliatory efforts” relating to the provision of reproductive health care; and policy H-120.960, “Protection for Physicians Who Prescribe Pain Medication,” which is specific to pain medicine.

However, additional testimony highlighted concerns about potential unintended consequences from calling on our AMA to oppose state governments from having jurisdiction over the regulation of the practice of medicine. Your Reference Committee was reminded that our House has extensive policy supporting strong state licensing authority, including “Protecting State Medical Licensing Boards from External Political Influence D-270.984,” which calls for our AMA to support minimizing “external interference with the independent functioning of state medical disciplinary and licensing boards.” Your Reference Committee points out that Policy H-275.998, “Physician Competence,” is one of many additional policies supporting state licensing boards’ disciplinary and other appropriate oversight roles. Your Reference Committee heard that there is a strong role for state regulation, and it was noted that it was important to leave a role for state medical boards. Further testimony noted that our AMA already opposes the criminalization of medical practice from inappropriate federal or state policies and will continue to do so. Therefore, your Refence Committee recommends that resolution 201 be adopted as amended and that existing AMA policy H-160.954 be reaffirmed.

Criminalization of Medical Judgment H-160.954
(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

(8) RESOLUTION 204 - IMPROVING PREP & PEP ACCESS

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 204 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association support efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements between pharmacists and ~~with~~ physicians, based on AMA's model legislation related to collaborative drug therapy management.

RESOLVED, that our AMA support a requirement that any pharmacy-associated prescription of PREP/PEP needs to be in accordance with the current CDC PREP/PEP clinical practice guidelines within the physician-led team.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 204 be adopted as amended.

HOD ACTION: Resolution 204 adopted as amended.

RESOLVED, that our American Medical Association support efforts to increase access to HIV pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) through the establishment of collaborative practice agreements with physicians. (New HOD Policy)

Your Reference Committee heard testimony generally in favor of resolution 204. Specifically, your Reference Committee heard extensive testimony about the importance of PEP and PrEP and the need to ensure increased access to these important medications. Testimony noted that access to PrEP and PEP improves health outcomes and that consistent and timely access to these treatments are imperative. Overall, testimony largely agreed that collaborative practice agreements between pharmacists and physicians can be a viable means for improving access to PEP and PrEP, but your Reference Committee heard testimony voicing concerns about the extent to which collaborative practice agreements will ensure the appropriate respective roles of pharmacists and physicians.

Testimony sought guidance regarding what makes an appropriate collaborative practice agreement, and some encouraged referral of resolution 204 for this question. However, your Reference Committee heard that our AMA has developed model state legislation concerning collaborative practice agreements with pharmacists, *An Act to Authorize Pharmacists to Perform Collaborative Drug Therapy Management,* which provides parameters for establishing a collaborative drug therapy management agreement between pharmacists and physicians. An amendment was offered to reference this model legislation, thereby providing parameters for appropriate collaborative drug therapy management agreements between pharmacists and physicians. Therefore, your Reference Committee recommends that resolution 204 be adopted as amended.

(9) RESOLUTION 216 - SAVING TRADITIONAL MEDICARE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 216 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association continue its efforts to fix the flawed Medicare payment system for physicians recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes ~~that increase revenue streams, reduce waste and inefficiency~~, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians (Directive to Take Action); and be it further

~~**RESOLVED, That our AMA address Medicare plans overpayments by urging the Department of Justice to prosecute those found complicit in fraudulent activity (Directive to Take Action); and be it further**~~

~~**RESOLVED, That our AMA advocate for change in CMS risk adjustment methods to guarantee a level playing field by using a competitive bidding process to replace the current benchmark system for determining Medicare Advantage bonus payments (Directive to Take Action); and be it further**~~

~~**RESOLVED, That our AMA support the "Save Medicare ACT" which proposes renaming Medicare "Advantage" plans as "Alternative Private Health Plans". (New HOD Policy)**~~

RESOLVED, That our AMA acknowledges that the term "Medicare Advantage" can be misleading, as it implies a superiority or enhanced value over traditional Medicare, which may not accurately reflect the nature and challenges of these plans. (New HOD Policy)

RESOLVED, that AMA Policy H-330.886 be reaffirmed.

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 216 be adopted as amended.

HOD ACTION: Resolution 216 adopted as amended.

RESOLVED, That our American Medical Association continue its efforts to fix the flawed Medicare payment system for physicians recognizing that Traditional Medicare is a critical healthcare program while educating the public on the benefits and threats of Medicare Part C expansion (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes that increase revenue streams, reduce waste and inefficiency, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians (Directive to Take Action); and be it further

RESOLVED, That our AMA address Medicare plans overpayments by urging the Department of Justice to prosecute those found complicit in fraudulent activity (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for change in CMS risk adjustment methods to guarantee a level playing field by using a competitive bidding process to replace the current benchmark system for determining Medicare Advantage bonus payments (Directive to Take Action); and be it further

RESOLVED, That our AMA support the “Save Medicare ACT” which proposes renaming Medicare “Advantage” plans as “Alternative Private Health Plans”. (New HOD Policy)

Your Reference Committee heard mixed testimony for resolution 216. Your Reference Committee heard testimony advocating for the merits of Medicare Advantage (MA) plans while also hearing testimony calling for significant reforms. However, testimony disagreed on how best to achieve improvements within MA. Your Reference Committee heard that our AMA has consistently advocated for improvements in both traditional Medicare and MA plans. Testimony stated that our AMA can readily adopt the first resolved as it aligns with our AMA's primary goal of fixing traditional Medicare. Your Reference Committee also heard that our AMA seeks to prohibit private plans from considering any physician as a participant without a specific signed contract and to work with Centers for Medicare & Medicaid Services (CMS) to stop all-products clauses from applying to MA plans. Your Reference Committee heard that in addressing issues of overpayments, marketing, network adequacy, and potentially fraudulent activities associated with MA, our AMA has actively implemented and advocated for policies emphasizing holistic education on MA's nuances, including

eliminating undue subsidies to private Medicare plans, and strengthening measures against fraud and abuse. Moreover, testimony noted that our AMA policy H-330.886 supports competitive bidding to determine payments to MA plans. This policy also notes the importance of network adequacy, standardized benefits, and appropriate geographic regions. Testimony stated that this policy aligns with the resolution's request for advocacy surrounding a change in CMS risk adjustment methods. Finally, your Reference Committee heard that the term “Medicare Advantage” is deeply embedded within AMA policy, will still be utilized by the government, and could cause confusion if it is changed within AMA policy. However, poignant testimony was heard concerning the misnomer of MA plans and the poor patient outcomes that result from uninformed patients choosing this plan based on its name alone. Therefore, your Reference Committee recommends that resolution 216 be adopted as amended.

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.

(10) RESOLUTION 218 - YOUTH RESIDENTIAL TREATMENT PROGRAM REGULATION

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 218 be amended by addition and deletion to read as follows:

~~**RESOLVED, that our American Medical Association advocate for the federal government to work with relevant parties to develop federal licensing standards for youth residential treatment programs (Directive to Take Action); and be it further**~~

RESOLVED, that our AMA recognizes the need for ~~federal~~ licensing standards for all youth residential treatment facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth; and be it further. (New HOD Policy)

RESOLVED, that our AMA support recommendations including, but not limited to, patient placement criteria and clinical practice guidelines, as developed by of nonprofit health care medical associations and specialty societies, as the standard for regulating youth residential treatment programs. (New HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 218 be adopted as amended.

HOD ACTION: Resolution 218 adopted as amended.

RESOLVED, that our American Medical Association advocate for the federal government to work with relevant parties to develop federal licensing standards for youth residential treatment programs (Directive to Take Action); and be it further

RESOLVED, that our AMA recognize the need for federal licensing standards for all youth residential treatment facilities (including private and juvenile facilities) to ensure basic safety and well-being standards for youth. (New HOD Policy)

Your Reference Committee heard mixed testimony for resolution 218. Your Reference Committee heard that the nation's mental health and substance use disorder crises would be greatly helped by greater use of evidence-based treatment modalities. Testimony highlighted that there are sham practices that take advantage of vulnerable individuals and families affected by mental illness or substance use disorders. However, additional testimony noted that there should not be federal licensing standards. Testimony noted that our AMA has opposed federal licensing efforts in multiple contexts with respect to physician

practices and the practice of medicine. Strong testimony stated that our AMA should not open the door to further government interference in the practice of medicine. Your Reference Committee heard that, instead of federal licensing standards, our AMA should focus on ensuring the use of evidence-based clinical practice guidelines developed by our partners in the Federation of Medicine. Your Reference Committee appreciates testimony highlighting our AMA's broad advocacy efforts to hold health plans accountable for mental health and substance use disorder parity failures. Additional testimony called attention to the partnerships between our AMA and multiple state and specialty societies. These partnerships support changes to state and federal laws and regulations that would require using medical society recommendations to determine the standard of care rather than false, financially derived standards used by health plans to delay and deny care. Therefore, your Reference Committee recommends that 218 be adopted as amended.

(11) RESOLUTION 219 - IMPROVING ACCESS TO POST-ACUTE MEDICAL CARE FOR PATIENTS WITH SUBSTANCE USE DISORDER (SUD)

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 219 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association advocate to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that our federal, state, and local governments remove barriers to evidence-based treatment for substance use disorders, including medications for opioid use disorder, ~~opioid agonist therapy (including methadone, suboxone or other appropriate treatments)~~ at skilled nursing facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that Medicare and Medicaid, including managed care organizations, remove barriers to ~~provide~~ coverage and treatment for substance use and opioid use disorder, including medications for opioid use disorder, ~~treatments~~ in skilled nursing facilities. (Directive to Take Action)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 219 be adopted as amended.

HOD ACTION: Resolution 219 adopted as amended.

RESOLVED, that our American Medical Association advocate to ensure that patients who require a post-acute medical care setting are not discriminated against because of their history of substance use disorder (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that our federal, state, and local governments remove barriers to opioid agonist therapy (including methadone, buprenorphine or other appropriate treatments) at skilled nursing facilities (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that Medicare and Medicaid provide coverage for substance use and opioid use disorder treatments in skilled nursing facilities. (Directive to Take Action)

Your Reference Committee heard supportive testimony for resolution 219. Your Reference Committee heard that individuals in a skilled nursing facility—or any other setting—should not suffer interruptions in care for an opioid use disorder (OUD) because of state or federal laws or regulations that interfere with continuity of care. Further testimony highlighted that individuals in a skilled nursing facility or other setting should not endure barriers to evidence-based substance use disorder (SUD) care regardless of the payer. Testimony noted that while Medicare and Medicaid may pose specific barriers to SUD care in a skilled nursing facility our AMA should still provide appropriate guidance to advocate to other payers to ensure patients receive the care they need. Your Reference Committee observes that nearly all proffered amendments were similar in wanting to broaden the scope of the resolution to protect patients who receive medications for OUD. Therefore, your Reference Committee recommends that resolution 219 be adopted as amended.

(12) RESOLUTION 223 - INITIAL CONSULTATION FOR CLINICAL TRIALS UNDER MEDICARE ADVANTAGE

RECOMMENDATION A:

Your Reference Committee recommends that Resolution 223 be amended by addition to read as follows:

RESOLVED, that our American Medical Association amend policy H-460.882, "Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations," by addition to read as follows:

4. Our AMA advocate that the Centers for Medicare and Medicaid Services allow ~~and pay for~~ out-of-network referral of patients with Medicare Advantage for the purpose of consultation for enrollment in a clinical trial, require covering plans to pay for such consultations, and that these consultations be considered administratively as participation in a clinical trial.
(Modify Current HOD Policy)

RECOMMENDATION B:

Your Reference Committee recommends that Resolution 223 be adopted as amended.

HOD ACTION: Resolution 223 adopted as amended.

RESOLVED, that our American Medical Association amend policy H-460.882, "Coverage of Routine Costs in Clinical Trials by Medicare Advantage Organizations," by addition to read as follows:

4.Our AMA advocate that the Centers for Medicare and Medicaid Services allow out-of-network referral of patients with Medicare Advantage for the purpose of consultation for enrollment in a clinical trial, and that these consultations be considered administratively as participation in a clinical trial. (Modify Current HOD Policy)

Your Reference Committee heard testimony that was generally supportive of the intent of resolution 223. Your Reference Committee heard that our AMA supports the concerns raised in the resolution concerning the roles and responsibilities of Medicare Advantage Organizations (MAOs) in clinical trials. Your Reference Committee heard strong support for the proposal to amend policy H-460.882 to urge Centers for Medicare & Medicaid Services (CMS) to cover initial consultation costs for Medicare Advantage (MA) patients enrolling in clinical trials. Testimony emphasized the importance of addressing the financial burdens that are placed on patients necessitating payment reform and highlighted the broader disadvantages of MA plans. As such, your Reference Committee heard testimony noting the need to allow and pay for these services. There was a consensus heard on treating these initial consultations as routine costs to simplify processes. Your Reference Committee heard that the current review of Medicare guidelines and NCD 310.1 for MA members in clinical trials includes a recommendation to categorize consultation for enrollment as a covered expense. Your Reference Committee heard that this proposal is aimed at reducing financial barriers for MA patients seeking clinical trials, ensuring these consultations are not just allowed but also funded. Overall, your Reference Committee heard a unanimous agreement on the need to improve coverage for initial consultations in clinical trials for MA patients. Therefore, your Reference Committee recommends that resolution 223 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(13) RESOLUTION 203 - ANTI-DISCRIMINATION PROTECTIONS FOR HOUSING VOUCHERS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 203 be adopted in lieu of Resolution 203.

RESOLVED that our American Medical Association support preventing discrimination against individuals and families who utilize public assistance for housing, including housing vouchers. (New HOD Policy)

HOD ACTION: Alternate Resolution 203 adopted in lieu of Resolution 203.

RESOLVED, that our American Medical Association support local, state, and federal policies requiring landlords to accept Section 8 and related housing vouchers as valid sources of individual and family income (New HOD Policy); and be it further

RESOLVED, that our AMA support local, state, and federal policies preventing landlords from discriminating against individuals and families who utilize public assistance. (New HOD Policy)

Your Reference Committee heard mixed testimony on resolution 203. Your Reference Committee heard supportive testimony stating that adequate, safe, and affordable housing is an important social determinant of health and that individuals in need of federal housing assistance and subsidized housing may bear a greater burden of mental and physical illness, physical violence, and economic hardship than the general population. Your Reference Committee further heard that two out of three Housing Choice (formerly Section 8) voucher households are not protected by anti-discrimination laws at the local, state, or federal levels and this especially impacts minoritized and marginalized communities, exacerbating disparities in the health of individuals, families, and communities. However, your Reference Committee also heard that it is outside the purview of our AMA to dictate housing policy. Considering these opposing views your Reference Committee believes that the intent of the resolution and the views expressed in testimony would be better captured by an alternate resolution. Therefore, your Reference Committee recommends that alternate resolution 203 be adopted in lieu of resolution 203.

(14) RESOLUTION 222 - EXPANSION OF REMOTE DIGITAL LABORATORY ACCESS UNDER CLIA

RECOMMENDATION A:

Your Reference Committee recommends that Alternate Resolution 222 be adopted in lieu of Resolution 222.

RESOLVED, that our AMA advocate to the Centers for Medicare and Medicaid Services that post-Public Health Emergency enforcement discretion of CLIA regulations 42 C.F.R. §§ 493.35(a), 493.43(a), and 493.55(a)(2) that requires laboratories to file a separate application for each laboratory location unless it meets a regulatory exception, be clarified to include all qualified physicians under CLIA, to review digital data, digital results, and digital images at a remote location under the primary location CLIA certificate. (Directive to Take Action)

RECOMMENDATION B:

The title of Resolution 222 be changed to read as follows:

OVERSIGHT MODERNIZATION OF CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

HOD ACTION: Alternate Resolution 203 adopted in lieu of Resolution 203 with a change of title.

OVERSIGHT MODERNIZATION OF CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

RESOLVED, that our American Medical Association advocate to the Centers for Medicare and Medicaid Services that post-Public Health Emergency enforcement discretion of Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations 42 C.F.R. §§ 493.35(a), 493.43(a), and 493.55(a)(2) that requires laboratories to file a separate application for each laboratory location unless it meets a regulatory exception, be clarified to include all qualified physicians under CLIA, to review digital data, digital results, and digital images at a remote location under the primary location CLIA certificate. (Directive to Take Action)

Your Reference Committee heard testimony supporting the intent of resolution 222, which focused primarily on modernizing language in CLIA following specific flexibilities that were granted during the public health emergency (PHE) and which will continue, pursuant to updated Centers for Medicare & Medicaid Services (CMS) guidance. Your Reference Committee heard testimony that highlighted how our AMA has long-standing policy on CLIA that has been used as the foundation for our advocacy positions up to now. Your Reference Committee also heard that it would be beneficial to amend our existing AMA policy in a manner that brings more clarity and consistency to our recent advocacy in this realm. The testimony also emphasized that a title change would potentially better represent our AMA activity and its stance on CLIA. Moreover, your Reference Committee heard from the author of the resolution that they supported the friendly amendment reflected in this report. Therefore, your Reference Committee recommends that Alternate Resolution 222 be adopted in lieu of resolution 222.

(15) RESOLUTION 224 - ERISA PREEMPTION OF STATE LAWS REGULATING PHARMACY BENEFIT MANAGERS

RECOMMENDATION:

Your Reference Committee recommends that Alternate Resolution 224 be adopted in lieu of Resolution 224.

RESOLVED, that our American Medical Association study, and create resources for states, on the implication of *Rutledge, Attorney General Of Arkansas v. Pharmaceutical Care Management Association*, and any other relevant legal decisions from the last several years, in reference to potentially allowing more successful challenges to the actions of healthcare plans protected by the Employee Retirement Income Security Act of 1974 (ERISA) when the quality of care or healthcare outcomes are questioned. (Directive to Take Action)

HOD ACTION: Alternate Resolution 224 adopted in lieu of Resolution 224.

RESOLVED, that our American Medical Association study enacted state pharmacy benefit management (PBM) legislation and create a model bill that would avoid the Employment Retirement Income Security Act of 1974 (ERISA) preemption. (Directive to Take Action)

Your Reference Committee heard testimony concerning the frustration caused by the limited reach of state managed care laws to only state-regulated plans and the desire for state laws to regulate self-funded Employment Retirement Income Security Act of 1974 (ERISA) plans. However, your Reference Committee also heard that our AMA's legal analysis of recent court cases, including the recent Supreme Court decision in *Rutledge*, involving the reach of state pharmacy benefit managers (PBM) laws is still ongoing, and moreover, some analyses offered in testimony may overestimate the reach and impact of these decisions. Further testimony highlighted that it is critical for efficiency, effectiveness, and reputational reasons, that our AMA further study the impact of such court decisions and produce an analysis and related resources to be used by medical societies and other interested parties to capitalize on any new state regulatory opportunities with regard to state regulation of health insurance, and specifically ERISA plans. Therefore, your Reference Committee recommends that alternate resolution 224 be adopted in lieu of resolution 224.

RECOMMENDED FOR REFERRAL

(16) RESOLUTION 206 - THE INFLUENCE OF LARGE LANGUAGE MODELS (LLMS) ON HEALTH POLICY FORMATION AND SCOPE OF PRACTICE

RECOMMENDATION:

Your Reference Committee recommends that Resolution 206 be referred.

HOD ACTION: Resolution 206 referred.

RESOLVED, that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on healthcare issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers. (New HOD Policy)

Your Reference Committee heard mixed testimony for resolution 206, highlighting the importance of addressing the risks of misinformation resulting from the use of Large Language Models (LLMs) including Generative Pre-trained Transformers (GPTs). Your Reference Committee heard testimony about the importance of physicians understanding and weighing the benefits and the risks of the use of these tools as heightened excitement and eagerness to implement these tools in everyday practice to lessen the existing administrative clinical burden, begins to increase. Your Reference Committee also heard persuasive testimony recommending referral of resolution 206 to the Board for further deliberation. Testimony emphasized that our AMA is currently in the process of fulfilling a directive from A-23 that directs our AMA to study and develop recommendations on the benefits and unforeseen consequences to the medical profession of LLMs such as, GPTs, and other augmented intelligence-generated medical advice or content. Since resolution 206 covers some of the topics that are already planned to be discussed in this upcoming report, testimony noted that resolution 206 should be referred so that these issues can be further studied and aligned with our current research. Further testimony noted that scope of practice will continue to be a heightened point of contention as the use of augmented intelligence (AI) becomes more widely used and more sophisticated among AI developers and the end users. Therefore, your Reference Committee recommends that resolution 206 be referred.

(17) RESOLUTION 207 - ON-SITE PHYSICIAN REQUIREMENT FOR EMERGENCY DEPARTMENTS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 207 be referred.

HOD ACTION: Resolution 207 amended.

RESOLVED, that our American Medical Association develop model state legislation and support federal and state legislation or regulation, with appropriate consideration for limited rural exceptions, requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., physician assistants and advanced practice nurses) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department. (Directive to Take Action)

HOD ACTION: Amended Resolution 207 referred.

RESOLVED, that our American Medical Association develop model state legislation and support federal and state legislation or regulation requiring all facilities that imply the provision of emergency medical care have the real-time, on-site presence of a physician, and on-site supervision of non-physician practitioners (e.g., physician assistants and advanced practice nurses) by a licensed physician with training and experience in emergency medical care whose primary duty is dedicated to patients seeking emergency medical care in that emergency department. (Directive to Take Action)

Your Reference Committee heard extensive and mixed testimony regarding resolution 207. Your Reference Committee heard about the importance of the on-site presence of a physician in an emergency department when patients are seeking emergency medical care, and the importance of physicians supervising non-physicians in the emergency department. There was strong sentiment around the importance of our AMA taking a firm stance on this issue as part of our extensive campaign supporting physician-led care. Testimony also noted that patients expect care from a physician when seeking care in an emergency department and that a growing number of emergency departments are staffed by non-physicians. Your Reference Committee heard that Indiana recently passed legislation that requires all emergency departments to have a physician on-site who is responsible for the emergency department at all times the emergency department is open. However, your Reference Committee also heard strong concerns that requiring the on-site presence of a physician in the emergency department will have a negative and potentially devastating impact on rural hospitals, including the risk of closure. Your Reference Committee received multiple amendments that strived to address this and other concerns with the language, including amendments offered by the resolution's author. Your Reference Committee also heard that given the complexity of the issue it warrants further study, including a deeper dive into the impact on rural hospitals, and the differing staffing capacities and needs between rural and urban facilities. Therefore, your Reference Committee recommends that resolution 207 be referred.

(18) RESOLUTION 215 - A PUBLIC HEALTH-CENTERED CRIMINAL JUSTICE SYSTEM

RECOMMENDATION:

Your Reference Committee recommends that Resolution 215 be referred.

HOD ACTION: Resolution 215 referred.

RESOLVED, that our American Medical Association support legislation that reduces the negative health impacts of incarceration by:

a. advocating for decreasing the magnitude of penalties, including the length of prison sentences, to create a criminal justice model focused on citizen safety and improved public health outcomes and rehabilitative practices rather than retribution,
b. advocating for legislation and regulations that reduce the number of people placed in prison conditions, such as preventing people who were formerly incarcerated from being sent back to prison without justifiable cause, and
c. supporting the continual review of sentences for people at various time points of their sentence to enable early release of people who are incarcerated but unlikely to pose a risk to society (Directive to Take Action); and be it further

RESOLVED, that our AMA (1) recognize the inefficacy of mandatory minimums and three-strike rules and the negative consequences of resultant longer prison sentences to the health of incarcerated individuals, and (2) support legislation that reduces or eliminates mandatory minimums and three-strike rules. (New HOD Policy)

Your Reference Committee heard mixed testimony for resolution 215. Your Reference Committee heard that individuals within the United States are incarcerated at exceptionally high rates, especially when compared to other Western democracies, and disproportionately affects communities of color. Testimony also highlighted the benefits of diversion programs and the negative health outcomes experienced by individuals who are incarcerated. However, your Reference Committee also heard that our AMA already has strong existing policy that supports proper health care in all situations including within the criminal justice system. Testimony highlighted that our AMA has engaged in extensive advocacy work concerning health care for incarcerated individuals. Testimony also noted that the resolution, though well intentioned, might not be actionable. For example, it was noted that there is no real understanding of what “decreasing the magnitude” of penalties entails. In consideration of the conflicting testimony and complexities of this issue which could benefit from further study, your Reference Committee recommends that resolution 215 be referred.

(19) RESOLUTION 217 - ADDRESSING WORK REQUIREMENTS FOR J-1VISA WAIVER PHYSICIANS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 217 be referred.

HOD ACTION: Resolution 217 referred.

RESOLVED, That our American Medical Association acknowledge that the requirement of 40 hours of direct patient care could impose a burden on IMG physicians and may hinder opportunities for professional growth (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for a revision in the J-1 waiver physician's requirement, proposing a transition to a comprehensive 40-hour work requirement that encompasses both direct clinical responsibilities and other professional activities. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning resolution 217. Your Reference Committee heard how important international medical graduates (IMGs) are to the medical community and the important role they play especially in underserved areas across the United States. Testimony highlighted how much work was expected of IMGs and how, due to patient load and administrative burdens, IMGs do not have much time for additional professional development. However, your Reference Committee also heard that though J-1 physicians do need to be in a fulltime program, there was significant confusion surrounding the accuracy of the 40 hours of direct patient care per week requirement. Therefore, due to a need for further clarification, your Reference Committee recommends that resolution 217 be referred.

(20) RESOLUTION 227 - REFORMING STARK LAW'S BLANKET SELF-REFERRAL BAN

RECOMMENDATION:

Your Reference Committee recommends that Resolution 227 be referred.

HOD ACTION: Resolution 227 referred.

Resolved, That our American Medical Association recognizes the substantial impact of the Stark law's unequal restrictions on independent physicians, contributing to the growing trend of hospital consolidation, which has led to negative consequences of restricted access to care and inflated costs (New HOD Policy); and be it further

Resolved, That our American Medical Association supports comprehensive Stark law reform aimed at rectifying the disparities by ending the blanket ban on self-referral practices, particularly in the context of capitated, risk-adjusted payment programs such as Medicare Advantage and Medicaid managed care (Directive to Take Action); and be it further

Resolved, That our American Medical Association is committed to advocating for equitable and balanced Stark law reform that fosters fair competition, incentivizes innovation, and facilitates the delivery of high-quality, patient-centered care (New HOD Policy).

Your Reference Committee heard mixed testimony for resolution 227. Testimony noted that the Stark Law referral ban disadvantaged physicians while allowing health systems to flourish. Further testimony noted how this ban has harmed the coordination of care and how private physician practices are greatly disadvantaged. However, conflicting testimony noted that the Stark law does allow physicians to self-refer Medicare and Medicaid patients under a broad exception (the in-office ancillary services exception). Your Reference Committee also heard that the requirement to make referrals to a particular provider does not apply if the patient expresses a preference for a different provider or if the referral is not in the patient's best medical interests -- in the eyes of the physician. Finally, your Reference Committee heard that our AMA has many policies calling on our AMA to rectify problematic conditions created by consolidation in health care markets and that our AMA advocates vigorously to address these problematic conditions. Due to the factually conflicting testimony, your Reference Committee recommends that resolution 227 be referred.

(21) RESOLUTION 233 - CORPORATE PRACTICE OF MEDICINE PROHIBITION

RECOMMENDATION:

Your Reference Committee recommends that Resolution 233 be referred.

HOD ACTION: Resolution 233 referred.

Resolved, That our American Medical Association amend policy H-215.981, Corporate Practice of Medicine, by deletion and substitution to read as follows:

1. Our AMA ~~vigorously opposes any effort to pass~~ will seek federal legislation to ~~preempting state laws~~ prohibit~~ing~~ the corporate practice of medicine by limiting ownership and corporate control of physician medical practices to physicians or physician-owned groups only and ensure private equity/non-medical groups do not have a controlling interest.

2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues. (Directive to Take Action).

Your Reference Committee heard testimony that sympathized with the underlying rationale of resolution 233. Nevertheless, testimony noted that the kinds of corporate ownership and corporate control issues addressed by the resolution are almost always addressed by state statutes and regulations. Federal law very rarely, if at all, concerns these kinds of garden-variety ownership and corporate control issues. Testimony also indicated that our AMA does provide assistance to state medical associations seeking help on corporate practice of medicine issues. However, additional testimony noted the desire for additional information on this topic so that physicians can better know how to navigate this issue in their state. Therefore, your Reference Committee recommends that resolution 233 be referred.

RECOMMENDED FOR REFERRAL FOR DECISION

(22) RESOLUTION 226 - DELAY IMMINENT PROPOSED CHANGES TO U.S. CENSUS QUESTIONS REGARDING DISABILITY

RECOMMENDATION:

Your Reference Committee recommends Resolution 226 be referred for decision.

HOD ACTION: Resolution 226 referred for decision.

RESOLVED, that our American Medical Association urge that the National Advisory Committee of the U.S. Census Bureau, that is meeting on November 16-17, 2023, delay a decision on the change in the U.S. Census disability questions until comprehensive input has been obtained from the disability community and key stakeholders (Directive to Take Action); and be it further

RESOLVED, that our AMA submit comments before the December 19,2023 deadline to the U.S Census Bureau regarding the changes proposed in the Federal Register to the disability questions in the census (Directive to Take Action); and be it further

RESOLVED, that our AMA request that the U.S. Census Bureau develop an extensive plan to improve the inclusion of individuals with disabilities across the activities of the U.S. Census Bureau (Directive to Take Action); and be it further

RESOLVED, that our AMA encourage the formation of a U.S. Government task force to develop a plan for improving and expanding disability data collection across the federal government. (New HOD Policy)

Your Reference Committee heard mixed testimony on resolution 226. Your Reference Committee heard that the U.S. Census Bureau has proposed revisions to the questions regarding disability in the census. Testimony highlighted concerns about these proposed revisions and noted that there has not been adequate input about these changes from the disability community and key stakeholders, and that a delay should be requested by our AMA and that our AMA should submit comments on the proposed changes. However, your Reference Committee also heard concerns that this resolution may be based upon inaccurate assertions about the process followed by the Census Bureau in proposing changes to the disability questions used in the census, and that in fact, the Census Bureau followed a years-long process in proposing changes as a result of testing done to ensure the census gathers data that meets the needs of its stakeholders. Your Reference Committee further heard that the disability questions are being revised to capture information on functioning in order to reflect advances in the measurement of disability and is conceptually consistent with the World Health Organization's International Classification of Functioning, Disability, and Health (ICF) disability framework.

Your Reference Committee further heard that this is an issue that was only recently brought to our AMA's attention, and concern that our AMA does not have the staff expertise or policy to guide substantive comments to the Census Bureau in the short turnaround time required

under the regulatory comment period. Your Reference Committee believes that in light of the questions and concerns raised about the background provided in the resolution and the lack of AMA policy to guide the development of comments to the Census Bureau in a short turn-around time, that resolution 226 should be referred for decision to ensure attention is brought to this issue before the November and December deadlines. Therefore, your Reference Committee recommends that resolution 226 be referred for decision.

(23) RESOLUTION 229 - FACILITATING APPROPRIATE REIMBURSEMENT OF DIAGNOSTIC RADIOPHARMACEUTICALS

RECOMMENDATION:

Your Reference Committee recommends that Resolution 229 be referred for decision.

HOD ACTION: Resolution 229 referred for decision.

Resolved, That our American Medical Association advocate with the congress and with Centers for Medicare and Medicaid Services to change the categorization of diagnostic radiopharmaceuticals by the Hospital Outpatient Prospective Payment System (OPPS) from "supplies" to correctly classify them as "drugs," as would be consistent with the Medicare Modernization Act (MMA) of 2003, and which will allow diagnostic radiopharmaceuticals, similar to other drugs, to similarly be paid separately for costs above the packaging threshold of $140 per-day (Directive to Take Action); and be it further

Resolved, That our AMA advocate for congressional efforts to urgently separate payment requirements for diagnostic radiopharmaceuticals under the Medicare prospective payment system for hospital outpatient department services to apply to diagnostic radiopharmaceuticals that are appropriate for the cost of radiopharmaceuticals and that carry a cost above that applied to them as supplies by Outpatient Prospective Payment System (Directive to Take Action).

Your Reference Committee heard mixed testimony on resolution 229. Your Reference Committee heard a range of testimonies, reflecting diverse opinions on the reimbursement of radiopharmaceuticals and related healthcare policies. Further testimony expressed support for equitable reimbursement by the Centers for Medicare & Medicaid Services (CMS), particularly focusing on the affordability challenges of radiopharmaceuticals. Your Reference Committee heard about the FIND Act being a significant step towards addressing high pharmaceutical costs. Additional testimony highlighted the need for direct engagement with CMS to align with the Medicare Modernization Act of 2003. Further concerns were expressed about oversimplifying these complex policy matters, raising the potential of unintended consequences of policy changes, such as increased costs in nuclear medicine ambulatory payment classifications (APCs). Your Reference Committee heard about the need for a nuanced understanding of the impact of the Hospital Outpatient Prospective Payment System (HOPPS) on access to care. Further testimony stressed the importance of differentiating radiopharmaceuticals from contrast agents, emphasizing their crucial role in diagnostics, especially in cancer therapy, impacting healthcare efficiency and patient access. Your Reference Committee heard non-supportive testimony urging a broader consideration of the overall high costs in healthcare, advocating for further study, and

congressional involvement. Your Reference Committee heard suggestions that immediate policy changes might offer short-term solutions, but a comprehensive, long-term approach is necessary for sustainable improvement. Your Reference Committee appreciates the urgency conveyed in the testimonies, reflecting a deep commitment to advancing healthcare outcomes and policies. Your Reference Committee heard a general inclination towards supporting policies for better reimbursement structures and recognizing radiopharmaceuticals as essential medical agents, balanced with a call for caution and deeper analysis. Due to the conflicting testimony and the potential need for immediate action, your Reference Committee recommends that resolution 229 be referred for decision.

RECOMMENDED FOR NOT ADOPTION

(24) RESOLUTION 220 - MERIT-BASED PROCESS FOR THE SELECTION OF ALL FEDERAL ADMINISTRATIVE LAW JUDGES

RECOMMENDATION:

Your Reference Committee recommends that Resolution 220 not be adopted.

HOD ACTION: Resolution 220 not adopted.

RESOLVED, that our American Medical Association support the pre-2018, merit-based process for the selection of all federal administrative law judges (ALJs), including the requirements that:

1. All federal ALJ candidates must be licensed and authorized to practice law under the laws of a State, the District of Columbia, the Commonwealth of Puerto Rico, or any territorial court established under the United States Constitution throughout the ALJ selection process,

2. All federal ALJ candidates must have a full seven (7) years of experience as a licensed attorney preparing for, participating in, and/or reviewing formal hearings or trials involving litigation and/or administrative law at the Federal, State, or local level, and

3. All federal ALJ candidates must pass an examination, the purpose of which is to evaluate the competencies/knowledge, skills, and abilities essential to performing the work of an Administrative Law Judge. (New HOD Policy)

Your Reference Committee heard mixed testimony concerning the adoption of resolution 220. Opposing testimony pointed out that the resolution implicated many constitutional and other legal questions on which many experts on the issues raised by resolution 220 could not agree. Testimony also pointed out that our AMA has no prior familiarity with these constitutional and legal questions. Finally, testimony showed that the action called for by resolution 220 would require our AMA to support efforts to restore competitive service requirements with respect to approximately 2,000 Administrative Law Judges (ALJs) in all of the federal agencies, most of which have nothing to do with physician concerns, and which would require our AMA to engage in advocacy far outside of its expertise and scope of work. Therefore, your Reference Committee recommends that resolution 220 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(25) RESOLUTION 202 - PROTECTING THE HEALTH OF PATIENTS INCARCERATED IN FOR-PROFIT PRISONS

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-430.986 and H-430.997 be reaffirmed in lieu of Resolution 202.

HOD ACTION: Resolution 202 referred.

RESOLVED, that our American Medical Association advocate against the use of for-profit prisons (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for for-profit prisons, public prisons with privatized medical services, and detention centers to be held to the same standards as prisons with public medical services, especially with respect to oversight, reporting of health-related outcomes, and quality of healthcare. (Directive to Take Action)

Your Reference Committee heard mixed testimony on resolution 202. Your Reference Committee heard that it is important to ensure that proper health care is administered to those in prisons and detention centers. Testimony highlighted the increased vulnerability of individuals that are incarcerated, particularly in for-profit prisons, which are motivated more by maximizing profits than funding the health services that are needed. However, your Reference Committee also heard that advocacy specifically concerning for-profit prison policy is beyond the scope of our AMA's focus.

Your Reference Committee further heard that our AMA already has existing policy that allows our AMA to advocate for appropriate health care in all forms of correctional facilities and has done extensive advocacy work in this space. Testimony noted that our AMA already has policy that correctional and detention facilities should provide medical, including psychiatric and substance use disorder, care that meets prevailing community standards and additional policy that requires our AMA to advocate for a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release. Your Reference Committee heard that our AMA should not be limiting our policy to just prisons that are "for-profit" when all prisons should be meeting proper health standards and when we already have broad policy that allows us to advocate for proper health care in all correctional facilities not just "for-profit" prisons. Therefore, your Reference Committee recommends that existing AMA policies H-430.986 and H-430.997 be reaffirmed in lieu of resolution 202.

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and

behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.

7.Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.

8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.

9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.

10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs,

including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons: (a) MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting; (b) knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; (c) knowledge of the health disparities among individuals who are involved with the criminal justice system.
14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles.

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

(26) RESOLUTION 208 - NON-PHYSICIAN PRACTITIONERS OVERSIGHT AND TRAINING

RECOMMENDATION:

Your Reference Committee recommends that AMA policies H-35.965, H-35.989, H-360.987, and H-270.958 be reaffirmed in lieu of Resolution 208.

HOD ACTION: AMA policies H-35.965, H-35.989, H-360.987, and H-270.958 reaffirmed in lieu of Resolution 208.

RESOLVED, that our American Medical Association encourage oversight and regulation of non physician providers by regulatory bodies comprised of individuals with equivalent and higher levels of training, including state composite medical boards. (New HOD Policy)

Your Reference Committee heard mixed testimony on resolution 208, with significant testimony—including that of the resolution's author—recommending reaffirmation of existing policy. Your Reference Committee heard that our AMA already has extensive policy aligned with this resolution, establishing that state medical boards should regulate certain non-physician practitioners as appropriate. For example, testimony highlighted that H-35.965 requires the oversight of physician assistants by state medical licensing and

regulatory boards, while H-360.987 establishes that advanced practice registered nurses shall be licensed and regulated jointly by the state medical and nursing boards. Finally, H-270.958 applies to any non-physician, establishing policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state. Given the strength of existing AMA policy on this issue, your Reference Committee recommends that existing AMA policies H-35.965, H-35.989, H-360.987, and H-270.958 be reaffirmed in lieu of resolution 208.

Regulation of Physician Assistants H-35.965
Our AMA: (1) will advocate in support of maintaining the authority of medical licensing and regulatory boards to regulate the practice of medicine through oversight of physicians, physician assistants and related medical personnel; (2) opposes legislative efforts to establish autonomous regulatory boards meant to license, regulate and discipline physician assistants outside of the existing state medical licensing and regulatory bodies' authority and purview; and (3) opposes efforts by organizations to board certify physician assistants in a manner that misleads the public to believe such board certification is equivalent to medical specialty board certification.

Physician Assistants H-35.989
1. Our AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
2. A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.

Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid Level Practitioners H-270.958

1. It is AMA policy that state medical boards shall have authority to regulate the practice of medicine by all persons within a state notwithstanding claims to the contrary by nonphysician practitioner state regulatory boards or other such entities.

2. Our AMA will work with interested Federation partners: (a) in pursuing legislation that requires all health care practitioners to disclose the license under which they are practicing and, therefore, prevent deceptive practices such as nonphysician healthcare practitioners presenting themselves as physicians or "doctors"; (b) on a campaign to identify and have elected or appointed to state medical boards physicians (MDs or DOs) who are committed to asserting and exercising the state medical board's full authority to regulate the practice of medicine by all persons within a state notwithstanding efforts by nonphysician practitioner state regulatory boards or other such entities that seek to unilaterally redefine their scope of practice into areas that are true medical practice.

3. The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.

4. While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly

responsible as the attending physician for the patient care services delegated to his physician assistant.
5. The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
6. In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.
7. Our AMA opposes legislation or regulation that allows physician assistant independent practice.

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987
Our AMA endorses the following principles:
(1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care.
(2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team.
(3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians.
(4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team.
(5) Certified nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists shall be licensed and regulated jointly by the state medical and nursing boards.
(6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

(27) RESOLUTION 210 - IMMIGRATION STATUS IN MEDICAID AND CHIP

RECOMMENDATION:

Your Reference Committee recommends that AMA policies D-440.927 and D-350.975, and D-440.985 be <u>reaffirmed in lieu</u> of Resolution 210.

HOD ACTION: Resolution 210 <u>adopted</u>.

RESOLVED, that our American Medical Association advocate for the removal of eligibility criteria based on immigration status from Medicaid and CHIP. (Directive to Take Action)

Your Reference Committee heard mixed testimony concerning resolution 210. Your Reference Committee heard that our AMA believes that all individuals should be able to receive access to health care and is actively working to improve access to healthcare and

minimize systemic health barriers for immigrant communities. Moreover, your Reference Committee heard how important access to programs such as CHIP and Medicaid are for individuals regardless of immigration status. However, your Reference Committee also heard that our AMA already has policy that specifically addresses allowing immigrants and their dependents to utilize non-cash public benefits including Medicaid and CHIP. Testimony stated that existing AMA policy has already been utilized numerous times to provide detailed comments concerning the Public Charge rule, eligibility requirements for Medicaid and CHIP for DACA recipients, and other legislation and regulations that concern allowing immigrants to access Medicaid and CHIP. Therefore, your Reference Committee recommends that existing AMA policies D-440.927, D-350.975, and D-440.985 be reaffirmed in lieu of resolution 210.

Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

Immigration Status is a Public Health Issue D-350.975
1. Our AMA declares that immigration status is a public health issue that requires a comprehensive public health response and solution.
2. Our AMA recognizes interpersonal, institutional, structural, and systemic factors that negatively affect immigrants' health.
3. Our AMA will promote the development and implementation of educational resources for healthcare professionals to better understand health and healthcare challenges specific for the immigrant population.
4. Our AMA will support the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities.

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

(28) RESOLUTION 213 - HEALTH TECHNOLOGY ACCESSIBILITY FOR AGING PATIENTS

RECOMMENDATION:

Your Reference Committee recommends that AMA policy H-480.937 be <u>reaffirmed in lieu of</u> Resolution 213.

HOD ACTION: Resolution 213 <u>referred</u>.

RESOLVED, that our American Medical Association support the development of a standardized definition of "age-friendliness" in health information technology (HIT) advancements New HOD Policy); and be it further

RESOLVED, that our AMA encourage appropriate parties to identify current best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults (New HOD Policy); and be it further

RESOLVED, that our AMA work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs (Directive to Take Action); and be it further

RESOLVED, that our AMA require EHR providers to provide standardized, easily accessible digital storage space for advance care paperwork. (New HOD Policy)

Your Reference Committee heard testimony largely in support of the spirit of resolution 213. Your Reference Committee also heard that the intent of this resolution was well represented in existing policy H-480.937. On closer review of policy, your Reference Committee agrees, and therefore, recommends reaffirmation.

Addressing Equity in Telehealth H-480.937
Our AMA:
(1) recognizes access to broadband internet as a social determinant of health;
(2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations;
(3) encourages telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations;
(4) supports efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities;
(5) encourages hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and non-physician provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth;
(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations;
(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;
(8) opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize

care from a separate or preferred telehealth network over the patient's current physicians; and

(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

Madam Speaker, this concludes the report of Reference Committee B. I would like to thank Kenneth Certa, MD, Sarah Fessler, MD, Amar Kelkar, MD, Lisa Mattson, MD, Michael Medlock, MD, Helene Nepomuceno, MD, and all those who testified before the Committee.

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