MEMORIAL RESOLUTIONS
ADOPTED UNANIMOUSLY

Carol E. Rose, MD
Introduced by Jill Owens, MD, Chair; John P. Williams, MD, Delegate, James D. Grant, MD, Delegate On behalf of the Pennsylvania Delegation and American Society of Anesthesiologists Delegation

Whereas, Carol E. Rose MD, passed away on October 16, 2023, at Family Hospice in Pittsburgh, PA; and

Whereas,, Dr. Rose had an enduring impact on those who were fortunate enough to work with her. She was a board-certified anesthesiologist at University of Pittsburgh Medical Center, associate professor of anesthesiology at the University of Pittsburgh School of Medicine, and later served on staff at Western Psych; and

Whereas, Dr. Rose embarked on her medical journey, graduating from the University of Miami (1978), defying norms and expectations as one of the few women among her peers, with the added distinction of being one of the more mature medical students at 33 years old; and

Whereas, Dr. Rose completed her residency at Mercy Hospital, now known as UPMC Mercy. After spending eight years at South Side Hospital, she worked at UPMC for 19 years. Dr. Rose assumed the role of director of electroconvulsive therapy anesthesiology and skillfully managed a dedicated team and provided invaluable anesthesia services to patients and making indelible marks in the field of anesthesiology; and

Whereas, Dr. Rose was actively engaged with both local and national medical organizations. She was highly involved with the Allegheny County Medical Society in Pennsylvania serving as Board of Director (2008) and advocated for Allegheny County to have its own district in the Pennsylvania Medical Society; and

Whereas,, Dr. Rose was dedicated to and a long-standing member of the Pennsylvania Medical Society, ascending to the position of Trustee (1992-2002). She achieved the historic milestone of becoming the Pennsylvania Medical Society's first female President (2001-2002); and

Whereas, Dr. Rose's exemplary leadership extended to the Pennsylvania Society of Anesthesiologists, where she served as President (1995-1996), as well as her role as a leader in the American Society of Anesthesiologists (ASA) delegation to the American Medical Association and a long-standing member of the Pennsylvania delegation to the American Society of Anesthesiologists. Dr. Rose was the pre-eminent coordinator of the ASA Delegation uniform selection, a role which she relished; and

Whereas,, She was elected as Chair of the Pennsylvania State Board of Medicine (2010-2011). She retired from her clinical practice at this time to focus on this pivotal role; and

Whereas,, Dr. Rose served on the Foundation of the Pennsylvania Medical Society Board of Trustees from 2001-2002. She was the first chair of the Foundation's Student Financial Service Committee in 2005 and would speak about financial health for medical students during seminars at the various medical schools. She was a life-long advocate for medical students and designated the Foundation of the Pennsylvania Medical Society as the charitable recipient of memorial funds to reflect her commitment to the accessibility of funds for the education of medical students; and

Whereas, Dr. Rose was a well-respected clinician and leader recognized for her professionalism, and valued by her patients; and

Whereas, Dr. Rose is survived by her husband of sixty-three years, Byron, who actively supported and encouraged her to pursue her dream of being a physician and her work for the profession; and therefore be it

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

RESOLVED, that this resolution be recorded and presented to Dr. Rose's Family.

RESOLUTIONS

Note: Testimony on each item is summarized in the reference committee reports. Multiple items were considered on the reaffirmation calendar and were submitted as part of the Committee on Rules and Credentials Supplementary Report on Saturday, November 11. All resolutions were extracted from the reaffirmation calendar and are included in the reference committee reports.

Alternate resolutions are considered to have been introduced by the reference committee.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

RESOLUTION 1 WAS NOT CONSIDERED

2. SUPPORT FOR INTERNATIONAL AID FOR REPRODUCTIVE HEALTHCARE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-420.947

RESOLVED, that our American Medical Association oppose restrictions on U.S. funding to non-governmental organizations solely because they provide reproductive health care internationally, including but not limited to contraception and abortion care; and it be further

RESOLVED, that our AMA supports funding for global humanitarian and non-governmental organizations for maternal healthcare comprehensive reproductive health services, including but not limited to contraception and abortion care.

RESOLUTION 3 WAS NOT CONSIDERED

4. RECONSIDERATION OF MEDICAL AID IN DYING (MAID)
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: REFERRED RESOLVED, that our American Medical Association oppose criminalization of physicians and health professionals who engage in medical aid in dying at a patient's request and with their informed consent, and oppose civil or criminal legal action against patients who engage or attempt to engage in medical aid in dying; and be it further

RESOLVED, that our AMA use the term "medical aid in dying" instead of the term "physician-assisted suicide" and accordingly amend HOD policies and directives, excluding Code of Medical Ethics opinions; and be it further

RESOLVED, that our AMA rescind our HOD policies on physician-assisted suicide, H-270.965 "Physician-Assisted Suicide" and H-140.952 "Physician Assisted Suicide," while retaining our Code of Medical Ethics opinion on this issue; and be it further

RESOLVED, that our AMA amend H-140.966 "Decisions Near the End of Life" by deletion as follows, while retaining our Code of Medical Ethics opinions on these issues:

Decisions Near the End of Life, H-140.966
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining

treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
~~(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.~~
(5) Our AMA supports continued research into and education concerning pain management.

RESOLVED, that our AMA study changing our existing position on medical aid in dying, including reviewing government data, health services research, and clinical practices in domestic and international jurisdictions where it is legal.

5. ADOPTING A NEUTRAL STANCE ON MEDICAL AID IN DYING
Introduced by Resident and Fellow Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association adopt a neutral stance on medical aid in dying and respect the autonomy and right of self-determination of patients and physicians in this matter.

6. INAPPROPRIATE USE OF HEALTH RECORDS IN CRIMINAL PROCEEDINGS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: ADOPTED
See Policy H-315.959

RESOLVED, that our American Medical Association encourage collaboration with relevant parties, including state and county medical societies, the American College of Correctional Physicians, and the American Bar Association, on efforts to preserve patients' rights to privacy regarding medical care while incarcerated while ensuring appropriate use of medical records in parole and other legal proceedings to protect incarcerated individuals from punitive actions related to their medical care.

7. IMPROVING ACCESS TO FORENSIC MEDICAL EVALUATIONS AND LEGAL REPRESENTATION FOR ASYLUM SEEKERS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association support public funding of legal representation for people seeking legal asylum; and be it further

RESOLVED, that our AMA support efforts to train and recruit physicians to conduct medical and psychiatric forensic evaluations for all asylum seekers through existing training resources, including, but not limited to, the Asylum Medicine Training Initiative.

RESOLUTION 8 WAS NOT CONSIDERED

9. PHYSICIANS ARRESTED FOR NON-VIOLENT CRIMES WHILE ENGAGED IN PUBLIC PROTESTS
Introduced by Academic Physicians Section

Reference committee hearing: see report of Reference Committee on Amendments to Constitution & Bylaws.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate to appropriate credentialing organizations and payers—including the Federation of State Medical Boards, state and territorial licensing boards, hospital and hospital system accrediting boards, and organizations that compensate physicians for provision of health care goods and services—that misdemeanor or felony arrests of physicians as a result of exercising their First Amendment rights of protest through nonviolent civil disobedience should not be deemed germane to the ability to safely and effectively practice medicine.

REFERENCE COMMITTEE B

201. OPPOSITION TO THE RESTRICTION AND CRIMINALIZATION OF APPROPRIATE USE OF PSYCHOTROPICS IN LONG TERM CARE
Introduced by American Association for Geriatric Psychiatry

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policies D-280.981 and H-160.954

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: and be it further

RESOLVED, that our AMA reaffirm policy H-160.954.

202. PROTECTING THE HEALTH OF PATIENTS INCARCERATED IN FOR-PROFIT PRISONS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate against the use of for-profit prisons; 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.

203. ANTI-DISCRIMINATION PROTECTIONS FOR HOUSING VOUCHERS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 203 ADOPTED
IN LIEU OF RESOLUTION 208
See Policy H-65.941

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

204. IMPROVING PREP & PEP ACCESS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-20.894

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 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.

205. CANNABIS PRODUCT SAFETY
Introduced by Oklahoma

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See D-95.956

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.

206. THE INFLUENCE OF LARGE LANGUAGE MODELS (LLMS) ON HEALTH POLICY FORMATION AND SCOPE OF PRACTICE
Introduced by American Academy of Ophthalmology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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.

207. ON-SITE PHYSICIAN REQUIREMENT FOR EMERGENCY DEPARTMENTS
Introduced by Michigan

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

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.

208. NON-PHYSICIAN PRACTITIONERS OVERSIGHT AND TRAINING
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee B.

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.

RESOLUTION 209 WAS NOT CONSIDERED

210. IMMIGRATION STATUS IN MEDICAID AND CHIP
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: POLICIES D-440.927 AND D-350.975, AND D-440.985 REAFFIRMED IN LIEU OF RESOLUTION 210

RESOLVED, that our American Medical Association advocate for the removal of eligibility criteria based on immigration status from Medicaid and CHIP.

RESOLUTION 211 WAS NOT CONSIDERED

RESOLUTION 212 WAS NOT CONSIDERED

213. HEALTH TECHNOLOGY ACCESSIBILITY FOR AGING PATIENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: REFERRED

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

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

RESOLUTION 214 WAS NOT CONSIDERED

215. A PUBLIC HEALTH-CENTERED CRIMINAL JUSTICE SYSTEM
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; 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.

216. SAVING TRADITIONAL MEDICARE
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-330.886 and H-390.832

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; and be it further

RESOLVED, That our AMA continue to address the funding challenges facing Traditional Medicare through legislative reform and policy changes, while at the same time advocating for sustainable, inflation-adjusted reimbursement to clinicians; and be it further

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.

RESOLVED, that AMA Policy H-330.886 be reaffirmed

217. ADDRESSING WORK REQUIREMENTS FOR J-1 VISA WAIVER PHYSICIANS
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; 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.

218. YOUTH RESIDENTIAL TREATMENT PROGRAM REGULATION
Introduced by International Medical Graduates Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-60.896

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.

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.

219. IMPROVING ACCESS TO POST-ACUTE MEDICAL CARE FOR PATIENTS WITH SUBSTANCE USE DISORDER (SUD)
Introduced by Washington

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-95.955

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; 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, at skilled nursing facilities; and be it further

RESOLVED, that our AMA advocate that Medicare and Medicaid, including managed care organizations, remove barriers to coverage and treatment for substance use and opioid use disorder, including medications for opioid use disorder, in skilled nursing facilities.

220. MERIT-BASED PROCESS FOR THE SELECTION OF ALL FEDERAL ADMINISTRATIVE LAW JUDGES
Introduced by American College of Legal Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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.

RESOLUTION 221 WAS NOT CONSIDERED

222. OVERSIGHT MODERNIZATION OF CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION 222 ADOPTED
IN LIEU OF RESOLUTION 222
TITLE CHANGED
See Policy H-260-961

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.

223. INITIAL CONSULTATION FOR CLINICAL TRIALS UNDER MEDICARE ADVANTAGE
Introduced by Association for Clinical Oncology

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-460.882

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, require covering plans to pay for such consultations, and that these consultations be considered administratively as participation in a clinical trial.

224. ERISA PREEMPTION OF STATE LAWS REGULATING PHARMACY BENEFIT MANAGERS

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTION 224
See Policy D-385.944

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.

225. ANTIPSYCHOTIC MEDICATION USE FOR HOSPICE PATIENTS
Introduced by Indiana

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-85.990

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.

226. DELAY IMMINENT PROPOSED CHANGES TO U.S. CENSUS QUESTIONS REGARDING DISABILITY
Introduced by American Association of Neuromuscular and Electrodiagnostic Medicine

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; 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; 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; 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.

227. REFORMING STARK LAW'S BLANKET SELF-REFERRAL BAN
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; 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; 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

RESOLUTION 228 WAS NOT CONSIDERED

229. FACILITATING APPROPRIATE REIMBURSEMENT OF DIAGNOSTIC RADIOPHARMACEUTICALS
Introduced by Organized Medical Staff Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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; 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

RESOLUTION 230 WAS NOT CONSIDERED

RESOLUTION 231 WAS NOT CONSIDERED

RESOLUTION 232 WAS NOT CONSIDERED

233. CORPORATE PRACTICE OF MEDICINE PROHIBITION
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: 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.

234. PHARMACY BENEFIT MANAGER (PBM) CONTROL OF TREATING DISEASE STATES
Introduced by Private Practice Physicians Section

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-120.924

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; 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

235. PREVENTING IMMINENT PAYMENT CUTS AND ENSURING THE SUSTAINABILITY OF THE MEDICARE PROGRAM
Introduced by Florida

Reference committee hearing: see report of Reference Committee B.

HOD ACTION: ADOPTED
See Policy D-390.921

RESOLVED, that our American Medical Association prioritize preventing the imminent 3.4% Medicare payment cut from taking effect by any means available; 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; 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; 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.

REFERENCE COMMITTEE C

301. CLARIFICATION OF AMA POLICY D-310-948 "PROTECTION OF RESIDENT AND FELLOW TRAINING IN THE CASE OF HOSPITAL OR TRAINING PROGRAM CLOSURE"
Introduced by Kelly Caverzagie, MD

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-310.948

RESOLVED, that our American Medical Association amend Policy D-310.948 "Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure" by addition and deletion to read as follows:

Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by ~~corporate and~~ nonprofit and for-profit entities and their effect on medical education.

302. MEDICAL STUDENT REPORTS OF DISABILITY-RELATED MISTREATMENT
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-90.990

RESOLVED, that our American Medical Association encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM) and other relevant bodies to include questions on mistreatment based on disability, as defined by United States Americans with Disabilities Act, in their surveys including the AAMC Medical School Graduation Questionnaire.

RESOLVED, that our AMA encourages medical schools to cultivate learning environments that foster belonging for students with disabilities.

RESOLUTION 303 WAS NOT CONSIDERED

304. HEALTH INSURANCE OPTIONS FOR MEDICAL STUDENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-295.942

RESOLVED, that our American Medical Association encourage medical schools to allow students and their families who qualify for and enroll in a other health insurance plans other than the institutionally offered health insurance plans, to be exempt from an otherwise mandatory student health insurance plans requirement, provided that the alternative plan has comparable care coverage and is accepted at the primary geographic locations of training; and be it further

RESOLVED, that our AMA support the continuation of comprehensive medical insurance benefits for inactive students taking an approved leave of absence during their time of degree completion and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence.

305. ADDRESSING BURNOUT AND PHYSICIAN SHORTAGES FOR PUBLIC HEALTH
Introduced by American Association of Public Health Physicians

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association (AMA) vigorously advocates for expanded training opportunities within residency programs, encompassing both preventive medicine residencies and public health physician training, in addition to advocating for increased funding and heightened federal support to address the repercussions of natural disasters; and be it further

RESOLVED, that our AMA steadfastly supports the allocation of state and national funds aimed at fortifying the roles of public health physicians, including Public Health and General Preventive Medicine Residency programs in multiple federal Public Health agencies; and be it further

RESOLVED that our AMA unequivocally calls for the reinstatement of the CDC Preventive Medicine Residency program or Fellowship, as the CDC is the nation's premier public health agency.

306. INCREASING PRACTICE VIABILITY FOR FEMALE PHYSICIANS THROUGH INCREASED EMPLOYER AND EMPLOYEE AWARENESS OF PROTECTED LEAVE POLICIES.
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: ADOPTED
TITLE CHANGED
See Policy H-405.960

RESOLVED, that our American Medical Association oppose any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons; and be it further.

RESOLVED, that our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends.

307. RE-EVALUATION OF SCORING CRITERIA FOR RURAL COMMUNITIES IN THE NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENT PROGRAM
Introduced by Idaho

Reference committee hearing: see report of Reference Committee C.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate, in partnership with other major medical associations at the federal level, for a comprehensive reevaluation and assessment of the effectiveness and equity of the Health Professional Shortage Area (HPSA) scoring criteria employed by the National Health Service Corps (NHSC) Loan Repayment Program with appropriate revisions to meet the physician workforce needs for the neediest rural communities and underserved areas.

RESOLUTION 308 WAS NOT CONSIDERED

RESOLUTION 309 WAS NOT CONSIDERED

REFERENCE COMMITTEE F

601. CARBON PRICING TO ADDRESS CLIMATE CHANGE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association amend D-135.966 by addition and deletion to read as follows:

Declaring Climate Change a Public Health Crisis D-135.966
Our AMA:

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions.
4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050.
5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.
6. Our AMA will advocate for federal and state carbon pricing systems and for US support of international carbon pricing.
7. Our AMA will work with the World Medical Association and interested countries' medical associations on international carbon pricing and other ways to address climate change.

RESOLUTION 602 WAS NOT CONSIDERED

RESOLUTION 603 WAS NOT CONSIDERED

RESOLUTION 604 WAS NOT CONSIDERED

RESOLUTION 605 WAS NOT CONSIDERED

606. PREVENTION OF HEALTHCARE-RELATED SCAMS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee F.

HOD ACTION: ADOPTED
See Policy H-175.971

RESOLVED, that our American Medical Association encourage relevant parties to educate patients and physicians on healthcare-related scams, including how to avoid and report them.

RESOLUTION 607 WAS NOT CONSIDERED

RESOLUTION 608 WAS NOT CONSIDERED

RESOLUTION 609 WAS NOT CONSIDERED

RESOLUTION 610 WAS NOT CONSIDERED

REFERENCE COMMITTEE J

801. IMPROVING PHARMACEUTICAL ACCESS AND AFFORDABILITY
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: POLICY H-110.987 REAFFIRMED IN LIEU OF FIRST RESOLVE
SECOND RESOLVE ADOPTED
See Policies H-110.962 and H-110.987

[Editor's note: Policy H-110.987 was reaffirmed in lieu of following resolve clause.]
RESOLVED, that our American Medical Association supports lowering out-of-pocket maximums in insurance plans including but not limited to ERISA plans, other forms of employer-sponsored insurance, plans offered on the ACA marketplace, TRICARE, and any other public or private payers; and be it further

[Editor's note: The following resolve clause was adopted.]
RESOLVED, that our AMA oppose Direct Member Reimbursement plans, where patients pay the full retail costs of a prescription drug that they may then be reimbursed for, due to their potential to expose patients to significant out-of-pocket costs.

802. IMPROVING NONPROFIT HOSPITAL CHARITY CARE POLICIES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association advocate for legislation and regulations that require nonprofit hospitals to notify and screen all patients for financial assistance according to their own eligibility criteria prior to billing; and be it further

RESOLVED, that our AMA support efforts to establish regulatory standards for nonprofit hospital financial assistance eligibility; and be it further

RESOLVED, that our AMA encourages the Centers for Medicare & Medicaid Services (CMS) to publish the charity-care-to-expense ratio and the charity-care-to-benefit ratio for hospitals listed in Medicare Cost Reports to improve transparency and compliance of charitable care and community benefit activities.

803. IMPROVING MEDICAID AND CHIP ACCESS AND AFFORDABILITY

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies H-290.954 and H-290.982

RESOLVED, that our American Medical Association oppose premiums, copayments, and other cost-sharing methods for Medicaid and the Children's Health Insurance Program, including Section 1115 waiver applications that would allow states to charge premiums or copayments to Medicaid beneficiaries; and be it further

RESOLVED, that our AMA amend policy H-290.982 “Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured” by deletion as follows;

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982
AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;
(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;
(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;
~~(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals~~; and be it further

RESOLVED, that our AMA encourage the Centers for Medicare & Medicaid Services to amend existing Section 1115 waivers to disallow states the ability to charge premiums or copayments to Medicaid beneficiaries.

804. REQUIRED CLINICAL QUALIFICATIONS IN DETERMINING MEDICAL DIAGNOSES AND MEDICAL NECESSITY
Introduced by AMDA – The Society for Post-Acute and Long-Term Care Medicine

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-320.975 and H-290.982

RESOLVED, that our American Medical Association (AMA) advocate for change to existing public and private processes including Utilization Management, Prior Authorization, Medicare and Medicaid audits, Medicare and State Public Health surveys of clinical care settings, to only allow physicians clinicians with adequate and commensurate training, scope of practice, and licensure to determine accuracy of medical diagnoses and assess medical necessity.

RESOLVED, that to prevent a delay in care, our AMA support favoring the treating physician's judgment if the reviewing physician is not available.

805. MEDICATION RECONCILIATION EDUCATION
Introduced by Michigan

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
SECOND RESOLVE REFERRED
See Policy D-300.973

RESOLVED, that our American Medical encourage the study of current medication reconciliation practices across transitions of care to evaluate the impact on patient safety and quality of care, including when there are dissimilar electronic health records, and to develop strategies, including the potential need for additional training, to reduce medical errors and ensure patient safety and quality of care.

[Editor's note: The following resolve clause, with amendments proposed by the reference committee, was referred.]
RESOLVED, that our American Medical Association ~~work with other appropriate organizations to determine whether~~ support education for relevant health care providers ~~physicians-in-training is sufficient~~ to attain the medication reconciliation core competencies necessary to reduce medical errors and ensure patient safety and quality of care ~~and provide recommendations for action as applicable~~.

806. EVIDENCE-BASED ANTI-OBESITY MEDICATION AS A COVERED BENEFIT

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTION 806 AND 820
See Policy H-150.953

RESOLVED, that our American Medical Association amend Policy H-150.953, "Obesity as a Major Public Health Problem," by addition of a new clause to read as follows:

9. Urge all payers to ensure coverage parity for evidence-based treatment of obesity, including FDA-approved medications without exclusions or additional carve-outs.

807. ANY WILLING PROVIDER

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED
See Policy H-285.984

RESOLVED, that our American Medical Association shall develop and advocate for model "Any Willing Provider" legislation nationwide, enabling all physicians to build successful practices and deliver quality patient care; and be it further

RESOLVED, that our AMA shall lobby for federal regulations or legislation mandating insurers to implement "Any Willing Provider" policies as a prerequisite for participating in federally-supported programs; and be it further

RESOLVED, that our AMA will work with state and national organizations, including insurance companies, to promote and support the adoption of "Any Willing Provider" laws, and will monitor the implementation of these laws to ensure that they are having a positive impact on access to quality health care.

808. PROSTHODONTIC COVERAGE AFTER ONCOLOGIC RECONSTRUCTION
Introduced by Young Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 808
See Policy H-475.992

RESOLVED, that our American Medical Association amend Policy H-475.992, “Definitions of “Cosmetic” and “Reconstructive” Surgery,” by addition and deletion:

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992

(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, <u>including prosthodontic reconstruction (including dental implants)</u> caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA <u>supports that reconstructive surgery be covered by all insurers and</u> encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.

809. OUTSOURCING OF ADMINISTRATIVE AND CLINICAL WORK TO DIFFERENT TIME ZONES – AN ISSUE OF EQUITY, DIVERSITY, AND INCLUSION
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association advocate that health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US should implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones; and be it further

RESOLVED, that our AMA support national legislation that calls on health plans that outsource their customer service facing operations to foreign countries in time zones separated by more than 4 hours from the US to implement 16 or 24-hour availability for their support services staffed by outsourced employees to allow local day shift work schedules for their own outsourced employees in different time zones and provider employees located in similar time zones; and be it further

RESOLVED, that our AMA advocate for fair treatment of outsourced employees in vastly different time zones by health plans.

RESOLUTION 810 WAS NOT CONSIDERED

811. EXPANDING THE USE OF MEDICAL INTERPRETERS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-160.924

RESOLVED, that our American Medical Association amend H-160.924, "Use of Language Interpreters in the Context of the Patient-Physician Relationship," by addition and deletion as follows:

Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924 27

1. AMA policy is that:
   (~~1~~a) further research is necessary on how the use of interpreters--both those who are trained and those who are not--impacts patient care;
   (b) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;
   (c) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations--to aid Limited English Proficiency (LEP) patients' involvement in meaningful decisions about their care;
   (d) patients should have access to documentation and communications in their preferred language, when feasible and in a manner that requires all payers to directly pay for such services; and
   (~~d~~e) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

2. Our AMA recognizes the importance of using medical interpreters as a means of improving quality of care provided to patients with LEP including patients with sensory impairments.

3. Our AMA encourage hospital systems, clinics, residency programs, and medical schools to pursue opportunities for physicians, staff, and trainees to voluntarily receive medical interpreter training and certification should they desire.

812. INDIAN HEALTH SERVICE IMPROVEMENTS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-350.987, H-350.945 and H-350.946

RESOLVED, that our American Medical Association support an increase to the Federal Medical Assistance Percentage (FMAP) to 100% for medical services which are received at or through an Urban Indian Organization that has a grant or contract with the Indian Health Service (IHS) and encourage state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally-driven health improvement programs; and be it further

RESOLVED, that our AMA support greater physician and federal oversight of the IHS National Core Formulary, ensuring that the pharmacy benefit for American Indian and Alaska Native patients represents the standard-of-care for prevalent diseases and medical conditions in this population and includes at least two standard-of-care drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be available for use by physicians in deciding the best treatment options for their patients; and be it further

RESOLVED, that our AMA support permanent authorization of the Special Diabetes Program for Indians and the Special Diabetes Program for Type 1 Diabetes Research along with inflationary increases for public health and health profession grants for physicians sponsored by IHS.

813. STRENGTHENING EFFORTS AGAINST HORIZONTAL & VERTICAL CONSOLIDATION
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policies D-160.906 and H-160.884

RESOLVED, that our American Medical Association advocate to adequately resource competition policy authorities such as the Federal Trade Commission (FTC) and Department of Justice Antitrust Division to perform oversight of health care markets; and be it further

RESOLVED, that our AMA oppose not-for-profit firm immunity from FTC competition policy enforcement in the health care sector; and be it further

RESOLVED, that our AMA support appropriate transaction value thresholds, including cumulative transaction values, for merger reporting in health care sectors to ensure that vertical acquisitions in health care do not evade antitrust scrutiny; and be it further

RESOLVED, that our AMA support health care-specific advocacy efforts that will strengthen antitrust enforcement in the health care sector through multiple mechanisms.

814. PROVIDING PARITY FOR MEDICARE FACILITY FEES
Introduced by Senior Physicians Section

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our American Medical Association promote awareness that the ‘site of service’ payment differential does not reflect quality of care; and be it further

RESOLVED, that our AMA seek legislative action or relief for independent physician practices, including rural and underserved practices, to be paid equally for office-based procedures whether or not they practice in offices, facilities or hospitals; and be it further

RESOLVED, that our AMA amend policy D-330.902, The Site-of-Service Differential, by addition to read as follows:

Our AMA will produce a graphic report yearly illustrating the fiscal losses and inequities that practices without facility fees have endured for decades as a result of the site of service differential factoring in inflation.

815. LONG-TERM CARE AND SUPPORT SERVICES FOR SENIORS

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 815
See Policies D-280.982, H-280.943, H-280.945 and H-280.991

RESOLVED, that our American Medical Association amend Policy D-280.982, Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options, by addition to read as follows:

Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options D-280.982

1. Our AMA will advocate for business models in long term care for the elderly which incentivize and promote the ethical and equitable use of resources to maximize care quality, staff and resident safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit.
2. Our AMA will, in collaboration with other stakeholders, including major payers, advocate for further research into alternatives to current options for long term care to promote the highest quality and value long term care services and supports (LTSS) models as well as functions and structures which best support these models for care.

RESOLVED, that our AMA amend Policy H-280.945, Financing of Long-Term Services and Supports, by addition to read as follows:

Financing of Long-Term Services and Supports H-280.945

Our AMA supports:
(1) policies and incentives that standardize and simplify private Long Term Care Insurance (LTCI) to achieve increased coverage and improved affordability for all Americans;
(2) adding transferable and portable LTCI coverage as part of workplace automatic enrollment with an opt-out provision potentially available to both current employees and retirees;
(3) allowing employer-based retirement savings to be used for LTCI premiums and LTSS expenses, including supporting penalty-free withdrawals from retirement savings accounts for purchase of private LTCI;
(4) innovations in LTCI product design, including the insurance of home and community-based services, and the marketing of long-term care products with health insurance, life insurance, and annuities;
(5) permitting Medigap plans to offer a limited LTSS benefit as an optional supplemental benefit or as separate insurance policy;
(6) Medicare Advantage plans offering LTSS in their benefit packages;
(7) permitting Medigap and Medicare Advantage plans to offer a respite care benefit as an optional benefit;
(8) a back-end public catastrophic long-term care insurance program;
(9) incentivizing states to expand the availability of and access to home and community-based services; and
(10) better integration of health and social services and supports, including the Program of All-Inclusive Care for the Elderly.

RESOLVED, that our American Medical Association amend Policy H-280.991, Policy Directions for the Financing of Long-Term Care, by addition to read as follows:

Policy Directions for the Financing of Long-Term Care H-280.991

1. Our AMA believes that programs to finance long-term care should:
(1) assure access to needed services when personal resources are inadequate to finance care.
(2) protect personal autonomy and responsibility in the selection of LTC service providers.
(3) prevent impoverishment of the individual or family in the face of extended or catastrophic service costs;
(4) account for equity in order to assure affordability of long-term care for all Americans
(~~4~~5) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual.
(~~5~~6) coordinate benefits across different LTC financing program.
(~~6~~7) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level;
(~~7~~8) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level;
(~~8~~9) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased;
(~~9~~10) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and
(~~10~~11) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high-quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms. 2. Our AMA will work with Centers for Medicare & Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance plans to provide long-term care coverage for patients with Alzheimer's and other forms of dementia.

RESOLVED, that our AMA support increased awareness and education about long-term care insurance, including a mandate for public and private insurers to provide such information to potential enrollees during their annual health insurance election.

816. REDUCING BARRIERS TO GENDER-AFFIRMING CARE THROUGH IMPROVED PAYMENT AND REIMBURSEMENT

Introduced by GLMA: Health Professionals Advancing LGBTQ+ Equality

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED
See Policy G-605.009

RESOLVED, that our American Medical Association appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care

817. EXPANDING AMA PAYMENT REFORM WORK AND ADVOCACY TO MEDICAID AND OTHER NON-MEDICARE PAYMENT MODULES FOR PEDIATRIC HEALTHCARE AND SPECIALTY POPULATIONS
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-385.901

RESOLVED, that our American Medical Association support appropriate demonstration projects, carve outs, and adjustments for pediatric patients and services provided to pediatric patients within the payment reform arena; and be it further

RESOLVED, that our AMA extend ongoing payment reform research, education, and advocacy to address the needs of specialties and patient populations not served by current CMMI models or other Medicare-focused payment reform efforts; and be it further

RESOLVED, that our AMA support and work with national medical specialty societies that are developing alternative payment models for specific conditions or episodes, target patient populations including pediatric populations, and medical and surgical specialties and continue to advocate that the Centers for Medicare and Medicaid Services, including the Center for Medicare and Medicaid Innovation; state Medicaid agencies; and other payers implement physician-developed payment models; and be it further

RESOLVED, that our AMA consider improved Medicaid payment rates to be a priority given the critical impact these payment rates have on patient care and patient access to care; and be it further

RESOLVED, that our AMA support and collaborate with state and national medical specialty societies and other interested parties on the development and adoption of physician-developed alternative payment models for pediatric health care that address the distinct prevention and health needs of children and take long-term, life-course impact into account.

818. AMENDMENT TO AMA POLICY ON HEALTHCARE SYSTEM REFORM PROPOSALS
Introduced by New England

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: FIRST RESOLVE NOT ADOPTED
SECOND RESOLVE REFERRED

[Editor's Note: The following Resolve was not adopted]
RESOLVED, that our American Medical Association remove opposition to single-payer health care delivery systems from its policy, and instead evaluate all health care system reform proposals based on our stated principles as in AMA policy; and be it further

[Editor's Note: The following Resolve was referred]
RESOLVED, that our AMA support a national unified financing health care system that meets the principles of freedom of choice, freedom and sustainability of practice, and universal access to quality care for patients.

819. AMEND VIRTUAL CREDIT CARD AND ELECTRONIC FUNDS TRANSFER FEE POLICY
Introduced by New York

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: ADOPTED AS FOLLOWS
TITLE CHANGED
See Policy D-190.968

RESOLVED, that our AMA advocate for legislation or regulation that would prohibit the use of VCCs for electronic health care payments; and be it further

RESOLVED, that our AMA advocate on behalf of physicians and plainly state that it is not advisable or beneficial for medical practices to get paid by VCCs; and be it further

RESOLVED, that our AMA engage in legislative and regulatory advocacy efforts to address the growing and excessive electronic funds transfer (EFT) add-on service fees charged by payers when paying physicians, including advocacy efforts directed at: (1) the issuance of Centers for Medicare & Medicaid Services (CMS) regulatory guidance affirming physicians' right to choose and receive timely basic EFT payments without paying for additional services, (2) CMS enforcement activities related to this issue, and (3) physician access to a timely no fee EFT option as an alternative to virtual credit cards (VCCs).

820. AFFORDABILITY AND ACCESSIBILITY OF TREATMENT OF OVERWEIGHT AND OBESITY
Introduced by Oregon

Resolution 820 was considered with Resolution 806.
See Resolution 806.

RESOLVED, that our American Medical Association join in efforts to convince Congress to address the affordability and accessibility of prevention and evidence-based treatment of obesity across the United States as well as, urge individual state delegations to directly advocate for their state insurance agencies and insurance providers in their jurisdiction to: 1. Revise their policies to ensure that prevention and evidence-based treatment of obesity is covered for patients who meet the appropriate medical criteria; and 2. Ensure that insurance policies in their states do not discriminate against potential evidence-based treatment of obese patients based on age, gender, race, ethnicity, socioeconomic status.

821. MODERNIZING THE AMA/SPECIALTY SOCIETY RVS UPDATE COMMITTEE (RUC) PROCESSES
Introduced by American College of Physicians

Reference committee hearing: see report of Reference Committee J.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association encourage the AMA/Specialty Society RVS Update Committee (RUC) to modernize the RUC's processes and implement the following principles:

1. Data-Driven Decision Making: Enhance the data used in making recommendations by shifting from almost exclusive reliance on surveys of physicians and others who perform services to broader use of evidence-based data and metadata (e.g., procedure time from operating logs, hospital length of stay data, and other extant data sources) that permit assessment of resource use and the relative value of physician and other qualified healthcare professional services comprehensively. This can ensure that data is reliable, verifiable, and can be accurately compared to or integrated with other important databases.
2. Collaboration and Transparency: Seek collaboration with healthcare data experts, stakeholders, and relevant organizations to maintain transparent data collection and analysis methodologies.

3. Continuous Review and Adaptation: Expand and enhance its system for continuous review and adaptation of relative value determinations beyond its Relativity Assessment Workgroup and other current strategies (e.g., New Technology/New Services list) to stay aligned with evolving healthcare practices and technologies.
4. Equity and Access: Work with the Current Procedural Terminology Editorial Panel and others, as appropriate, to identify the impact that factors related to healthcare equity and access have on the resources used to provide the services of physicians and other qualified healthcare professionals and how to account for those resources in the description and subsequent valuation of those services.
5. Broader Engagement: Actively engage with other parties to gather input and ensure that relative value determinations align with the broader healthcare community's goals and values.
6. Education and Training: Invest in the education and training of its members, AMA and specialty society staff, and other participants (e.g., specialty society RUC advisors) to build expertise in evidence-based data analysis and metadata utilization.
7. Timely Implementation: Invest the necessary resources and establish a clear timeline for the implementation of these modernization efforts, with regular progress self-assessments and adjustments as needed; and be it further

RESOLVED, that our AMA provide an informational report back to the House of Delegates at the 2025 annual meeting on the RUC process and modernizations efforts.

RESOLUTION 822 WAS NOT CONSIDERED

REFERENCE COMMITTEE K

901. SILICOSIS FROM WORK WITH ENGINEERED STONE
Introduced by Arizona

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy D-365.994

RESOLVED, That our American Medical Association encourage physicians, including occupational health physicians, pulmonologists, radiologists, and pathologists, and other health-care professionals, to work together to report all diagnosed or suspected cases of silicosis in accordance with National Institute for Occupational Safety and Health (NIOSH) guidance; and be it further

RESOLVED, That our AMA should advocate for the establishment of preventive measures to reduce exposure of workers to silica levels above the evidence-based permissible exposure level (PEL) for respirable crystalline; and be it further

RESOLVED, That our AMA should advocate for the establishment of a registry of cases of silicosis to be maintained for workers diagnosed with silicosis resulting from engineered stonework or from other causes, either by state Departments of Public Health or their Division of Occupational Safety and Health; and be it further

RESOLVED, That our AMA should advocate for the establishment of state funds to compensate workers who have been diagnosed with silicosis resulting from their work with silica, to recognize the progression and the need for increasing levels of compensation over time; and be it further

RESOLVED, That our AMA recommends that State Medical Associations should take action with respect to the prevention of silicosis and to the recognition and compensation of affected workers in their states.

902. POST MARKET RESEARCH TRIALS
Introduced by Integrated Physician Practice Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-100.944

RESOLVED, That our American Medical Association advocate that the Food and Drug Administration use its authority to require and enforce timely completion of post-marketing trials or studies whenever sponsors rely on surrogate endpoints to support approval; and be it further

RESOLVED, That our AMA advocate that the Food and Drug Administration use its authority to require that pharmaceuticals that received approval using surrogate endpoints demonstrate direct clinical benefit in post-market trials, of appropriate size and scope for its relevant patient population, as a condition of continued approval; and be it further

RESOLVED, That our AMA advocate that the Food and Drug Administration require drug manufacturers to make the findings of their post-market trials publicly available.

903. SUPPORT EDUCATION AND EMERGENCY INTERVENTIONS FOR STATUS EPILEPTICUS

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 903
See Policy H-440.796

RESOLVED, That our AMA encourage awareness efforts to increase recognition of the signs of status epilepticus.

904. UNIVERSAL RETURN-TO-PLAY PROTOCOLS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED IN LIEU OF RESOLUTION 904
See Policy H-470.954

RESOLVED, that our AMA encourage evidence-based studies regarding post-injury management protocols and return-to-play criteria that can help guide physicians who are caring for injured athletes.

905. SUPPORT FOR RESEARCH ON THE RELATIONSHIP BETWEEN ESTROGEN AND MIGRAINE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: NOT ADOPTED

RESOLVED, that our American Medical Association support further research regarding the role of estrogen as a risk factor for stroke and cardiovascular events at the dosages and routes found in, inclusive of but not limited to combined oral contraceptive pills, vaginal rings, transdermal patches, hormone replacement therapy, and gender affirming hormone therapy in individuals with migraine and migraine with aura.

RESOLVED, that our AMA work with relevant stakeholders to advocate for increased resources to allow for appropriate education and assessment, when indicated, of migraine and migraine with aura consistent with current diagnostic guidelines in medical practice sites inclusive of but not limited to primary care, obstetrics and gynecology, endocrinology, neurology, and cardiology clinics.

906. ONLINE CONTENT PROMOTING LGBTQ+ INCLUSIVE SAFE SEX PRACTICES
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-485.994

RESOLVED, that our American Medical Association amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows: -

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Television Broadcast and Online Streaming of Sexual Encounters and Public Health Awareness on Social Media Platforms, H-485.994

The AMA urges television broadcasters and online streaming services, producers, ~~and~~ sponsors, and any associated social media outlets to encourage education about inclusive safe sexual practices, including but not limited to condom use and abstinence, in television or online programming of sexual encounters, and to accurately represent the consequences of unsafe sex.

RESOLUTION 907 WAS NOT CONSIDERED

RESOLUTION 908 WAS NOT CONSIDERED

909. HIGH RISK HPV SUBTYPES IN MINORITIZED POPULATIONS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED FOR DECISION

RESOLVED, that our AMA amend H-440.872, "HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide," by addition as follows:

HPV Vaccine and Cervical and Oropharyngeal Cancer Prevention Worldwide H-440.872
1. Our AMA (a) urges physicians and other health care professionals to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine HPV related cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and HPV related cancer screening in countries without organized HPV related cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases in all individuals, regardless of sex, such as, but not limited to, cervical cancer, head and neck cancer, anal cancer, and genital cancer, the availability and efficacy of HPV vaccinations, and the need for routine HPV related cancer screening in the general public.
3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits; (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations; and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.
4. Our AMA encourages appropriate parties to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.
5. Our AMA will study requiring HPV vaccination for school attendance.
6. Our AMA encourages collaboration with interested parties to make available human papillomavirus vaccination to people who are incarcerated for the prevention of HPV-associated cancers.
7. Our AMA supports further research by relevant parties of HPV self-sampling in the United States to determine whether it can decrease health care disparities in cervical cancer screening.
8. Our AMA advocate that racial, ethnic, socioeconomic, and geographic differences in high-risk HPV subtype prevalence be taken into account during the development, clinical testing, and strategic distribution of next-generation HPV vaccines.

910. SICKLE CELL DISEASE WORKFORCE
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy H-350.973

RESOLVED, that our American Medical Association amend H-350.973, "Sickle Cell Disease," by addition to read as follows:

Sickle Cell Disease H-350.973
Our AMA:
(1) recognizes sickle cell disease (SCD) as a chronic illness;
(2) encourages educational efforts directed to health care providers and the public regarding the treatment and prevention of SCD;
(3) supports the inclusion of SCD in newborn screening programs and encourages genetic counseling for parents of SCD patients and for young adults who are affected, carriers, or at risk of being carriers;
(4) supports ongoing and new research designed to speed the clinical implementation of new SCD treatments;
(5) recommends that SCD research programs have input in the planning stage from the local African American community, SCD patient advocacy groups, and others affected by SCD;
(6) supports the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises;
(7) supports the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections; and
(8) encourages the development of model school policy for best in-school care for children with sickle cell disease;
(9) supports expanding the health care and research workforce taking care of patients with sickle cell disease; and
(10) collaborates with relevant parties to advocate for improving access to comprehensive, quality, and preventive care for individuals with sickle cell disease, to address crucial care gaps that patients with sickle cell disease face and improve both the quality of care and life for patients affected by sickle cell disease.

RESOLUTION 911 WAS NOT CONSIDERED

RESOLUTION 912 WAS NOT CONSIDERED

913. PUBLIC HEALTH IMPACTS OF INDUSTRIALIZED FARMS
Introduced by Medical Student Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-135.908

RESOLVED, that our American Medical Association recognizes that concentrated animal feeding operations (CAFOs) as may be a public health hazard; and be it further

RESOLVED, that our AMA encourage the Environmental Protection Agency and appropriate parties to remove the regulatory exemptions for CAFOs under the Emergency Planning and Community Right-to-Know Act and the Comprehensive Environmental Response, Compensation, and Liability Act and tighten restrictions on pollution from CAFOs.

914. ADVERSE CHILDHOOD EXPERIENCES
Introduced by American Academy of Pediatrics

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED AS FOLLOWS
See Policy H-515.952

RESOLVED, That our AMA collaborate with the CDC and other relevant interested parties to advocate for the inclusion of additional evidence-based categories to the currently existing Adverse Childhood Experiences (ACEs)

categories for the purposes of continuing to improve research into the health impacts of ACEs and how to mitigate them; and be it further

RESOLVED, That our AMA work with the CDC and other relevant interested parties to advocate for resources to expand research into ACEs and efforts to operationalize those findings into effective and evidence-based clinical and public health interventions; and be it further

RESOLVED, that our AMA support the establishment of a national ACEs response team grant to dedicate federal resources towards supporting prevention and early intervention efforts aimed at diminishing the impacts ACEs have on the developing child.

915. SOCIAL MEDIA IMPACT ON YOUTH MENTAL HEALTH
Introduced by American Academy of Child and Adolescent Psychiatry

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association work with relevant parties to develop guidelines for age-appropriate content and access and to develop age-appropriate digital literacy training to precede social media engagement among children and adolescents; and be it further

RESOLVED, that our AMA amend policy D-478.965 by insertion as follows:

(4) advocates for and support media and social networking services addressing and developing safeguards for users, including protections for youth online privacy, effective controls allowing youth and caregivers to manage screentime content and access, and to develop age-appropriate digital literacy training; and be it further

RESOLVED, that our AMA advocate that the federal government requires social media companies to share relevant data for further independent research on social media's effect on youth mental health and fund future federal research on the potential benefits and harms of social media use on youth mental health.

916. ELIMINATION OF BUPRENORPHINE DOSE LIMITS

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ALTERNATE RESOLUTION ADOPTED
IN LIEU OF RESOLUTION 916
See Policy D-95.972

RESOLVED, that our American Medical Association support patients' ability to receive buprenorphine doses that exceed dosage limits listed in FDA-approved labeling when recommended by their prescriber for the treatment of opioid use disorder; and be it further

RESOLVED, that our AMA urge interested parties, including federal agencies, manufacturers, medical organizations, and health plans to review the evidence concerning buprenorphine dosing and revise labels and policies accordingly, in light of increasing mortality related to high-potency synthetic opioids.

RESOLUTION 917 WAS NOT CONSIDERED

RESOLUTION 918 WAS NOT CONSIDERED

RESOLUTION 919 WAS NOT CONSIDERED

RESOLUTION 920 WAS REASSIGNED TO REFERENCE COMMITTEE B. SEE RESOLUTION 225.

921. ADDRESSING DISPARITIES AND LACK OF RESEARCH FOR ENDOMETRIOSIS
Introduced by Women Physicians Section

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy D-420.989

RESOLVED, that our American Medical Association collaborate with stakeholders to recognize endometriosis as an area for health disparities research that continues to remain critically underfunded, resulting in a lack of evidence-based guidelines for diagnosis and treatment of this condition amongst people of color; and be it further

RESOLVED, that our AMA collaborate with stakeholders to promote awareness of the negative effects of a delayed diagnosis of endometriosis and the healthcare burden this places on patients, including health disparities among patients from communities of color who have been historically marginalized; and be it further

RESOLVED, that our AMA advocate for increased endometriosis research addressing health disparities in the diagnosis, evaluation, and management of endometriosis, and be it further

RESOLVED, that our AMA advocate for increased funding allocation to endometriosis-related research for patients of color, especially from federal organizations such as the National Institutes of Health.

922. PRESCRIPTION DRUG SHORTAGES AND PHARMACY INVENTORIES
Introduced by American Association of Neurological Surgeons

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: REFERRED

RESOLVED, that our American Medical Association work with the pharmacy industry to develop and implement a mechanism to transfer prescriptions without requiring a new prescription; and be it further

RESOLVED, that our AMA advocate for legislation and/or regulations permitting pharmacies to transfer prescriptions to other pharmacies when prescription medications are unavailable at the original pharmacy or the patient requests the prescription be transferred.

923. ELIMINATING ELIGIBILITY CRITERIA FOR SPERM DONORS BASED ON SEXUAL ORIENTATION
Introduced by American Society for Reproductive Medicine

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy D-420.988

RESOLVED, that our American Medical Association work with other interested organizations to ask the US Food and Drug Administration (FDA) to eliminate its eligibility criteria for sperm donation based on sexual orientation, with a report back at I-24.

924. LABORATORY DEVELOPED TESTS PROPOSED FDA RULE
Introduced by American Society of Clinical Pathology

Reference committee hearing: see report of Reference Committee K.

HOD ACTION: ADOPTED
See Policy D-270.982

RESOLVED, that our American Medical Association submit a comment to the FDA proposed rule entitled "Medical Devices; Laboratory Developed Tests" (Published October 3, 2023) requesting a 60-day extension period to the current comment period.