

Memo to: Delegates, Alternate Delegates
Executive Directors, Member Organizations of the House of Delegates

From: Bruce A. Scott, MD, Speaker, House of Delegates
Lisa Bohman Egbert, MD, Vice Speaker, House of Delegates

Date: October 29, 2021

Subject: Handbook Addendum - Supplemental Business and Information

We are pleased to provide the attached resolutions that were received after the Delegates' Handbook resolution deadline:

- 020 Recognizing and Remediating "Structural Urbanism" Bias as a Factor in Rural Health Disparities
- 021 Free Speech and Civil Discourse in the American Medical Association
- 022 Prohibition of Racist Characterization Based on Personal Attributes
- 119 Bundling Physician Fees with Hospital Fees
- 120 COBRA for College Students
- 121 Medicaid Tax Benefits
- 122 Increase Funding, Research and Education for Post-Intensive Care Syndrome
- 229 CMS Administrative Requirements
- 230 Medicare Advantage Plan Mandates
- 231 Prohibit Ghost Guns
- 232 Ban the Gay/Trans (LGBTQ+) Panic Defense
- 233 Insurers and Vertical Integration
- 234 Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients
- 316 Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
- 317 Creating a More Accurate Accounting of Medical Education Financial Costs
- 318 The Medical Student Match Mismatch
- 408 Ensuring Affordability and Equity in COVID-19 Vaccine Boosters
- 611 September 11th as a National Holiday
- 612 UN International Radionuclide Therapy Day Recognition
- 613 Due Process at our AMA
- 614 Insurance Industry Behaviors
- 615 Employed Physicians
- 616 Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System
- 617 Together We are Stronger Marketing Campaign
- 707 Fifteen Month Lab Standing Orders
- 708 Insurance Coverage for Scalp Cooling (Cold Cap) Therapy
- 709 Prior Authorization - CPT Codes for Fair Compensation
- 710 Physician Burnout is an OSHA Issue

In addition, your Speakers wish to inform you that the charts listing actions taken in follow-up to resolutions and report recommendations from the November 2020 and June 2021 Special Meetings will be posted on the November 2021 Special Meeting website.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 020
(N-21)

Introduced by: Iowa

Subject: Recognizing and Remedying “Structural Urbanism” Bias as a Factor in Rural Health Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Rural Americans’ health disparities are significant and unacceptable, with mortality
2 rates 23% higher, and preventable hospitalizations 40% higher-- across all racial and age
3 groups; and
4

5 Whereas, The differences in rural vs. urban health measures have been worsening over the last
6 30 years; and
7

8 Whereas, The percent of physicians who practice in rural areas is about 11%, despite 20% of
9 Americans living in rural America; and
10

11 Whereas, Health care research (Johnston, et al.¹) has shown that the biggest reason for worse
12 rural mortality and preventable hospitalization rates is the shortage in “local-area supply of
13 specialists, which explained 55% of the differences in hospitalization rates and 40% of the
14 difference in mortality rates”; and
15

16 Whereas, Medicare’s physician geographic payment policy since 1992 (developed under the
17 direction of consultants from the Urban Institute) has chronically discriminated against rural
18 physicians, with the current policy adjusting rural physician E&M payments as much as 25-30%
19 lower than some urban areas, and adjusting rural diagnostic testing payments 50-60% lower
20 than some urban areas; and
21

22 Whereas, Another research group (Probst, et al.²) wrote that “rural health disparities are due in
23 part to declining healthcare provider availability and accessibility in rural communities” and
24 “these problems are exacerbated by structural urbanism” ... a bias which “systematically
25 shortchanges rural areas”. They also suggested that “current models of health care funding...
26 are innately biased in favor of large populations” and “until this bias is recognized, the
27 development of viable models of care across the rural-urban continuum cannot move forward”;
28 and
29

30 Whereas, In the CME report on Rural Health Physician Workforce Disparities, telehealth was
31 touted as one way to remedy rural health disparities, and the CME recognized some of the
32 telehealth barriers such as the current site of service Medicare payments. The problem is that
33 without geographic equity in telehealth payments there would be no financial incentive for urban
34 physicians to serve rural vs. urban patients, and keeping Medicare’s geographically adjusted
35 payments unchanged would give incentives for rural physicians to receive higher telehealth
36 payment for urban patients; and

Whereas, National telehealth services who serve rural and urban hospitals and physician groups do not give geographic discounts for their services, which means there is a national, not a local, "market price" for teleservices, unlike Medicare's geographic payment policy which shortchanges rural physicians; therefore be it

RESOLVED, That our American Medical Association: (1) formally recognize that systemic bias in healthcare financing, called "Structural Urbanism," has been a factor in leading to rural health disparities; (2) in future AMA strategic planning to reduce all of America's health disparities, include plans to reduce/remedy the structural urbanism bias; and (3) point out, in advocating for health equity for all Americans, that Medicare payment policies have played a role in the shortage of rural physicians and the poorer health outcomes in rural America (Directive to Take Action); and be it further

RESOLVED, That our AMA, as part of our current advocacy for telehealth reform, specify that geographic payment equity be required in any telehealth legislation. (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Our AMA has prioritized the identification and remediation of health disparities, and this resolution asks for action to help address a major, unacceptable disparity in health care access and outcomes, with identification of causes for the 23% higher mortality and 40% higher preventable hospitalizations that could impact 60 million rural Americans.

The resolution is also timely because the COVID-19 pandemic has highlighted the need for telehealth legislation to help improve access to care to all Americans, especially underserved rural residents. The telehealth resolution would ensure that increased access, which telehealth legislation would bring, is not a hollow promise.

References:

1. Johnston K, Wen H, Maddox KEJ. Lack of Access to Specialists Associated with Mortality and Preventable Hospitalizations of Rural Medicare Beneficiaries. Health Aff (Millwood) 2019; 38(12): 1993-2002
2. Probst J, Eberth JM, Crouch E. Structural Urbanism Contributes to Poorer Health Outcomes for Rural America. Health Aff (Millwood) 2019; 38(12): 1976-1984

RELEVANT AMA POLICY

Geographic Practice Cost Index D-400.985

Our AMA will: (1) use the AMA Physician Practice Information Survey to determine actual differences in rural vs. urban practice expenses; (2) seek Congressional authorization of a detailed study of the way rents are reflected in the Geographic Practice Cost Index (GPCI); (3) advocate that payments under physician quality improvement initiatives not be subject to existing geographic variation adjustments (i.e., GPCIs); and (4) provide annual updates on the Centers for Medicare and Medicaid Services efforts to improve the accuracy of Medicare Economic Index weights and geographic adjustments and their impact on the physician payment schedule, and AMA advocacy efforts on these issues.

Citation: (Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Appended: CMS Rep. 1, I-11; Reaffirmed in lieu of Res. 119, A-12 and Res. 122, A-12; Reaffirmation: I-12; Reaffirmation I-13)

Elimination of Payment Differentials Between Urban and Rural Medical Care H-240.971

Our AMA (1) supports elimination of Medicare reimbursement differentials between urban and rural medical care; and (2) supports efforts to inform the Congress of the impact of such programs on the rural population.

Citation: Res. 107, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Equal Pay for Equal Work D-400.989

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

Citation: BOT Rep. 14, A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmed: Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Reaffirmed: CMS Rep. 01, A-19

Improving Rural Health H-465.994

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
 - Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
 - Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
 - Study efforts to optimize rural public health.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19

Access to and Quality of Rural Health Care H-465.997

(1) Our AMA believes that solutions to access problems in rural areas should be developed through the efforts of voluntary local health planning groups, coordinated at the regional or state level by a similar voluntary health planning entity. Regional or statewide coordination of local efforts will not only help to remedy a particular community's problems, but will also help to avoid and, if necessary, resolve existing duplication of health care resources. (2) In addition to local solutions, our AMA believes that on a national level, the implementation of Association policy for providing the uninsured and underinsured with adequate protection against health care expense would be an effective way to help maintain and improve access to care for residents of economically depressed rural areas who lack adequate health insurance coverage. Efforts to place National Health Service Corps physicians in underserved areas of the country should also be continued.

Citation: CMS Rep. G, A-87; Modified: Sunset Report, I-97; Reaffirmation A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21

Enhancing Rural Physician Practices H-465.981

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

Citation: CMS Rep. 9, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:

A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and

Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies (such as telehealth) to alleviate rural physician workforce shortages.

Citation: CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01;

Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18;

Appended: Res. 318, A-19

Rural Health H-465.982

The AMA: (1) encourages state medical associations to study the relevance of managed competition proposals to meeting health care needs of their rural populations; (2) encourages state associations to work with their respective state governments to implement rural health demonstration projects; and (3) will provide all adequate resources to assist state associations in dealing with managed competition in rural areas.

Citation: (CMS Rep. H, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

Economic Viability of Rural Sole Community Hospitals H-465.979

Our AMA: (1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.

Citation: (CMS Rep. 3, A-15)

Closing of Small Rural Hospitals H-465.990

Our AMA encourages legislation to reduce the financial constraints on small rural hospitals in order to improve access to health care.

Citation: (Res. 145, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10;

Reaffirmed in lieu of Res. 807, I-13; Reaffirmed: CMS Rep. 3, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(N-21)

Introduced by: Louisiana

Subject: Free Speech and Civil Discourse in the American Medical Association

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, On June 1, 2021, Dr. Russ Kridel, Chair, AMA Board of Trustees, issued a message
2 to the members of the American Medical Association House of Delegates regarding certain
3 recent events pertaining to discussion of the AMA's *Organizational Strategic Plan to Embed*
4 *Racial Justice and Advance Health Equity*; and
5

6 Whereas, As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the
7 same professionalism that we try to exhibit daily as practicing physicians". However, many at
8 recent meetings of the AMA House, particularly those held virtually, we have witnessed some
9 loss of professionalism in regard to comments regarding the strategic plan. Some members of
10 our House are being personally attacked and threatened by others for their thoughts and ideas.
11 Name calling, unsettling calls to family members, and other unprofessional communications
12 have occurred;" and
13

14 Whereas, In light of recent deterioration in civility and professionalism in policy debate and
15 discussion at the American Medical Association, the Louisiana Delegation to the AMA
16 developed and submitted Late Resolution 1003 at the June meeting calling for enhanced
17 standards of dignity, respect, tolerance and professionalism in AMA policy debate and
18 discussions; and
19

20 Whereas, Louisiana-submitted Late Resolution 1003 was recommended for acceptance as
21 business of the House of Delegates by the AMA HOD Committee on Rules and Credentials,
22 and was recommended as meeting the priority threshold and recommended for acceptance as
23 business by the AMA HOD Resolution Committee; and
24

25 Whereas, The AMA House of Delegates refused to consider Late Resolution 1003, thereby
26 failing to address the recent deterioration in civility and professionalism characterizing AMA
27 policy debate and discussion; therefore be it
28

29 RESOLVED, That it be the policy of our American Medical Association that:
30

31 Our American Medical Association unequivocally commits to truly open discourse,
32 debate, exchange of ideas, and argument;
33

34 Our American Medical Association unequivocally commits to a culture which
35 recognizes the inherent dignity and worth of its members, which resolves that
36 freedom of expression and civility must coexist, and where those who disagree will do
37 so without enmity;

1 Our American Medical Association unequivocally commits to the principle that
2 dissenting and unpopular voices must be afforded the opportunity to be heard;
3

4 Our American Medical Association unequivocally commits that members of the
5 American Medical Association of different faiths, philosophies, and persuasions may
6 speak their minds and honor their deepest convictions without fear of punishment or
7 retaliation;
8

9 Our American Medical Association unequivocally commits that the mere exposure to
10 ideas that some may find offensive is not an act of violence or hatred;
11

12 Our American Medical Association unequivocally commits to a prohibition of the
13 listing of people or organizations to be regarded as unacceptable, untrustworthy,
14 excluded, or avoided based on ideological positions or differences;
15

16 Our American Medical Association unequivocally commits that ideological
17 demonization of opponents to block debate and to silence disagreement in the
18 proceedings of the American Medical Association is unprofessional conduct subject to
19 appropriate disciplinary action;
20

21 Our American Medical Association unequivocally commits that defamation, obscenity,
22 intimidation, threats, and incitement to violence, have no place in the proceedings of
23 the American Medical Association, and if exhibited are unprofessional conduct subject
24 to appropriate disciplinary action. (New HOD Policy)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023*. As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians". However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed a loss of professionalism during comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred. As the strategic plan will once again be discussed at the November 2021 meeting, the debate and hopefully the adoption of these policies and principles are paramount in order to have a professional and courteous conversation regarding the production and contents of the equity report. We believe the Speakers saw this firsthand during the June meeting.

¹ Russ Kridel, "A Communication from the Board Chair," email of June 1, 2021 (copy on file with author).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022
(N-21)

Introduced by: Louisiana

Subject: Prohibition of Racist Characterization Based on Personal Attributes

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Recent events at the American Medical Association have resulted in that entity
2 publicly promulgating statements that are racially exclusive and racially characterizing, as
3 contained in the AMA *Organizational Strategic Plan to Embed Racial Justice and Advance*
4 *Health Equity*ⁱ (hereinafter *the Equity Strategic Plan*); and

5
6 Whereas, *The Equity Strategic Plan* endorses a racially exclusive definition of racism: Racism,
7 as defined by Camara Jones, MD, MPH, PhD, is a “system of structuring opportunity,” which
8 assigns value based on race, disadvantaging people of color while offering advantage to
9 whites.... (P. 15); and

10
11 Whereas, *The Equity Strategic Plan* includes the following racially characterizing statements:
12 We must develop a critical consciousness that seeks truth and acknowledges the historical
13 realities that powerful organizations and structures, rooted in white patriarchy and affluent
14 supremacy such as the AMA, have both intentionally and unintentionally made invisible (p. 5).
15 White supremacy, constantly adapting to legal and cultural challenges, persists in part by the
16 way many whites ignore their whiteness to the point of invisibility, their role in a racial hierarchy,
17 and the privilege it gives them (p. 13). Locating white supremacy in individuals, rather than in
18 structures, is how the shared commitment to white ignorance preserves one’s sense of self
19 while allowing oppressive structures to persist (p. 14); and

20
21 Whereas, Attempts by the Louisiana Delegation to the AMA to have the AMA House of
22 Delegates adopt policy, at its June 2021 Special Meeting, that prohibits racist characterization of
23 person or groups of persons based on personal attributes were unsuccessful; therefore be it

24
25 RESOLVED, That it be the policy of our American Medical Association that no person or group
26 of persons shall be considered or characterized as racist based on personal attributes of race,
27 color, religion, sex (including pregnancy, sexual orientation, or gender identity), national origin,
28 age, disability, or genetic information. (New HOD Policy)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023*. As noted by Dr. Kridel, "Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians". However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed a loss of professionalism during comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred. As the strategic plan will once again be discussed at the November 2021 meeting, the debate and hopefully the adoption of these policies and principles are paramount in order to have a professional and courteous conversation regarding the production and contents of the equity report. We believe the Speakers saw this firsthand during the June meeting.

ⁱ American Medical Association, *Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity*, (Chicago: American Medical Association, 2021), <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>.

RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20

Discrimination Against Patients by Medical Students H-295.865

Our AMA opposes the refusal by medical students to participate in the care of patients on the basis of the patient's race, ethnicity, age, religion, ability, marital status, sexual orientation, sex, or gender identity.

Citation: (Res. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(N-21)

Introduced by: New York

Subject: Bundling Physician Fees with Hospital Fees

Referred to: Reference Committee A

Whereas, There is some thought about bundling the fees of physicians with those of the hospital in which the services are provided; and

Whereas, Such “bundled” payments will go to the hospital which will then control the payments; and

Whereas, Such a policy will likely make it not only harder for the physician to get paid, but also much more dependent on the hospitals; and

Whereas, Hospitals would similarly never agree to bundled payments that went directly to physicians; therefore be it

RESOLVED, That our American Medical Association oppose bundling of physician payments with hospital payments, unless the physician has agreed to such an arrangement in advance.
(New HOD Policy)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

New York rates this resolution as a number one priority requiring action to ensure that physicians are compensated fairly and accurately. This issue is vital and affects all physicians who have a relationship of any type with a hospital or hospital system. Physicians have no visibility to bundled payments and cannot therefore verify that their share of a payment is paid properly. Only the hospital would have information about what share of a bundled payment belonged to the appropriate physician or the hospital. The proposed 17% share of the hospital payment is inadequate in terms of payment and does not specify how the bundled payment would be disbursed. Bundled payments to hospitals do not account for how many physicians were involved in the care of a hospitalized patient and would make it very difficult for practices to claim secondary or supplemental benefits under any coordinated benefits the patient might have. This would increase physician stress since income would be affected and increased time would be required on the part of physicians to verify that they are paid fairly. Data used for the purposes of Fairhealth cost estimates could be affected by bundling of payments to hospitals. This issue would have far-reaching consequences if implemented.

RELEVANT AMA POLICY**Health Care Reform Physician Payment Models D-385.963**

1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

Citation: Sub. Res. 128, A-10; Appended: Res. 819, I-10; Appended: CMS Rep. 8, A-11; Appended: CMS Rep. 1, A-11; Reaffirmation A-11; Modified: BOT Rep. 18, A-12; Reaffirmation: I-12; Appended: Res. 702, A-13; Appended: Res. 827, I-14; Modified: Speakers Rep., I-15; Reaffirmed: CMS Rep. 09, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(N-21)

Introduced by: New York

Subject: COBRA for College Students

Referred to: Reference Committee A

Whereas, The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a health insurance program that allows an eligible employee and his or her dependents the continued benefits of health insurance coverage in the case that an employee loses his or her job or experiences a reduction of work hours; and

Whereas, COBRA allows former employees to obtain continued health insurance coverage at group rates that otherwise might be terminated and which are typically less expensive than those associated with individual health insurance plans; and

Whereas, Such COBRA coverage reduces the disruption, financial and otherwise, that could occur when a person's employment is terminated; and

Whereas, College students enjoy similar group rate discounts with student health insurance; and

Whereas, These students, upon graduation or other termination of an enrollment, potentially face similar disruption in their healthcare coverage; therefore be it

RESOLVED, That our American Medical Association call for legislation similar to COBRA to allow college students to continue their healthcare coverage, at their own expense, for up to 18 months after graduation or other termination of enrollment. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution calls for an important option for recent college graduates who need to retain/obtain health insurance. Most, if not all, once graduated do not have the option of continued coverage under their parent's health insurance due to loss of student status and/or their age. EVERYONE needs to have health insurance and this has been a critically important issue as the COVID pandemic has progressed. While they are seeking employment, it would be beneficial to all if a COBRA-type program existed which would cover these new graduates/ job seekers until they are hired and covered by employer health insurance.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 121
(N-21)

Introduced by: New York

Subject: Medicaid Tax Benefits

Referred to: Reference Committee A

Whereas, There are many patients with Medicaid or no health insurance that physicians care for routinely for little or no payment; and

Whereas, It may be politically complicated to rectify this fact directly with improved payments to physicians; and

Whereas, One way to offset the problem would be to use tax deduction techniques; and

Whereas, The AMA currently has contrary policy, H-180.965, "Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured," that opposes providing tax deductions or credits for the provision of care to the medically uninsured and underinsured; therefore be it

RESOLVED, That our American Medical Association advocate for legislation that would allow physicians who take care of Medicaid or uninsured patients to receive some financial benefit through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use the unpaid charges for such patients as a tax deduction. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution and its goals had strong support in the MSSNY House of Delegates. This resolution is particularly important because AMA currently has contrary policy 180.965 that indicates that "the AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured." If AMA is to support physicians, this policy must change.

Physicians are often faced with treatment for patients having no insurance, but physicians can no longer afford to provide care as a charitable act. Payments from Medicaid do not adequately compensate physicians for patient care. Tax credits would provide incentive to continue treating uninsured patients and help to counteract patient care without payment.

RELEVANT AMA POLICY

Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured H-180.965

The AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured.

Citation: BOT Rep. 49, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 141, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(N-21)

Introduced by: Society of Critical Care Medicine

Subject: Increase Funding, Research and Education for Post-Intensive Care Syndrome

Referred to: Reference Committee A

1 Whereas, AMA Policy D-460.965, "Call for Increased Funding, Research and Education for Post
2 Viral Syndromes," asks for coding and funding for the post-acute sequelae of COVID-19; and
3

4 Whereas, The COVID-19 pandemic has substantially increased the number of patients requiring
5 critical care; and
6

7 Whereas, After critical illness, new or worsening impairments in physical, cognitive, and/or
8 mental health function are common among patients who survive, independent of virally driven
9 mechanisms; and
10

11 Whereas, There is attention and heightened interest by both the public and medical
12 communities to understand post-COVID effects, with new terminologies being used such as
13 "long-COVID," "long-haul COVID" and "Chronic COVID" which includes patients with COVID
14 discharged from the ICU; and
15

16 Whereas, Post-intensive care syndrome (PICS) is a defined term which the critical care
17 community is using in research, diagnosis and treatment and thus already captures an
18 important population of post-COVID patients making it topical to more formally define via ICD-10
19 codes and work efforts; and
20

21 Whereas, One-quarter to one-half or more of critical illness survivors will suffer from some
22 component of PICS, including muscle weakness, poor mobility, poor concentration, poor
23 memory, fatigue, anxiety, and depressed mood, which are typically corroborated by examination
24 and formal testing; and
25

26 Whereas, Although recovery is possible, many of the signs and symptoms of PICS last for
27 months to years, increasing health care utilization, particularly within the first 90 days of
28 discharge (1); and
29

30 Whereas, Current relevant ICD-10 codes are limited to G72.81, Critical illness myopathy, and
31 F43.1, Post-traumatic stress disorder, which do not encompass the breadth or specificity of
32 symptoms experienced by patients with PICS; therefore be it
33

34 RESOLVED, That our American Medical Association support the development of an ICD-10
35 code or family of codes to recognize Post-Intensive Care Syndrome (PICS) (New HOD Policy);
36 and be it further

- 1 RESOLVED, That our AMA advocate for legislation to provide funding for research and
- 2 treatment of Post-Intensive Care Syndrome, including for those cases related to COVID-19.
- 3 (Directive to Take Action)

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

Received: 10/14/21

AUTHORS STATEMENT OF PRIORITY

The Society of Critical Care Medicine seeks to include “Increase Funding, Research and Education for Post-Intensive Care Syndrome” for consideration as an urgent resolution in our special meeting in November. This resolution asks the AMA to support the development of an ICD-10 code for post-intensive care syndrome (PICS) and that the AMA advocate for funding research and treatment of PICS. There has been much interest in understanding post-COVID effects (ie long covid or chronic covid) and many of these patients have been sick enough to receive care in the ICU. Prior to the pandemic, the critical care community was focused around PICS - a syndrome comprised of physical and cognitive symptoms which occur after ICU stay and critical illness. Many of these patients with PICS are the very same COVID patients that researchers, physicians and the lay public seek to understand. We believe this resolution is timely to help us avoid re-inventing the wheel when it comes to data collection and research, and to help us accelerate understanding of how to treat post-COVID illness and other post-ICU related illnesses. If this resolution is not considered, there is a risk of advancing a uncoordinated research and treatment agenda during the pandemic for both COVID and general ICU patients.

(1) Mikkelsen ME, Still M, Anderson BJ, et al. Society of Critical Care Medicine's International Consensus Conference on Prediction and Identification of Long-Term Impairments After Critical Illness. Crit Care Med. 2020;48(11):1670-1679. doi:10.1097/CCM.0000000000004586

RELEVANT AMA POLICY

Call for Increased Funding, Research and Education for Post Viral Syndromes D-460.965

Our AMA: (1) supports the development of an ICD-10 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection (“PASC” or “Long COVID”) and other novel post-viral syndromes as distinct diagnoses; (2) will advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with viral infections, such as COVID-19; (3) will provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequelae associated with viral infections, such as COVID-19; and (4) will collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequelae associated with viral infections, such as COVID-19, to minimize the harm and disability current and future patients face.

Citation: Alt. Res. 410, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(N-21)

Introduced by: New York

Subject: CMS Administrative Requirements

Referred to: Reference Committee B

1 Whereas, The American Medical Association (AMA) has previously affirmed that administrative
2 simplification, including automation and standardization of electronic transactions, is a high
3 priority in order to provide affordable, timely, and effective care; and
4

5 Whereas, The National Standards Group (NSG) at the Centers for Medicare/Medicaid Services
6 (CMS) Office of Burden Reduction is empowered to enforce administration simplification
7 requirements to ensure standardization throughout the ecosystem of payers, providers, and
8 clearinghouses; and
9

10 Whereas, Many insurers, including government payers, have transitioned to and mandated
11 electronic billing rather than paper claim submission; and
12

13 Whereas, Some health insurers and their claim processing subsidiaries have begun to charge a
14 processing fee for claims submitted electronically and even for the electronic payments they
15 provide to physicians and their practices; and
16

17 Whereas, Violations of administrative simplification requirements by health plans and payor
18 business associates, including clearinghouses, are prevalent and have an adverse effect on
19 healthcare practices and patients via higher costs and resulting in limited access to affordable
20 healthcare; and
21

22 Whereas, NSG at the CMS Office of Burden Reduction has stated that the enforcement
23 mechanism against health plan violations is based on the idea of 'voluntary compliance', the
24 only program of this type in the Federal Government where compliance is 'voluntary' but has
25 failed to impose any financial penalties in the past 7 years on health plans for violation of HIPAA
26 administrative simplification requirements; and
27

28 Whereas, The American Medical Association and Medical Group Managers Association have
29 advocated to HHS/CMS that existing federal laws require health insurers to offer network
30 physicians no-charge option for electronic funds transfer (EFT), but that has not stopped health
31 insurers and/or their vendors from inappropriately charging for EFT; and
32

33 Whereas, At the same time, HHS/CMS has imposed numerous financial penalties on physicians
34 and other providers in healthcare, for violations of HIPAA privacy rules which are governed by
35 the same rules as the HIPAA administrative simplification requirements, (including financial
36 penalties for failure to implement EMR, Meaningful Use (MU) and PQRS, MACRA, MIPS, "Open
37 Payments," Sunshine Act violations, and numerous others); and

1 Whereas, Physicians strongly disapprove of the failure by the NSG at the CMS Office of Burden
2 Reduction to resolve complaints related to payments via non-compliant methods including
3 virtual credit cards and for imposing fees for receiving EFT payments by health plans and
4 clearinghouses, therefore be it

5
6 RESOLVED, That our American Medical Association forcefully advocate that the Centers for
7 Medicare and Medicaid Services (CMS) investigate all valid allegations of HIPAA Administrative
8 simplification requirements thoroughly and offers transparency in its processes and decisions as
9 required by the Administrative Procedure Act (APA) (Directive to Take Action); and be it further

10
11 RESOLVED, That our AMA forcefully advocate that the CMS resolve all complaints related to
12 the non-compliant payment methods including opt-out virtual credit cards, charging processing
13 fees for electronic claims and other illegal electronic funds transfer (EFT) fees (Directive to Take
14 Action); and be it further

15
16 RESOLVED, That our AMA communicate its strong disapproval of the failure by the CMS Office
17 of Burden Reduction to effectively enforce the HIPAA administrative simplification requirements
18 as required by the law and its failure to impose financial penalties for non-compliance by health
19 plans (Directive to Take Action); and be it further

20
21 RESOLVED, That our AMA, through legislation, regulation or other appropriate means,
22 advocate for the prohibition of health insurers charging physicians and other providers to
23 process claims and make payment. (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The inequity in the way that physicians are treated by CMS versus how health insurance plans are treated must stop. There are federal regulations that are supposed to prohibit health insurers from charging for electronic payments. Yet CMS has not enforced this law and as a result, there are increasing complaints of health insurers inappropriately charging for EFT. Physicians and their offices are on the front lines of patient care – the more time we must devote to administrative burdens, penalties, sorting out payment denials, deduction of processing fees from payments – is less time to see patients. The uneven enforcement of administration simplification requirements places the heaviest burden on physician offices NOT the insurance industry. This must stop, penalties must be enforced and imposed upon insurers as they are on physicians. Health insurers should be prohibited from charging fees for processing claims – the premiums paid to an insurer cover the expenses for an insured and that includes processing and paying the claim.

RELEVANT AMA POLICY

Administrative Simplification in the Physician Practice D-190.974

1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.

Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmation A-14; Reaffirmation: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmation: I-17; Reaffirmation: A-19; Modified: CMS Rep. 09, A-19

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(N-21)

Introduced by: New York

Subject: Medicare Advantage Plan Mandates

Referred to: Reference Committee B

1 Whereas, Some municipalities are requiring their retirees to change from traditional Medicare
2 health insurance coverage to Medicare Advantage plans; and
3

4 Whereas, Medicare Advantage plans may have restrictive networks; and
5

6 Whereas, Medicare Advantage plans further privatize patients' Medicare, without discussion or
7 agreement by the persons concerned, all in the interest of saving money for the employer; and
8

9 Whereas, Forcing use of Medicare Advantage plans does not consider the retiree's personal
10 health concerns, including the ability to find continued care with their own doctors or hospitals
11 with whom they may have long relationships; therefore be it
12

13 RESOLVED, That our American Medical Association advocate for federal legislation to ensure
14 that no person should be mandated to change from traditional Medicare to Medicare Advantage
15 plans. (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

As State, city and local governments continue to be pressured by rising healthcare costs, the effort to force employees and retirees (aka, patients) to accept less expensive and less inclusive health plans will increase. This mandate has already begun in New York City. Many Medicare Advantage plans have very limited networks and would force patients to select a health plan that may not include the physicians with whom they have developed long relationships and years of care. Forcing patients into other plans interrupts continuing care across all specialties and should not be permitted. This represents the worst kind of government interference in the health of patients. AMA needs to work with CMS to ensure that no patient is forced to choose or forced to switch to Medicare Advantage plan coverage.

RELEVANT AMA POLICY

Ending Medicare Advantage Auto-Enrollment H-285.905

Our AMA will work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of "auto-enrollment" of individuals into Medicare Advantage Plans.

Citation: Res. 216, I-16

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

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

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

Elimination of Subsidies to Medicare Advantage Plans D-390.967

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(N-21)

Introduced by: New York

Subject: Prohibit Ghost Guns

Referred to: Reference Committee B

1 Whereas, Homemade, difficult to trace firearms are increasingly turning up at crime scenes; and

2
3 Whereas, The most important part of a gun is the lower receiver - the 'chassis' of the weapon,
4 the part housing vital components such as the hammer and trigger; and

5
6 Whereas, Under federal law, the lower receiver is considered a firearm - while other gun
7 components do not require a background check for purchase; and

8
9 Whereas, Dozens of companies sell what are known as "80%" lower receivers - ones that are
10 80% finished, lack a serial number and can be used to make a homemade gun; and

11
12 Whereas, The Gun Control Act (1968) and the Brady Gun Violence Prevention Act (1993) allow
13 for homemade weapons; and

14
15 Whereas, Ghost guns don't have any unique markings and therefore present black holes to
16 police investigators; and

17
18 Whereas, Ghost guns provide an easy avenue for people banned from owning guns to obtain
19 them; and

20
21 Whereas, According to the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) 30% of
22 all weapons recovered by the bureau in California were homemade; and

23
24 Whereas, These weapons have been connected with mass shootings, police shootouts and
25 arms trafficking; therefore be it

26
27 RESOLVED, That our American Medical Association support state and federal legislation and
28 regulation that would subject homemade weapons to the same regulations and licensing
29 requirements as traditional weapons. (New HOD Policy)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

This resolution expands the current AMA policy on gun safety. Additionally, it dovetails with the recently stated objectives of the US President and Senate Majority Leader. The best solution is a national (federal) one and AMA should be a part of that as a national organization. AMA must expand its policy to include this.

RELEVANT AMA POLICY**Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997**

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.

Therefore, the AMA:

- (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
- (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
- (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
- (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
- (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
- (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
- (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;

(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;

(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);

(d) the imposition of significant licensing fees for firearms dealers;

(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and

(f) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(N-21)

Introduced by: New York, Medical Student Section, Minority Affairs Section,
GLMA: Health Professionals Advancing LGBTQ Equality,
American Academy of Psychiatry and the Law, American Psychiatric
Association, California, American Academy of Child and Adolescent
Psychiatry, American Association of Geriatric Psychiatry

Subject: Ban the Gay/Trans (LGBTQ+) Panic Defense

Referred to: Reference Committee B

Whereas, The gay/trans panic (to be more inclusive will use “LGBTQ+ panic”) defense strategy is a legal strategy that uses a victim’s sexual orientation or gender identity/expression as an excuse for a defendant’s violent reaction, seeking to legitimize and even to excuse violent and lethal behavior (1); and

Whereas, The LGBTQ+ panic defense strategy gives defendants three options of defense: 1) insanity or diminished capacity, 2) provocation, 3) self-defense (3); and

Whereas, To claim:

- insanity, defendants claim that the sexual orientation or gender of the victim is enough to induce insanity (1);

- provocation, defendants claim “victim’s proposition, sometimes termed a “non-violent sexual advance” was sufficiently “provocative” to induce the defendant to kill the victim”(1);

- self-defense, “defendants claim they believed that the victim, because of their sexual orientation or gender identity/expression, was about to cause the defendant serious bodily harm (3)”; and

Whereas, Studies have shown that jurors with higher homonegativity and religious fundamentalism ratings assigned higher victim blame, lower defendant responsibility, and more lenient verdicts in the “LGBTQ+ panic” conditions (5,6,7); and

Whereas, “Gay panic disorder” was removed from the DSM in 1973 because the APA recognized that no such condition exists; and

Whereas, Many murder sentences have been reduced or defendants have been acquitted using the LGBTQ+ panic defense strategy such as in the Matthew Shepard case, to successfully mitigate a charge from murder to criminally negligent manslaughter as recently as 2018 (1); and

Whereas, The LGBTQ community makes up 3.5% of the US population yet, sexual orientation is the motivator of 17% of hate crime attacks with one in four transgender people becoming the victim of a hate crime in their lifetime (4, 5); and

Whereas, The LGBTQ+ panic defense has only been banned in 11 states as of February 2021, with legislation having been introduced in 12 more states (1, 2); and

Whereas, New York State passed a law in June 2019 banning the gay/trans (LGBTQ+) Panic Defense, preventing a setback in protections for LGBTQ+ people; and

Whereas, At least 44 Transgender or Gender Non-Conforming persons have been killed in the US during the year 2020, the highest total since HRC started tracking in 2013 (9); and

Whereas, There is not a race panic defense for a reason, and similar reasoning must disallow a gay/trans (LGBTQ+) panic defense; therefore be it

RESOLVED, That our American Medical Association seek a federal law banning the use of the so-called “gay/trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual assault cases (Directive to Take Action); and be it further

RESOLVED, That our AMA publish an issue brief and talking points on the topic of so called “gay/trans (LGBTQ+) panic” defense, that can be used by our AMA in seeking federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called “gay/trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY:

Transgender people, our patients, specifically transgender women of color, are at an extremely high risk of dying by homicide. Last year a record number of deaths were recorded in the US (46- an underestimate given the under reporting of transgender identity). By mid-April, there are 15 known homicides of transgender people as reported by HRC. If this pace continues for 2021, another record will be broken on pace for over 50 homicides this year. AMA must act now to protect transgender people, and to send a clear message to all of our transgender patients and our LGBTQ+ patients, that we see them, value them, support them, and fight for them. This resolution must be heard at the AMA – it was extracted in June from the “not for consideration list” for further consideration and is being resubmitted **with support from seven additional organizations**. This is a critically important resolution that needs to be moved forward by the AMA so that model legislation can be shared and to provide justice for transgender people.

RELEVANT AMA POLICY

Preventing Anti-Transgender Violence H-65.957

Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an

individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.

Citation: Res. 008, A-19

Access to Basic Human Services for Transgender Individuals H-65.964

Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.

Citation: Res. 010, A-17

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

References:

1. "Gay and Trans 'Panic' Defense." Gay and Trans "Panic" Defense, The National LGBT Bar Ass'n, 2019, lgbtbar.org/programs/advocacy/gay-trans-panic-defense/.
2. The LGBTQ+ "Panic" Defense Map. LGBTQ Bar Association. Downloaded 18 February 2021 at: <https://lgbtbar.org/programs/advocacy/gay-trans-panic-defense/gay-trans-panic-defense-legislation/>
3. Holden, A. (2019). *The gay/Trans panic defense: What it is, and how to end it*. American Bar Association. <https://www.americanbar.org/groups/crsj/publications/member-features/gay-trans-panic-defense/>
4. Federal Bureau of Investigation, U.S. Dep't of Justice. "Table 5, Offenses, Known Offender's Race by Bias Motivation, 2007." Hate Crime Statistics, 2007d (released Oct. 2008). www.fbi.gov/ucr/hc2007/table_05.htm (accessed Jan. 11, 2009).
5. Coston, Liz. "Understanding and Handling Hate Crimes against Gay, Bisexual, and Transgender People." Scholars Strategy Network, 9 Nov. 2018, scholars.org/brief/understanding-and-handling-hate-crimes-against-gay-bisexual-and-transgender-people.
6. Michalski N D and Nunez N. When is Gay Panic Accepted? Exploring Juror Characteristics and Case Type as Predictors of a Successful Gay Panic Defense. *Journal of Interpersonal Violence*; first published online 22 April 2020. Downloaded at: <https://journals-sagepub-com.proxy.library.stonybrook.edu/doi/pdf/10.1177/0886260520912595>
7. Tomei J, etl al. The Gay Panic Defense: Legal Defense Strategy or Reinforcement of Homophobia in Court. *Journal of Interpersonal Violence*; 2020 Nov;35(21-22):4239-4261
8. Salerno, J. M., Najdowski, C. J., Bottoms, B. L., Harrington, E., Kemner, G., & Dave, R. (2015). Excusing murder? Conservative jurors' acceptance of the gay-panic defense. *Psychology, Public Policy, and Law*, 21(1), 24-34
9. An Epidemic of Violence: Fatal Violence Against Transgender and Gender Nonconforming People in the United States in 2020. Human Rights Campaign, 2021. Downloaded 18 February 2021 at: <https://hrc-prod-requests.s3-us-west-2.amazonaws.com/FatalViolence-2020Report-Final.pdf?mtime=20201119101455&focal=none>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(N-21)

Introduced by: New York

Subject: Insurers and Vertical Integration

Referred to: Reference Committee B

1 Whereas, Insurers already enjoy significant marketplace advantages, such as keeping
2 healthcare data opaque from other stakeholders, marketplace consolidation, and monopsony
3 power; and
4

5 Whereas, These advantages have not resulted in cost savings (or even stability) for
6 consumers--in fact cost increases born by consumers have been outsized and correlated with
7 consolidation; and
8

9 Whereas, Insurers have increasingly been pursuing mergers--in the name of promoting
10 efficiency; and
11

12 Whereas, These "efficiencies" rarely, if ever, benefit the consumer; and
13

14 Whereas, These combined entities (especially vertical ones) are more competitive among their
15 competitors than the uncombined ones (accelerating further consolidation); and
16

17 Whereas, The combined entities are also positioned (due to their superior access to capital) to
18 unfairly disrupt entities at other points in the supply chain such as medical practices, community
19 pharmacies, and safety net hospitals; therefore be it
20

21 RESOLVED, That our American Medical Association seek legislation and regulation to prevent
22 health payers (except non-profit HMO's) from owning or operating other entities in the health
23 care supply chain. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

As a matter of protecting public health and reducing health payor interference in patient care delivery, it is critical that AMA continue to actively work to prevent large entities from creating these monopolies. While the AMA has taken important steps in recent years to challenge these mergers and acquisitions, existing AMA policy is four years old. The efforts on the part of health payers to absorb practices, pharmacy benefit managers, medical equipment suppliers etc. continues and will create a health care market without any competition. This will not be good for our patients nor for physicians. These entities should be controlled by nothing more than the competitive free market system. Allowing health insurers to control more and more elements of the health care supply chain will result in even greater interference in the physician-patient relationship and decrease access to care for our patients. AMA is strongly urged to take immediate action to update its policy on this subject.

RELEVANT AMA POLICY

Health Insurance Company Purchase by Pharmacy Chains D-160.920

Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMAs concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies.

Citation: BOT Action in response to referred for decision Res. 234, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(N-21)

Introduced by: Illinois, California, Iowa, Georgia, New Jersey, Pennsylvania, American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society of Retina Specialists

Subject: Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients

Referred to: Reference Committee B

1 Whereas, A topical stock-item medication is an unlabeled ointment or drop that the hospital
2 operating room (OR), or Emergency Room (ER), or Ambulatory Surgical Treatment Center
3 (ASTC) staff has on stand-by or is retrieved from a dispensing system for a specified patient for
4 use during a procedure or visit; and
5

6 Whereas, Topical stock-item agents are charged to the patient, but unused medication often
7 gets discarded when the patient is discharged, even if the medication is recommended for
8 post-discharge care to aid in the patient's healing; and
9

10 Whereas, Because regulations governing the ability to dispense the remaining portion of stock-
11 item medications for post-discharge use can be unclear or appear overly burdensome, many
12 facilities do not allow the practice; and
13

14 Whereas, Patients may need to purchase duplicate agents for post-discharge use, increasing
15 patient cost and creating medication waste; and
16

17 Whereas, Similar issues of cost inefficiencies and medical waste arise with the use of
18 medications such as multiuse eye drops that are only allowed for single-patient use, but could
19 safely be used in multiple patients; and
20

21 Whereas, The Joint Commission has previously approved specific policies and procedures
22 implemented by the Utah Valley Regional Medical Center for the use of multi dose eye drops in
23 multiple patients; therefore be it
24

25 RESOLVED, That our American Medical Association work with national specialty societies,
26 state medical societies and/or other interested parties to advocate for legislative and regulatory
27 language that permits the practice of dispensing stock-item medications to individual patients
28 upon discharge in accordance with labeling and dispensing protocols that help ensure patient
29 safety, minimize duplicated patient costs, and reduce medication waste (Directive to Take
30 Action); and be it further

- 1 RESOLVED, That our AMA work with the Food and Drug Administration, national specialty
- 2 societies, state medical societies and/or other interested parties to advocate for legislative and
- 3 regulatory language that permits the practice of using multi dose eye drop bottles
- 4 post-operatively in accordance with safe handling and dispensing protocols that help ensure
- 5 patient safety, minimize duplicated patient costs, and reduce medication waste. (Directive to
- 6 Take Action)

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

Received: 10/15/21

AUTHORS STATEMENT OF PRIORITY

This resolution reflects an issue that is urgent and affects most physicians and their patients. Health care costs are rising at an unsustainable rate, which jeopardizes access to care. There is significant medical waste associated with the disposal of certain stock medications, which patients could continue to use safely if they were dispensed to the patient upon discharge. AMA action or policy statement will have a positive impact. We should quickly pursue clarifying legislative and regulatory language that removes this barrier to the efficient and safe use of medications that would otherwise be wasted.

Reference:

Using multi dose eye drops in a health care setting: a policy and procedural approach to safe and effective treatment of patients. Jensen MK, et al. JAMA Ophthalmology 2014. <https://jamanetwork.com/journals/jamaophthalmology/article-abstract/1901216>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(N-21)

Introduced by: New York

Subject: Medical Education Debt Cancellation in the Face of a Physician Shortage
During the COVID-19 Pandemic

Referred to: Reference Committee C

1 Whereas, There is a physician shortage facing our nation; andⁱ

2
3 Whereas, The shortage is going to worsen since 2 of 5 current physicians will be 65 years or
4 older and in retirement age this year; andⁱ

5
6 Whereas, The shortage is amplified now during the COVID-19 pandemic, demonstrating now
7 more than ever the need for a sufficient and robust physician workforce; andⁱ

8
9 Whereas, An unprecedented number of physicians now plan to retire in the next year and many
10 of whom are under 45 years old and therefore would be retiring earlier than expected by
11 workforce shortage predictors due to COVID-19; andⁱⁱ

12
13 Whereas, 8% of physicians surveyed across the United States have closed their practices
14 during the pandemic, amounting to approximately 16,000 closed practices further exacerbating
15 the shortage of healthcare providers; andⁱⁱⁱ

16
17 Whereas, The COVID-19 pandemic has placed immense financial strain on physicians across
18 specialties who have reported loss of staff, lack of reimbursement, and closure of independent
19 physician practices during the COVID-19 pandemic; and^{iii,iv}

20
21 Whereas, Young physicians are expected to be part of the workforce for many years to come,
22 yet the majority of healthcare workers (HCW) who died during the COVID-19 pandemic were
23 under 60 years old with primary care physicians (PCPs) accounting for a disproportionate
24 number of these HCW deaths; and^{v,vi}

25
26 Whereas, Before the pandemic, the physician shortage in New York State (NYS) was already
27 predicted to be between 2,500 and 17,000 by 2030; and^{vii}

28
29 Whereas, During the pandemic, the shortage has been amplified in that New York City has had
30 the highest COVID-19 death rate in the country with NYS accounting for the greatest number of
31 HCW deaths in the USA; and^{v,viii}

32
33 Whereas, 73% of medical students graduated with debt in 2020; and^{ix}

34
35 Whereas, The cost of medical school has increased 129% in the past 20 years after adjusting
36 for inflation, affecting newer generations of students and physicians substantially more than past
37 ones; and^x

1 Whereas, The average medical student debt is \$207,003--an approximately 28% increase in the
2 past 10 years--however, the average physician ultimately pays \$365,000-\$440,000 for an
3 educational loan with interest; and^{ix,x,xi}

4
5 Whereas, In the United States, 50% of low-income medical school graduates have educational
6 debt that exceeds \$100,000; and^x

7
8 Whereas, The financial barrier to entry into medical school is significant in that over half of
9 medical students belong to the top quintile of US household income, with 20-30% of students
10 belonging to the top 5% of income; however, only less than 5% of students come from the
11 lowest quintile of US household income; and^x

12
13 Whereas, A recent study found that higher debt levels among medical students is more likely to
14 motivate them to choose higher paying specialties than primary care specialties; and^{xii}

15
16 Whereas, Higher burdens of educational debt has been demonstrated to cause residents to
17 place greater emphasis on financial considerations when choosing a specialty; and^{xiii}

18
19 Whereas, The COVID-19 pandemic is producing a secondary surge in primary care need that
20 has been studied previously in natural disasters and has been shown to persist for years;
21 and^{xiv,xv}

22
23 Whereas, It is well-established that health inequities existed before the pandemic in that
24 individuals with low socioeconomic status are more likely to also be from minority populations,
25 and are more likely to have worse health outcomes; and^{xvi}

26
27 Whereas, These inequities have now been exacerbated by the pandemic, with the heaviest
28 burden of COVID-19 disease falling upon Black, Latinx, and immigrant communities; and^{xvii}

29
30 Whereas, Over 27 million Americans have lost their employer-sponsored health insurance
31 during the pandemic; thus, we will need more physicians now than ever before to address these
32 disparities and rising needs in health care; and^{xviii}

33
34 Whereas, 72% of physicians surveyed across specialties reported loss of income during the
35 pandemic, with over half of these respondents reporting losses of 26% or more; andⁱⁱⁱ

36
37 Whereas, Policies modeled to include provisions for debt relief or increase in incomes were
38 found by one study to be more likely to incentivize students to choose primary care physician
39 specialties; and^{xix}

40
41 Whereas, Current AMA policies support methods to alleviate debt burden but do not address
42 debt cancellation specifically; and

43
44 Whereas, \$50 billion of the initial CARES Act Provider Relief Fund were allocated to support the
45 current healthcare system by giving hospitals and providers funding "to support health care-
46 related expenses or lost revenue attributable to COVID-19..."; however, funding formulas based
47 on market shares of Medicare costs and total patient revenue are most likely to bankrupt
48 independent physicians, specifically primary care providers; and^{xx,xxi}

49
50 Whereas, One study found that primary care internists whose medical education were funded
51 through Public Service Loan Forgiveness and Federally Granted Loans were predicted to have

1 significantly less net present value than primary care internists who received military or private
2 funding; and^{xxii}

3
4 Whereas, Medical education debt has been shown to be a significant barrier for
5 underrepresented minorities and low/middle income strata students to choose medicine for a
6 career; and^{xxii}

7
8 Whereas, A key strategy to address health needs of underserved communities involves
9 recruiting students from these communities as they may be more likely to return to address local
10 health needs; and^{xxiii}

11
12 Whereas, One medical school has created a debt-free program for matriculated students and
13 saw (1) an increase in applicants to supply the future physician workforce and (2) an increase in
14 applicants from groups underrepresented in medicine to help address socioeconomic and
15 racial/ethnic disparities in the medical workforce and in healthcare; and^{xxiv}

16
17 Whereas, There is currently a student debt forgiveness resolution in the United States Senate to
18 cancel \$50,000 of student debt which will also apply to all medical students, training physicians,
19 and early career physicians; and^{xxv}

20
21 Whereas, Data suggests women and people of color will benefit most from such debt
22 cancellation because they are most in need; therefore be it^{xxv}

23
24 RESOLVED, That our American Medical Association study the issue of medical education debt
25 cancellation and consider the opportunities for integration of this into a broader solution
26 addressing debt for all medical students, physicians in training, and early career physicians.
27 (Directive to Take Action)

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

Received: 10/13/21

The topic of this resolution is currently under study by the Council on Medical Education.

AUTHOR'S STATEMENT OF PRIORITY

Students, training and attending docs are facing increasing amounts of administrative, regulatory and financial pressures that take a toll and cause increased rates of physician stress, demoralization, burnout and depression.

Data and experience show that physician stress and burnout result in reduced quality of care and reduced quality of patient-doc relationships and reduced patient satisfaction.

This loan forgiveness if achieved would reduce burdens on students and physicians and would contribute to reduced burnout and depression and mitigate reductions in quality of care that result from high levels of burnout.

Students and physicians need help now - this can't wait until the November AMA meetings. Physician needs will be forgotten by the end of summer when we are projected to be near herd immunity.

RELEVANT AMA POLICY

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953

In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.

Citation: Res. 202, I-20

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes,

and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i)

Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19

ⁱ "The Complexities of Physician Supply and Demand: Projections From 2018 to 2033." American Association of Medical Colleges. June 2020. Retrieved from <<https://www.aamc.org/media/45976/download>>

ⁱⁱ The Physicians Foundation 2020 Physician Survey: Part 2. The Physicians Foundation. <https://physiciansfoundation.org/research-insights/the-physicians-foundation-2020-physician-survey-part-2/>. Published September 17, 2020. Accessed March 10, 2021.

ⁱⁱⁱ The Physicians Foundation 2020 Physician Survey: Part 1. The Physicians Foundation. <https://physiciansfoundation.org/research-insights/2020physiciansurvey/>. Published August 18, 2020. Accessed March 10, 2021.

^{iv} Primary Care & COVID-19: Week 9 Survey. Primary Care Collaborative. <https://www.pcpcc.org/2020/05/13/primary-care-covid-19-week-9-survey>. Published May 13, 2020. Accessed March 10, 2021.

^v Our key findings about US healthcare worker deaths to date. The Guardian. <https://www.theguardian.com/us-news/ng-interactive/2020/dec/22/lost-on-the-frontline-our-findings-to-date>. Published February 10, 2021. Accessed March 10, 2021.

^{vi} Gouda D, Singh PM, Gouda P, Gouda B. An Overview of Health Care Worker Reported Deaths During the COVID-19 Pandemic. *The Journal of the American Board of Family Medicine*. 2021;34(Supplement):S244-S246. doi:10.3122/jabfm.2021.s1.200248

^{vii} New York Physician Supply and Demand Through 2030. The Center for Health Workforce Studies. <https://www.albany.edu/news/images/PhysicianShortagereport.pdf>. Published March 2009. Accessed March 10, 2021.

^{viii} CDC COVID Data Tracker. Centers for Disease Control and Prevention. https://covid.cdc.gov/covid-data-tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fcases-in-us.html#compare-trends_newcases. Published 2021. Accessed March 10, 2021.

^{ix} "Medical Student Education: Debt Costs, and Loan Repayment Fact Card for the Class of 2020". American Association of Medical Colleges. October 2020. Retrieved from <<https://store.aamc.org/medical-student-education-debt-costs-and-loan-repayment-fact-card-for-the-class-of-2020.html>>

^x Average Medical School Debt [2021]: Student Loan Statistics. EducationData. <https://educationdata.org/average-medical-school-debt>.

^{xi} "Trends in Cost and Debt at U.S. Medical Schools Using a New Measure of Medical School Cost of Attendance". *Analysis in Brief*. American Association of Medical Colleges. Vol 12. No 2. July 2012. Retrieved from <<https://www.aamc.org/media/5951/download#:~:text=In%201978%20indebted%20graduates%20across,average%2C%207.8%20percent%20per%20year>>

^{xii} Pisaniello MS, Asahina AT, Bacchi S, et al. Effect of medical student debt on mental health, academic performance and specialty choice: a systematic review. *BMJ Open*. 2019;9(7):e029980. Published 2019 Jul 2. doi:10.1136/bmjopen-2019-029980

^{xiii} West CP, Drefahl MM, Popkave C, Kolars JC. Internal medicine resident self-report of factors associated with career decisions. *J Gen Intern Med*. 2009 Aug;24(8):946-9. doi: 10.1007/s11606-009-1039-0. Epub 2009 Jun 24. PMID: 19551448; PMCID: PMC2710478.

^{xiv} Weinstein E, Ragazzoni L, Burkle F, Allen M, Hogan D, Della Corte F. Delayed Primary and Specialty Care: The Coronavirus Disease-2019 Pandemic Second Wave. *Disaster Medicine and Public Health Preparedness*. 2020;14(3):e19-e21. doi:10.1017/dmp.2020.148

^{xv} Runkle JD, Brock-Martin A, Karmaus W, Svendsen ER. Secondary Surge Capacity: A Framework for Understanding Long-Term Access to Primary Care for Medically Vulnerable Populations in Disaster Recovery. *American Journal of Public Health*. 2012;102(12):e24-e32. doi:10.2105/ajph.2012.301027

^{xvi} Chowkwanyun M, Reed AL Jr. Racial Health Disparities and Covid-19 - Caution and Context. *N Engl J Med*. 2020 Jul 16;383(3):201-203. doi: 10.1056/NEJMp2012910. Epub 2020 May 6. PMID: 32374952.

^{xvii} Krouse HJ. COVID-19 and the Widening Gap in Health Inequity. *Otolaryngol Head Neck Surg*. 2020 Jul;163(1):65-66. doi: 10.1177/0194599820926463. Epub 2020 May 5. PMID: 32366172.

^{xviii} Geyman JP. Beyond the COVID-19 Pandemic: The Urgent Need to Expand Primary Care and Family Medicine. *Fam Med*. 2021 Jan;53(1):48-53. doi: 10.22454/FamMed.2021.709555. PMID: 33471922.

^{xix} Vaughn BT, DeVrieze SR, Reed SD, Schulman KA. Can we close the income and wealth gap between specialists and primary care physicians? *Health Aff (Millwood)*. 2010 May;29(5):933-40. doi: 10.1377/hlthaff.2009.0675. PMID: 20439883.

^{xx} Mulvany C. CARES Act payback problem for some healthcare providers. Healthcare Financial Management Association (HFMA). <https://www.hfma.org/topics/coronavirus/cares-act-payback-problem-for-some-healthcare-providers-.html>. Published May 20, 2020. Accessed March 15, 2021.

^{xxi} Chin MH. Cherry Blossoms, COVID-19, and the Opportunity for a Healthy Life. *The Annals of Family Medicine*. 2021;19(1):63-65. doi:10.1370/afm.2630

^{xxii} Marcu MI, Kellermann AL, Hunter C, Curtis J, Rice C, Wilensky GR. Borrow or Serve? An Economic Analysis of Options for Financing a Medical School Education. *Academic Medicine*. 2017;92(7):966-975. doi:10.1097/acm.0000000000001572

^{xxiii} Larkins S, Michielsen K, Iputo J, Elsanousi S, Mammen M, Graves L, Willems S, Cristobal FL, Samson R, Ellaway R, Ross S, Johnston K, Derese A, Neusy AJ. Impact of selection strategies on representation of underserved populations and intention to practise: international findings. *Med Educ*. 2015 Jan;49(1):60-72. doi: 10.1111/medu.12518. PMID: 25545574.

^{xxiv} Kang, Y, et al. "Debt-Free Medical Education - A Tool for Health Care Workforce Diversity." *JAMA*. December 2020. Retrieved from <<https://jamanetwork.com/channels/health-forum/fullarticle/2774066>>

^{xxv} Warren, E et al. US Senate Resolution. 116th Congress, 2d Session. Retrieved from <<https://www.warren.senate.gov/imo/media/doc/Schumer%20Warren%20resolution.pdf>>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(N-21)

Introduced by: Illinois, American Society of Anesthesiologists

Subject: Creating a More Accurate Accounting of Medical Education Financial Costs

Referred to: Reference Committee C

Whereas, The usual reference to the cost of medical education typically is the summation of tuition for the period of 4 years of medical education; and

Whereas, There are 3 years of required postgraduate training prior to a medical school graduate's ability to fully practice medicine, during which time school loans are typically deferred and interest is compounded; and

Whereas, Matriculation into medical school typically requires completion of a four-year undergraduate degree; and

Whereas, The demands of medical education typically prohibit students from undertaking simultaneous endeavors that provide remuneration for their work; and

Whereas, Most postgraduate medical education is performed in large urban settings where cost-of-living consumes much of the stipend paid to interns and residents leaving little for repayment of school loans; and

Whereas, The frequently publicized cost of medical education underrepresents the actual financial responsibility of the prospective medical student and the general public; therefore be it

RESOLVED, That our American Medical Association study the costs of medical education, taking into account medical student tuition and accrued loan interest, to come up with a more accurate description of medical education financial costs. (Directive to Take Action)

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

Received: 10/15/21

The topic of this resolution is currently under study by the Council on Medical Education.

AUTHORS STATEMENT OF PRIORITY

This issue impacts all medical students and our medical education pipeline. AMA has policy related to this resolution, but underlying data to support the financial burden imposed by medical education is lacking. Taking action now to initiate the collection of data and analysis will be of tremendous benefit to future medical students and our ability to advocate on their behalf.

RELEVANT AMA POLICY

D-305.984 - Reduction in Student Loan Interest Rates

...

3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.
4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.
5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training.

Res. 316, A-03 Reaffirmed: BOT Rep. 28, A-13 Appended: Res. 302, A-13 Modified and Appended: 301, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(N-21)

Introduced by: North Carolina, District of Columbia, Georgia, Oklahoma, Mississippi,
New Jersey, Tennessee, South Carolina, Kentucky

Subject: The Medical Student Match MisMatch

Referred to: Reference Committee C

1 Whereas, The National Resident Matching Program (NRMP) has run a computer based, well
2 organized, evolving matching program placing medical student seniors and graduates in
3 available residency slots since 1952; and
4

5 Whereas, The number of NRMP applicants has risen significantly since 2017 to include US-MD
6 seniors, US-DO seniors, US-IMGs, IMGs and some repeat or specialty applicants (total 48,502
7 for 2021) without a matching rise in US Residency slots (only 38,106 potential residency slots
8 for matching); and
9

10 Whereas, The US National Resident Matching Program (NRMP) has a consistent mismatch of a
11 significant number of applicants, sometimes a bit less or more, each year now for about 10
12 years with dramatic increases in the last two years; and
13

14 Whereas, The average senior medical student graduates with about \$250,000.00 of debt and
15 about 20% of these graduates with over \$400,000.00 of medical school debt; and
16

17 Whereas, Most states require completion of a residency accredited by the Accreditations
18 Council for Graduate Medical Education (ACGME) before full state medical licensure; and
19

20 Whereas, A non-matching student may be facing significant debt with no way to repay, since no
21 job prospects as a resident physician will still leave existing educational debt; and
22

23 Whereas, A non-matching student has graduated from medical school; and
24

25 Whereas, Even without recent data we believe the potential for large debt, but no job, will
26 certainly increase health professional disparity since the potential mismatch and large debt will
27 discourage an ethnically diverse or a racially diverse medical student and thus the profession;
28 and
29

30 Whereas, AMA has both robust policy on all the above issues and a powerful FREIDA computer
31 application (see www.ama-assn.org/amgone/freida/); therefore be it
32

33 RESOLVED, That our American Medical Association hire or assign staff to staff up the FREIDA
34 system with AMA employees to: (1) work with the FREIDA system, further educate rising senior
35 students how to have a successful match; (2) give real time help to medical students to navigate
36 post no-match; (3) help no-match medical students navigate loan repayment strategies; and (4)
37 help no-match medical students find jobs in the medical or public or commercial sectors
38 (Directive to Take Action); and be it further

1 RESOLVED, That our AMA Council on Medical Education and the Medical Student and
2 Resident Fellow Sections develop a joint task force to update no-match data and reasons for
3 the phenomenon and suggestions for improvement or amelioration (Directive to Take Action);
4 and be it further

5
6 RESOLVED, That the new FREIDA staff engage with AMA legal and AMA advocacy staff to
7 redouble our AMA efforts to expand, to increase, to originate and to fund residency slots across
8 the US. (Directive to Take Action)

Fiscal Note: Estimated \$175,000 annually to implement this resolution.

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Obviously, the Resident Match Mismatch effects students and residents, but they now are about half of AMA membership. BUT as the physician shortage grows over time, the Mismatch will begin to effect even more, in fact MOST physicians and practices. THIS is the time to ACT, because the Mismatch has greatly increased over the last two years; AND with a new Administration in DC, THIS IS the time for AMA ACTION for more Residency slots, particularly with President Biden's interest in "Human Infrastructure." To really move along the project, we need NEW POLICY as listed. WE CAN MAKE a difference in a Democrat controlled DC, particularly with our preponderance, now, at AMA, of IN TUNE AMA leadership. The AMA is best positioned to lead in this arena at this time.

AMA Policy and References

THE MATCH HISTORY AND BACKGROUND

AMA Policy

See [FREIDA™ AMA Residency & Fellowship Programs Database \(ama-assn.org\)](#)

Key AMA Match Policy is D-310.977 first written in 2005 and modified and amended many times since.

H-200.949 Primary Care Workforce

H-310.910 Preliminary Year Program Placement

H-200.954 US Physician Shortage

D-310.974 Policy Suggestions to Improve the National Matching Program

References

The Match: Explaining the Application Process and Your Residency Results. St George's University, from the SGU Pulse, the Medical School Blog, March 17, 2021 (adopted from 2018 version), Grenada, West Indies.

Match Day Explained: How Med Students Take the Next Career Step. March 4, 2016, from the University of Michigan, Med U.

Brendan Murphy: AMA News Writer

Medical Students match in record numbers, celebrate virtually, March 20, 2020

[2021 Main Residency Match Results and Data Report Now Available - The Match, National Resident Matching Program \(nrmp.org\)](#)

[Trends in Race/Ethnicity Among Applicants and Matriculants to US Surgical Specialties, 2010-2018 | Health Disparities | JAMA Network Open | JAMA Network](#)

THE MISMATCH

References

Brendan Murphy, AMA staff writer

Why medical students aren't matching -June 7, 2015 (staff writers)

No Match for you? SOAP offers last minute option – March 8, 2021

Ten Years After, Kristi Dyer, August 15, 2009...from MOM supported by Amazon Services, LLC

[Graduate Medical Education \(GME\) Funding News & Info | American Medical Association \(ama-assn.org\)](#)

AMA Policy

H-310.910 Preliminary Year Program Placement

H-305.988 Availability of First-Year Residency Positions

H-200.954 US Physician Shortage

H-200.949 Principles to Address Primary Care Workforce

D-305.967 Full Funding of Graduate Medical Education

MEDICAL STUDENT DEBT

References

Medical Student Debt, AMSA, 2021 from the ASMA web page, some based on AAMC data from the 1994-2003 Questionnaire
What is the Average Medical Student Debt? From NerdWallet 2021. From their web page
How to pay off student debt. From Weatherby Healthcare, 2021 (a CHG Company) their web page

AMA Policy
H-305.925 Medical Education Costs and Medical Student Debt

POTENTIAL JOBS IF NOT MATCHED

References

Ten Years Later...see above

Physician Jobs without ABME Board Certification or Medical Licensure. 2021. From the MDJourney, by the WPFamily web page.
16 Jobs for Physicians without a Residency or Licensure. By Catherine Carroll on the Physician Tycoon web page.

AMA Policy
See above
D-200.980 Physician Practices in Underserved Areas

RELEVANT AMA POLICY

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should

be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Citation: CME Rep. 04, I-18

US Physician Shortage H-200.954

Our AMA:

(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;

(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;

(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;

(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;

(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;

(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;

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

Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Reaffirmed: CME Rep. 3, A-21

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988

Our AMA:

- 1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
- 2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
- 3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
- 4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
- 5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
- 6. supports continued study of the relationship between medical student indebtedness and career choice;
- 7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
- 8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
- 9. encourages for-profit hospitals to participate in medical education and training;
- 10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
- 11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
- 12. will advocate that resident and fellow trainees should not be financially responsible for their training.

Citation: CME Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 313, I-95; Reaffirmed by CME Rep. 13, A-97; Modified: CME Rep. 7, A-05; Modified: CME Rep. 13, A-06; Appended: Res. 321, A-15; Reaffirmed: CME Rep. 05, A-16; Modified: CME Rep. 04, A-16

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-

interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21 Reaffirmed in lieu of: Res. 311, A-21

Preliminary Year Program Placement H-310.910

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.

4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to "couples matching," and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on

a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully “couples match” with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

Citation: Res. 306, A-12; Appended: CME Rep. 03, A-19

Policy Suggestions to Improve the National Resident Matching Program D-310.974

Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; (4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants; (5) advocate that the words “residency training” in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, “The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report” and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and (6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.

Citation: (CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12)

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).

7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College

of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the

Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980

1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations. (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program. (c) Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.

2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.

3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.

4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).

5. Our AMA supports elimination of the tax liability when employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

Citation: CME Rep. 1, I-08; Modified: CME Rep. 4, A-10; Reaffirmation I-11; Appended: Res. 110, A-12; Reaffirmation A-13; Reaffirmation A-14; Appended: Res. 312, I-16; Appended: Res. 312, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(N-21)

Introduced by: New York

Subject: Ensuring Affordability and Equity in COVID-19 Vaccine Boosters

Referred to: Reference Committee D

1 Whereas, Development of COVID-19 vaccine was developed in record time in response to a
2 worldwide pandemic emergency; and
3

4 Whereas, The federal government funded development and purchase of COVID-19 vaccine for
5 no cost distribution to the states, allowing the possibility of equity in the administration of this
6 precious commodity; and
7

8 Whereas, Booster doses are likely to be needed to maintain the health and economy of our
9 country; and
10

11 Whereas, Such boosters must be equitably available to all willing recipients in the states around
12 our country to maintain herd immunity; therefore be it
13

14 RESOLVED, That our American Medical Association support the public purchase and cost-free
15 distribution of COVID-19 booster vaccine doses. (New HOD Policy)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

This resolution is critically important to ensure the health of America. The COVID-19 booster has been debated and has been authorized by the CDC and FDA for those with compromised immune systems and those age 65 and older. Indications are that immune response from previous vaccinations does not last well in all patients and booster shots will be required. Many patients have already begun to receive their Covid booster shots. Physicians and the organizations which represent us have a responsibility to ensure that booster shots are available to those needing it, and indeed with time to all Americans. The AMA must take a position supporting the availability of booster shots without cost to those needing and/or wanting them.

RELEVANT AMA POLICY

COVID-19 Vaccination Rollout to Emergency Departments and Urgent Care Facilities D-440.918

Our AMA will work with other relevant organizations and stakeholders to lobby the current Administration for the distribution of COVID-19 vaccinations to our nation's emergency departments and urgent care facilities during the COVID-19 public health emergency.

Citation: Res. 228, A-21

Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related

- a. Develop a data-driven rationale for improved vaccine administration fees.
- b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
- c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
- d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related

- a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
- b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
- c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
- d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

- a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
- b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to

patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.

- b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
- c. Improve accountability by adopting performance measurements.
- d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
- e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

Citation: CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation: I-12; Reaffirmation I-14;
Reaffirmed: CMS Rep. 3, I-20

An Urgent Initiative to Support COVID-19 Vaccination and Information Programs D-440.921

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination information program by: (1) educating physicians on speaking with patients about COVID-19 infection and vaccination, bearing in mind the historical context of “experimentation” with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about up-to-date, evidence-based information regarding COVID-19 and associated infections as well as the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations; and (5) educating physicians and other healthcare professionals on means to disseminate accurate information and methods to combat medical misinformation online.

Citation: Res. 408, I-20; Reaffirmed: Res. 228, A-21 Reaffirmed: Res. 421, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 611
(N-21)

Introduced by: New York

Subject: September 11th as a National Holiday

Referred to: Reference Committee F

1 Whereas, September 11, 2001 took over 3,000 lives in an act of terrorism against the United
2 States of America; and

3
4 Whereas, September 11, 2021 marked the twentieth anniversary of that horrific day; and

5
6 Whereas, Thousands of responders, uniformed and civilian, employed and volunteers, served at
7 Ground Zero, the Pentagon and Shanksville, PA, risking their lives, being exposed to debris,
8 powdered cement, fumes, vapors, dust, and a variety of other irritants, including exposure to
9 human remains, as well as many severe psychological stressors, and the devastation to the
10 World Trade Center site itself; and

11
12 Whereas, There are many Americans who now live with September 11 related medical and
13 mental health conditions as well as those whose lives were prematurely shortened because of
14 the impact of these toxic exposures; and

15
16 Whereas, The effects of the 9/11 attack have forever altered the world in every aspect of life
17 from mental, emotional, medical, business, security, education, etc.; and

18
19 Whereas, Every American and every individual has felt the impact from lost loved ones who
20 were taken away too early, or from the increased security and vigilance needed to protect this
21 country; and

22
23 Whereas, Every life lost on that day represents the freedoms for which we were attacked; and

24
25 Whereas, *Patriot Day, 9/11*, is already recognized as a day of remembrance; and

26
27 Whereas, The terror attack on US soil on September 11, 2001 should never be minimized or
28 forgotten; and

29
30 Whereas, The United States Congress holds the authority to create a Federal Holiday according
31 to Title V of the United States Code (5 U.S.C. 6103); therefore be it

32
33 RESOLVED, That our American Medical Association support and recognize September 11th as
34 an annual day of observance to remember and recognize all who died and who continue to
35 suffer health consequences from the events of 9/11, to honor first- and all responders from
36 around the country, and to recognize and forever remind us of the unity our country experienced
37 on 9/11/01 and the months that followed. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000
Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

This year marked the passing of twenty years since the attack on both towers of the World Trade Tower and the Pentagon, and the tragedy memorialized at Shanksville, Pennsylvania. The horror of that day remains for those who lived through it and should not be ignored by those who have not. Too many innocent people lost their lives to the worst terrorist attack on US soil and many more have died or become ill as a consequence of those events. That terrible day should be recognized annually as a day of remembrance to honor America's dead resulting from that day as well as those who lost their lives or health as a consequence of "working the pile" and those subsequent effects. The unprovoked and unprecedented 9/11 attack changed the history of the United States, its people and the world. The AMA should officially recognize, remember and memorialize that day.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612
(N-21)

Introduced by: New York

Subject: UN International Radionuclide Therapy Day Recognition

Referred to: Reference Committee F

1 Whereas, The General Assembly of the United Nations advocates for proclaiming International
2 days of recognition to highlight specific values of worldwide human interest; and
3

4 Whereas, The United Nations General Assembly documents describe the purpose of
5 proclaiming “International Days” as follows: “International days are occasions to educate the
6 general public on issues of concern, to mobilize political will and resources to address global
7 problems, and to celebrate and reinforce achievements of humanity”; and
8

9 Whereas, The year marks the 80th year from the first recorded use of radioiodine therapy to
10 treat human disease; and
11

12 Whereas, Saul Hertz, MD (1905 - 1950) discovered the medical uses of radionuclides, and his
13 breakthrough work with radioactive iodine (RAI) created a dynamic paradigm change integrating
14 the sciences of physics, biology, physiology and medicine; and
15

16 Whereas, Radioactive iodine (RAI) is the first and remains the Gold Standard of targeted cancer
17 therapies; and
18

19 Whereas, In early 1941, Dr. Hertz administered the first therapeutic treatment of (Cyclotron-
20 produced) radioactive iodine (RAI) at the Massachusetts General Hospital, which led to the first
21 series of twenty-nine patients with hyperthyroidism being treated successfully with RAI; and
22

23 Whereas, Dr. Hertz expanded the successful use of RAI of treating hyperthyroidism and Graves’
24 disease to the treatment of thyroid cancer in 1946; and
25

26 Whereas, This work generating and utilizing radioactive material for medical therapy leaves an
27 enduring legacy, impacting countless generations of patients, numerous institutions worldwide
28 and setting the cornerstone for the field of Nuclear Medicine, and has for all future generations,
29 augmented and forever altered the approach to medical therapies; and
30

31 Whereas, This novel work marks the advent of what we now recognize as modern medicine,
32 utilizing molecular medicine and the ever evolving promise of targeted molecular therapies for
33 the treatment of human disease; and
34

35 Whereas, To appropriately recognize and honor this groundbreaking scientific and medical
36 breakthrough on its 80th year anniversary, and to honor Dr. Saul Hertz and to remember and
37 celebrate this extraordinary accomplishment; therefore be it

- 1 RESOLVED, That our American Medical Association support the efforts of the American
- 2 College of Nuclear Medicine to create and introduce a United Nations General Assembly
- 3 (UNGA) Resolution for the creation of a new International Day of recognition with the suggested
- 4 name of "International Radionuclide Therapy Day." (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The discovery of radionuclides and their use in medical applications cannot be extolled loud enough. The number of lives that have been saved because of this discovery are too many to count. AMA should support the efforts to declare this an International Day of recognition. The uses of radionuclide therapy continue to be expanded and discovered and have benefitted innumerable patients. An entire medical specialty has been built around this discovery and its medical use, that should be honored.

Perhaps of more overall impact, this is a chance to highlight the overall importance of the science of the Practice of Medicine, nationally and internationally.

This Resolution fits the Top Priority criteria as it is:

1. Within our AMA mission plan of facilitating education to the public about the importance of evidence-based medicine
2. Requires new policy to implement
3. No current policy exists on this topic, and it is an advantageous issue on which to have policy
4. AMA action will have a positive impact
5. AMA is most appropriate body to bring this issue forward.

Also, delaying this Resolution until June would necessarily have the negative impact of delaying the development of a UNGA Resolution for an additional year, due to UN Resolution submission schedule.

Another important consideration for urgent timing is that Barbara Hertz, the daughter of Saul Hertz, is still alive and well and we should want to get this done while she can still enjoy and celebrate this commemoration of her father's work.

A few References for interest:

Hertz B. A tribute to Dr. Saul Hertz: The discovery of the medical uses of radioiodine. *World J Nucl Med.* 2019;18(1):8-12.
doi:10.4103/wjnm.WJNM_107_18

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6357704/>

<https://endocrinenews.endocrine.org/january-2016-thyroid-month-the-saga-of-radioiodine-therapy/>

<https://www.intechopen.com/books/thyroid-cancer-advances-in-diagnosis-and-therapy/dr-saul-hertz-1905-1950-discovers-the-medical-uses-of-radioactive-iodine-the-first-targeted-cancer-t>

[Radioactive Iodine in the Study of Thyroid Physiology. VII. The Use of Radioactive Iodine Therapy in Graves' Disease. \(Dec. 1946\)](#)

<http://saulhertzmd.com/home>

SERIES NO.	CASE-HOSP. NO.	BMR PRIOR TO I^{131}	DOSAGE OF I^{131} and DATE OF ADMINISTRATION	BMR PRIOR TO SUB-TOTAL THYROIDECTOMY	POSTOP. THYROID BMR	THYROID WEIGHT	HISTOLOGY	TOTAL THYROID IRRADIATION (r)	ESTIMATED THYROID WT. BEFORE I^{131}	% OF RaI (URINE) EXCRETED - 72 HRS.	FOLLOWING THE ADMINISTRATION OF I^{131}
								12 HR.	5 DAY		
1	ELIZABETH D.	+30	21mC 3-31-41 } 3.6 1.5mC 4-16-41 } mC	(-3)(-7)	(-29)	34	INVOLUTION	470 220	660 240	35	20 28
5		+35	57mC 7-11-41	PLANNED EXAMINATION	(-20)	31	HYPERPLASIA NO INVOL.	1000	1150	40	27
10		+55	07mC 2-2-42	(+3)	(-26)	26 30	HYPERPLASIA MOD. INVOL.	120	80	60	38
14		+50	15mC 7-15-42	(-15)	(-24)	55	HYPERPLASIA INVOLUTION	650	—	60	71
16		+25	10mC 8-11-42	(-8)	(-24)	28	INVOLUTION	1800	—	45	6
19		+65	18mC 8-26-42 } 28 8mC 3-8-43 } mC 5mC 3-9-43 }	(+8) (+5)	(+36) (-10)	35	SLYPERPLASIA INVOLUTION	2000 1500	—	60	9 15 7
2		+35	14mC 5-10-41 } 5.6 0.9mC 41 } mC 2.8mC 42 } 0.8mC 42 }	NOT OPERATED PERSISTENT THYROTOXICOSIS ANOTHER 20mC PROPOSED				160 110 120 100	140 100 120 100	40	54* 48 78 —
4		+30	3.6mC 7-14-41 } 5.8 2.2mC 7-31-41 } mC	EYES BETTER. NO GOITER. BMR (+2) OFF MED. - 4 YRS				270 170	300 180	60	55 56
3		+50	34mC 6-6-41 20mC 1-9-46	REMISSION FOR 1 YR - THEN (RECENTLY FOR TRUE RECURRENCE)				430 4300	410 —	45 30 (RECURRENT)	45 35

* OPHTHALMOPATHIC TYPE

SERIES NO.	CASE-HOSP. NO.	DOSE OF I^{131} and DATE OF ADMINISTRATION	BMR BEFORE I^{131}	BMR LEVEL OFF IODIDES	TIME OFF IODIDES	THYROID SIZE '46	ESTIMATED THYROID WT. (gm.)	% OF RaI EXCRETED 72 HOURS	ESTIMATED THYROID IRRADIATION (r)	THYROID 12 HOUR	8 DAYS *
6		2.3mC 7-24-41 } 4.0 1.7mC 7-30-41 } mC	+45	DEC. '42 (-9) MAY. '43 (-16) JAN. '46 (-7)	4 YRS. +	N	45	35 22	320 280	390 300	
7		ET 9.) 1.4mC 9-19-41 } 2.9 1.5mC 9-21-41 } mC	+65	1-8-46 (-6)	4 YRS.	N	45	9 20(?)	260 260(?)	280 220(?)	
8		ET 9.) 1.6mC 9-24-41	+30	7-17-45 (-3) 5-27-46 (+4)	7 MOS	FIRM 2 X N	40	15	300	250	
9		4.9mC 11-26-41	+30	5-8-45 (-10)	4 YRS.	N	60	17	650	420	
11		5.8mC 4-9-42	+37	7-9-42 (-12) 2-24-44 (+9) 2-3-46 (-13)	3.5 YRS.	N	60	17	750	380	
12		7.5mC 5-15-42	+55	45 (+11) 2-3-46 (-13)	3 YRS.	HARD 1.5 X N	60-75	26	950	500	
13		12mC 6-9-42	+30	3-45 (+6) 2-3-46 (-10)	3 YRS.	N	40	71	750		
15		6mC 8-11-42 } 10 4mC 8-11-42 } mC	+35	4-45 (-6) 2-3-46 (+2)	10 MOS.	N	40	10	2000		
17		13mC 8-15-42	+50	6-10-44 (-15) 1-6-46 (-9)	3 YRS. +	N	60	14	1300		
18		10.5mC 8-15-42	+35	8-22-44 (+19) 2-16-46 (+4)	3 YRS. +	N	40	15	2000		
20		10mC 11-14-42	+50	4-3-45 (-1) 2-16-46 (-5)	2 YRS. +	N	45	20	1600		
21		14mC 11-20-42	+45	1-8-46 (-13)	3 YRS. +	N	50	15(?)	2000		
22		13mC 3-9-43	+20	6-30-43 (-8)	2 YRS. +	? N (LMB)	55	33	2200		
23		8mC 3-15-43 } 18 10mC 3-16-43 } mC	+55	6-9-43 (-11) 2-16-46 (-3)	2 YRS. +	FIRM 1.5 X N	75	76 67	500		
24		10.5mC 3-26-43 } 15 4.5mC 3-27-43 } mC	+40	12-45 (-5)	2 YRS. +	N (Dr. J.C.) (ZILHARDT)	50	57? 31	1000		
25		16mC 4-2-43	+44	9-28-44 (-7) 4-27-45 (+9) 3-20-46 (+4)	2 YRS. +	N (Dr. J.C.) (Aug)	50	20.6 63.0	750		
26		12mC 4-6-43	+39	45 (-8) 1-16-46 (+2)	2 YRS. +	N	45	85	350		
27		13mC 4-12-43	+40	7-17-45 (-16) 2-15-46 (-10)	2 YRS. +	N	50	33	1600		
28		10.5mC 4-13-43 } 22 11.0mC 4-13-43 } mC	+55	12-45 (+6) 2-3-46 (+6)	2 YRS. +	N	75	---?	2000		
29		8mC 3-29-43 } 12 4mC 3-30-43 } mC	+30	2-46 (+4)	2 YRS. +	N	55	10 53(?)	1200 250		

* 8 DAY ISOTOPE FIGURES ASSUME NO LOSS OF IODINE FROM THYROID DURING DECAY; THEY ARE THEREFORE EXCESSIVE. THEY WERE NOT MEASURED FOR CASES 13-29

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 613
(N-21)

Introduced by: Mississippi, District of Columbia, New Jersey, Oklahoma, South Carolina,
Tennessee

Subject: Due Process at our AMA

Referred to: Reference Committee F

1 Whereas, Most Americans assume the US Constitution guarantees due process before the
2 government may deprive someone of "life, liberty, or property," particularly as stated in the Fifth
3 and Fourteenth Amendments to the United States Constitution, including notice, opportunity for
4 hearing, confrontation and cross-examination, discovery, basis of decision, and availability of
5 counsel in the United States" (quote from the Library of Congress at Congress.gov, Amt5.4.1
6 "The Right to Due Process: Overview); and
7

8 Whereas, Since 1980 the AMA has supported the right of physician due process and has
9 adopted general guidelines for due process to be adapted in each instance to suit the
10 circumstances and conditions of health care organizations (Guidelines for Due Process
11 H-265.998); and
12

13 Whereas, Most American physicians believe that AMA members deserve the right to due
14 process before any adverse action may be taken against them by the Council on Ethical and
15 Judicial Affairs (CEJA), the Conduct Liaison or Committee on Conduct at AMA Meetings and
16 Events (CCAM) pursuant to the Policy on Conduct at AMA Meetings and Events H-140.837, or
17 the AMA Speakers office, or the Speakers Elections Committee, or the AMA House of
18 Delegates staff office; therefore be it
19

20 RESOLVED, That any American Medical Association member accused of any offense internal
21 to AMA, such as a complaint on/to the AMA Code of Conduct Hotline at 800-398-1496 ([AMA
22 Code of Conduct for meeting attendees and employees | American Medical Association \(ama-
23 assn.org\)](https://www.ama-assn.org)) be entitled to due process based on principles of fundamental fairness before any
24 adverse action may be taken against such AMA member as a result of any such complaint,
25 including but not limited to notice of complaint and opportunity to be heard coincident with any
26 AMA based investigation (New HOD Policy); and be it further
27

28 RESOLVED, That our AMA prohibit inappropriate usage of AMA public or private media
29 platforms and take reasonable steps to enforce the existing Digital Code of Conduct ([Code of
30 Conduct | American Medical Association \(ama-assn.org\)](https://www.ama-assn.org)) including but not limited to prompt and
31 thorough investigation of alleged violations of the Digital Code of Conduct as if the complaint
32 were formally filed on the Code of Ethics Hotline. (New HOD Policy)
33

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Due process is important to ALL physicians and particularly at our AMA. We need to act NOW to avoid further damage from our rampant recent ill-behaviors on AMA sponsored social media platforms and the Complaint Hotline. We all agree that fairness and diversity are now viewed as among our CORE AMA VALUES. We need NEW policy to rein in abuses seen over the last 12 months or so. The HOD action will obviously have positive impact and only the AMA can act on this important and timely internal action.

Reference: from the above AMA web page
Digital Code of Conduct

By accessing and using this website you agree to the following Code of Conduct. If you do not agree to the Code of Conduct, [Terms of Use](#), and [Privacy Policy](#), you must immediately terminate use of this site.

To help the American Medical Association (AMA) maintain dialogue that is relevant and respectful of the rights of others, you understand that when you submit comments, posts or images on AMA's digital platforms, you will not:

- Spread false and/or defamatory information.
- Include content that is discriminatory, abusive, vulgar, hateful, harassing, obscene, profane, sexually oriented, threatening, invasive of a person's privacy or right to publicity, or otherwise violative of any law.
- Infringe on copyrights, trademarks or trade secrets.
- Post content that includes private and/or personal information, such as home phone numbers and email addresses.
- Seek medical advice (consult your personal physician) or disclose personal health information.
- Promote commercial services and products or causes.
- Post in manner that would constitute spamming (e.g., posting with such frequency or repetitiveness that others may be discouraged from posting, posts that are irrelevant to the topic and/or the AMA's mission, and "follow me" posts) or trolling (defined as comments that appear intended to send the discussion in a fruitless direction).

RELEVANT AMA POLICY

Guidelines for Due Process H-265.998

While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires:

- (1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her.
- (2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity of no less than 30 days to prepare for the hearing.
- (3) It is the duty and responsibility of the hearing officer to conduct a fair, objective, expeditious and independent hearing pursuant to established rules.
- (4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing.
- (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her.
- (6) The physician is entitled to the opportunity to present a defense to the charges against him or her.
- (7) To the extent feasible, the hearing panel should evaluate the issues and evidence presented related to the proposed corrective action while blinded to the patient outcome.
- (8) The hearing panel should render a decision based on the evidence produced at the hearing.
- (9) The hearing panel should include in its decision the conclusions reached and actions recommended and, as an important focus if feasible, remedial steps for the physician and for the health care facility itself. When feasible, the hearing panel should include terms that permit measurement and validation of the completed remediation process.
- (10) The hearing panel should endeavor to state its findings, the clinical basis and support for its findings, its recommendations, and actions as clearly as possible.

(11) Within 10 days of the receipt of the hearing panel's decision, the physician, medical executive committee or health care organization, if it brought the correction action, has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts and/or evidence in support of the appeal. The grounds for an appeal of the decision shall be: (a) substantial non-compliance with the procedures required in the medical staff bylaws; or (b) the decision is against the manifest weight of the evidence. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician, medical executive committee and the health care organization. The MEC shall appoint an appeal board consisting of members of the medical staff who did not sit on the original hearing panel, or, at the request of the MEC, the governing body or at least three members thereof may sit as the appeal board. The appeal board shall consider the record of the hearing before the hearing panel. If the appeal board determines that significant relevant evidence, which could bear on the outcome of the proceeding, was not entertained by the hearing panel, it may refer the matter back to the hearing panel for further deliberation or, at the appeal board's discretion, it may receive and consider the new evidence. Similarly, if the appeals board determines that there was not substantial compliance with the hearing procedures in the medical staff bylaws, the appeal board may refer the matter back to the hearing body or, at the appeal board's discretion, it may convene additional hearings to correct any defect in the process. Upon completion of the appeal board's deliberations, the appeal board shall present its recommendation(s) to the governing body as to whether the recommendations(s) of the hearing body should be affirmed, modified, or reversed.

(12) In any hearing, the interest of patients and the public must be protected.

Citation: BOT Rep. II, A-80; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05; Reaffirmed: Res. 12, A-06; Reaffirmed: BOT Rep. 06, A-16; Reaffirmed: Res. 235, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 614
(N-21)

Introduced by: New Jersey, District of Columbia, Oklahoma, Pennsylvania, South Carolina, Tennessee, California, American Society of Anesthesiologists, New York, Florida, American College of Allergy, Asthma and Immunology

Subject: Insurance Industry Behaviors

Referred to: Reference Committee F

Whereas, In 2000, the AMA with several state medical societies, led by Florida, California, Missouri and New York, and specialty societies, led by OB-GYN, and several individual physicians, successfully sued the commercial health insurance carriers in a RICO lawsuit. The settlement was substantial, paying costs of all parties and leading to at least two foundations, including the Physicians Foundation for Health System Excellence; and

Whereas, In 2009 the AMA again, with other partners, successfully sued the Aetna and Cigna groups of companies for \$11 Million each with success for similar offences listed in the United Healthcare suit; and

Whereas, Many insurers are once again treating physicians and other claimants unfairly; and

Whereas, The recent published September 28, 2021 AMA Report "*Competition in Health Insurance: A comprehensive study of U.S. markets – an 2021 Update*" demonstrates increasing market share across the United States of certain insurance companies in certain regions of the United States and points out " Research finds evidence that insurer consolidation leads to the exercise of monopsony power vis-à-vis physicians in the form of lower physician earnings and employment." (page 3-4); and

Whereas, The health insurance industry in particular is using its market share to unfairly gain leverage against physicians and medical practices resulting in:

- 1) Unilateral reductions in reimbursements
- 2) Retroactive audits without cause
- 3) Manufactured claims denials
- 4) Egregious and unnecessary payment delays
- 5) Forced arbitration on abusive terms, requiring physicians to pay for the process
- 6) Scurrilous interpretation the AMA CPT Code and Vignettes to the disadvantage of the physician
- 7) Cancellation of contracts and/or arbitrary termination of certain providers and reduction of networks; therefore be it

RESOLVED, That our American Medical Association step up its ongoing review of the proper use of the AMA CPT Code and Vignettes in medical billing claims payments and its misuse by the US Health Insurance Industry (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA undertake as soon as practical a formal, legal review of ongoing
 2 grievous behaviors of the health insurance industry including: (1) a search for potential litigation
 3 partners across the medical federation; and (2) dissemination of the findings to the appropriate
 4 internal AMA divisions and Councils for review and preparation for potential civil, regulatory
 5 and/or legislative action by/in the US Court System, the US Federal or State regulatory
 6 agencies and/or the US Congress. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$300,000 annually.

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Growing Insurance Industry coding and payment Misbehavior effects most physicians. We need to act at this meeting to start what might be a several year process. Protection of physician practice viability and economics is our AMA CORE ACTIVITY. We need to authorize new policy to get going on this key issue, particularly in this time of "COVID." AMA is the expected and only organization to take on such a project.

RELEVANT AMA POLICY

Third Party Payer Coverage Process Reform and Advocacy D-185.986

1. Our AMA, working with interested state medical and national specialty societies, will develop model legislation and/or regulations to require that commercial insurance companies, state Medicaid agencies, or other third party payers utilize transparent and accountable processes for developing and implementing coverage decisions and policies, and will actively seek the implementation of such model legislation and/or regulations at the national and state levels.
2. Our AMA will work with specialty and service organizations to advocate that private insurance plans and benefit management companies develop transparent clinical protocols as well as formal processes to write / revise them; that those processes should seek input from the relevant national physician organizations; and that such clinical coverage protocols should be easily and publicly accessible on their websites, just as Medicare national and local coverage determinations are publicly available.
3. Our AMA will advocate that when private insurance plans and benefit management companies make changes to or revise clinical coverage protocols, said companies must inform all insured individuals and participating providers in writing no less than 90 days prior to said change(s) going into effect.

Citation: (Res. 820, I-11; Appended: Res. 807, I-12)

Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959

1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.
2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.
3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.
4. Our AMA will continue to encourage regulators to enforce existing prompt pay requirements.

Citation: Sub. Res. 713, A-02; Modified: Res. 714, A-03; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: Res 132, A-14; Reaffirmed: Sub. Res. 715, A-15; Appended: Res. 805, I-18

Insurance Companies Use of Contractors to Recover Payments D-385.965

1. Our AMA will seek legislation to limit insurance companies, their agents, or any contractors from requesting payment back on paid claims to no more than 90 days after payment is made.
(a) Such legislation would require insurance companies, their agents, or any contractors to have a defined and acceptable process for physicians to dispute these maneuvers to get payment back on claims already processed, verified, and paid.
(b) Such legislation would ban insurance companies, their agents or contractors from using re-pricers and re-reviewers and to adhere to their own pricing and reviewing guidelines as agreed upon in their contracts with physicians.
2. Our AMA will pursue legislation to regulate self-insured plans in this regard and apply the same rules to Medicare and other federal plans.

Citation: Res. 215, A-09; Reaffirmed: BOT Rep. 09, A-19

Insurance Company Denial of Payment for Office Visit and Invasive Procedure Done on the Same Day H-385.944

Our AMA supports insurance company payment for evaluation and management services and procedures performed on the same day, where consistent with CPT guidelines.

Citation: Sub. Res. 829, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17

A Level Playing Field in Negotiations Between Health Insurance Companies and Physicians D-383.982

Our AMA will make passage of legislation in the US Congress to exempt physicians from antitrust actions in their negotiations with insurance companies a top legislative priority of the AMA, remain vigilant on this issue, continue to regularly provide updates on our AMA Web site and through other AMA communication tools, request sponsors nationally, and allocate appropriate funding and resources necessary to successfully advocate its passage into law.

Citation: Res. 202, I-11; Reaffirmed: Res. 206, A-19

Insurance Company Economic Profiling of Physicians D-406.996

Our AMA will: (1) take all appropriate steps to actively oppose all efforts by third party payers to rank, profile or otherwise "score" physicians purely for corporate cost containment purposes; and (2) widely publicize insurance industry economic profiling practices and how they impact patient care and access.

Citation: Res. 820, I-07; Reaffirmed: CMS Rep. 01, A-17

Inappropriate Bundling of Medical Services by Third Party Payers D-70.986

Our AMA will study the problems associated with inappropriate bundling of medical services, including the bundling of preoperative assessment in making the decision for surgery with the procedure, and present a report with potential solutions, including an analysis of legislative, judicial, and regulatory remedies.

Citation: (Res. 813, I-00; Rescinded: CMS Rep. 6, A-10)

Appropriate Use of Component Codes in Current Procedural Terminology (CPT) D-70.987

- (1) Our AMA will pursue methods of wide distribution for existing coding products and services developed by national specialty societies in cooperation with the AMA and the CPT Editorial Panel.
- (2) Our AMA will advocate that the Department of Health and Human Services (DHHS) designate CPT guidelines and instructions as contained in the CPT Book and approved by the

CPT Editorial Panel as the national implementation standards for CPT codes. (3) The CPT Editorial Panel consider developing CPT coding combinations that comply with CPT coding rules and guidelines and that could serve as a basis for payer software programs.

Citation: BOT Rep. 8, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Transition to ICD-10 Code Sets D-70.954

Our American Medical Association will develop systems to help physicians transition to the ICD-10 coding system.

Citation: Res. 810, I-09; Rescinded: CEJA Rep. 03, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 615
(N-21)

Introduced by: Oklahoma, Alabama, District of Columbia, Georgia, Mississippi, New Jersey,
North Carolina, South Carolina, Tennessee

Subject: Employed Physicians

Referred to: Reference Committee F

1 Whereas, The percentage of practicing US physicians who are employed is now heading
2 towards 75% and may go higher with early retirement of older “private practice” physicians; and
3

4 Whereas, The Southeastern Delegation to AMA (SED) supports both pluralistic health insurer or
5 payor mix and pluralistic physician practice styles and settings; and
6

7 Whereas, Many physicians are losing influence in the health care system under some
8 employment models; and
9

10 Whereas, Physicians’ employment by a hospital completely changes any past relationships to
11 the hospital administration, whether the hospital has an active Organized Medical Staff or not;
12 and
13

14 Whereas, Many physicians are naïve about contract negotiations and terms and can’t afford
15 legal or accounting review; and
16

17 Whereas, Many employed physicians are naïve about contract renewals and supporting
18 employer accounting systems and can’t afford their own forensic accountants; and
19

20 Whereas, The AMA is currently limited in the scope of its potential work with employed
21 physicians and hospital or corporate medical staffs; and
22

23 Whereas, The SED believes that continued membership growth of AMA will depend on the AMA
24 adapting to the needs of employed physicians; and
25

26 Whereas, The process of providing additional support for employed physicians may take several
27 years; may involve input from the AMA Councils; may require input from internal AMA or
28 contract legal counsel; may require input and study by the AMA Board and AMA CEO; and
29

30 Whereas, The SED believes our AMA should start “the process” for change now; therefore be it
31

32 RESOLVED, That our American Medical Association dedicate full-time staff to the Employed
33 Physician to aggressively address relevant AMA Policy pertaining to the Employed Physician
34 (Directive to Take Action); and be it further

1 RESOLVED, That our AMA study amending Policy G-615.105 to read as follows:

2
3 Employed Physicians and the AMA G-615.105

4 1. Our AMA will become the lead association for physicians who maintain
5 employment or contractual relationships with hospitals, health systems, and other
6 entities.

7 2. As a benefit of membership our AMA will provide assistance, such as information,
8 advice, and legal opinions, as appropriate, to employed physicians, physicians in
9 independent practice, and independent physician contractors in matters pertaining to
10 their relationships with hospitals, health systems, and other entities, including, but not
11 limited to, breach of contracts, contract negotiations and contract renewals, medical
12 staff bylaws, sham peer review, economic credentialing, and the denial of due
13 process.

14 3. Our AMA will also work through the Organized Medical Staff Section and other
15 sections and special groups as appropriate to represent and address the unique
16 needs of physicians who maintain employment or contractual relationships with
17 hospitals, health systems, and other entities. (Directive to Take Action); and be it
18 further

19
20 RESOLVED, That the representation of the Organized Medical Staff Section (OMSS) in the
21 AMA House of Delegates be increased from the current one Delegate to many Delegates based
22 on AMA membership numbers of employed physicians using the mathematical model(s), to
23 calculate the numbers of the New OMSS Delegates, currently being used at AMA for the
24 Medical Student and Resident and Fellows Sections to calculate the numbers of Regional
25 Medical Students and the numbers of Regional Resident/Fellows in the AMA House of
26 Delegates. The AMA would develop a practical meaning of the phrase "Employed Physician"
27 for the purposes of AMA membership counting, but as an editorial comment, the SED suggests
28 starting with employed Non-Resident/Non-Fellow physicians who have no ownership interest
29 (or, say, less than 1% ownership each) in their employer organization (New HOD Policy); and
30 be it further

31
32 RESOLVED, That the Organized Medical Staff Section have one designated member who is a
33 defined employed physician on all AMA Boards and Committees and Councils to match the
34 MSS, the RFS and the YPS. (New HOD Policy)

Fiscal Note: Estimated cost to implement this resolution is \$720,000 annually.

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Over 70% of physicians are now employed. This time of COVID has placed employed physicians at INCREASED vulnerability and disadvantage for practice and personal sustainability as employers and insurance companies have taken advantage of the difficult COVID health care system situation. THIS is our top Core Value, Physician and Physician practice sustainability. This will start a process that could take several years, BUT THIS IS THE TIME TO START with important NEW POLICY and a new AMA Office of the Employed Physicians. Obviously, AMA can make a positive impact and of course is really the only organization to undertake this important task.

HISTORY

H – 225.947 Physician Employment Trends
H – 225.950 Principles of Physician Employment
G – 615.105 Employed Physicians
D – 225.973 Employed Physicians Bill of Rights

References

The early Clinic histories from relevant Wikipedia articles.

Representation of Physicians in Emerging Delivery Systems; AMA Council on Long Range Planning and Development Report, 1994.

Rosemary Strevens. Health Care in the Early 1960's. Health Care Financing Review. Winter issue, 1996. Vol 1, #2.

Travis Singleton and Phillip Miller. The Physician Employment Trend: What you need to know. Fam Pract Manage 2015: August (4) 11-15.

The Physician Employment Movement. Career Letter, NEJM, July 23, 2014

Laura Dyrda. 70% Physicians now Employed by Hospitals or Corporations. July 1, 2021. VMG Health at info@vmghealth.com

The AMA OMSS web page: [Organized Medical Staff | American Medical Association \(ama-assn.org\)](https://www.ama-assn.org/organized-medical-staff)

EMPLOYMENT CONTRACTS

AMA Policy

H - 225.964 Hospital Employed/Contracted Physicians Reimbursement

H – 285.946 Fair Physician Contracts

References

Scott Backer, Gretchen Townsend, Holly Carnell, Melesa Freerks and McGuire Woods. Physician Compensation. In the Beckers Hospital Review, August 19, 2013

Kim Stanger. Physician Contract Check List. Proprietary to the Holland and Hurt Law Firm, from Shaw Publications

EMPLOYED PHYSICIAN SAFEGUARDS

AMA Policy

D – 215.990 AMA Assistance to Physician-Hospital/Healthcare System Relationships

H – 383.999 Physician Negotiations

H – 385.976 Physician Collective Bargaining

D – 225.977 Physician Independence

H – 235.999 All Physicians Employed by Hospitals Required to be on Staff

References

Brendan Murphy, AMA staff writer - So, you are an employed physician: what you need to know. June 2017.

<https://es4p.com> - Essentials for Physicians – Business Podcasts and Seminars

Travis Singleton and Phillip Miller. Physician Employment. August 2015 from the FPM Journal by the AAFP

Winn Halverhout, Husch Blackwell, Barbara Yosses. Compliance in Physician Employment. Proprietary to the Husch Blackwell Law Firm, published by the Health Care Compliance Association, 2010.

from the American College of Surgeons

https://www.facs.org/-/media/files/advocacy/regulatory/2018_employed_surgeons_primer.ashx

RELEVANT AMA POLICY

Employed Physicians and the AMA G-615.105

1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.

Citation: Res. 601, I-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

Physician Employment Trends and Principles H-225.947

1. Our AMA encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize

under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.

2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession.

Citation: CMS Rep. 5, I-15; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19

AMA Principles for Physician Employment H-225.950

1. Addressing Conflicts of Interest

a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.

c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and

(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.

e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

Refer to the AMA Code of Medical Ethics for further guidance on conflicts of interest.

2. Advocacy for Patients and the Profession

a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.

b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

- a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
- b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.
- c) When a physician's compensation is related to the revenue he or she generates, or to similar factors, the employer should make clear to the physician the factors upon which compensation is based.
- d) Termination of an employment or contractual relationship between a physician and an entity employing that physician does not necessarily end the patient-physician relationship between the employed physician and persons under his/her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee. Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.
- (e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. When such cause relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff, the physician should be afforded full due process under the medical staff bylaws, and the agreement should not be terminated before the governing body has acted on the recommendation of the medical staff. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges. When such cause is non-clinical or not otherwise a concern of the medical staff, the physician should be afforded whatever due process is outlined in the employer's human resources policies and procedures.
- (f) Physicians are encouraged to carefully consider the potential benefits and harms of entering into employment agreements containing without cause termination provisions. Employers should never terminate agreements without cause when the underlying reason for the termination relates to quality, patient safety, or any other matter that could trigger the initiation of disciplinary action by the medical staff.
- (g) Physicians are discouraged from entering into agreements that restrict the physician's right to practice medicine for a specified period of time or in a specified area upon termination of employment.
- (h) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

Refer to the AMA Annotated Model Physician-Hospital Employment Agreement and the AMA Annotated Model Physician-Group Practice Employment Agreement for further guidance on physician employment contracts.

4. Hospital Medical Staff Relations

- a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.
- b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.
- c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.
- d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

Refer to the AMA Conflict of Interest Guidelines for the Organized Medical Staff for further guidance on the relationship between employed physicians and the medical staff organization.

5. Peer Review and Performance Evaluations

- a) All physicians should promote and be subject to an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.
- b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.
- c) Peer review of employed physicians should be conducted independently of and without interference from any human resources activities of the employer. Physicians--not lay administrators--should be ultimately responsible for all peer review of medical services provided by employed physicians.
- d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.
- e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.
- (f) Upon termination of employment with or without cause, an employed physician generally should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws. Automatic rescission of medical staff membership and/or clinical privileges following termination of an employment agreement is tolerable only if each of the following conditions is met:
 - i. The agreement is for the provision of services on an exclusive basis; and
 - ii. Prior to the termination of the exclusive contract, the medical staff holds a hearing, as defined by the medical staff and hospital, to permit interested parties to express their views on the matter, with the medical staff subsequently making a recommendation to the governing body as to whether the contract should be terminated, as outlined in AMA Policy H-225.985; and
 - iii. The agreement explicitly states that medical staff membership and/or clinical privileges must be resigned upon termination of the agreement.

Refer to the AMA Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations (AMA Policy H-375.965) for further guidance on peer review.

6. Payment Agreements

a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

Our AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

Citation: BOT Rep. 6, I-12; Reaffirmed: CMS Rep. 6, I-13; Modified in lieu of Res. 2, I-13; Modified: Res. 737, A-14; Reaffirmed: BOT Rep. 21, A-16; Reaffirmed: CMS Rep. 05, A-17; Reaffirmed: CMS Rep. 07, A-19; Reaffirmed: CMS Rep. 11, A-19; Modified: BOT Rep. 13, A-19

Hospital Employed/Contracted Physicians Reimbursement H-225.964

AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians.

Citation: (Sub. Res. 723, I-96; Reaffirmed: Res. 812, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: BOT Rep. 4, I-12)

All Physicians Employed by Hospitals Required to be on Staff H-235.999

The AMA believes that physicians having contractual or financial arrangements with hospitals should be members of the organized medical staff and responsible to it, should be subject to the bylaws of the medical staff, and should conduct their professional activities according to the standards, rules and regulations adopted by it.

Citation: BOT Rep. R, Rec. 3, A-77; Reaffirmed: I-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18

Fair Physician Contracts H-285.946

Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to:

- (1) disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies;
- (2) which proprietary "correct coding" CPT bundling program is employed;
- (3) grievance and appeal mechanisms;
- (4) conditions under which a contract can be terminated by a physician or health plan;
- (5) patient confidentiality protections;

- (6) policies on patient referrals and physician use of consultants;
 - (7) a current listing by name and specialty of the physicians participating in the plan; and
 - (8) a current listing by name of the ancillary service providers participating in the plan.
- Citation: Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08; Reaffirmed: CMS Rep. 01, A-18

Physician Negotiation H-383.999

1. All activities of our American Medical Association regarding negotiation by physicians maintain the highest level of professionalism, consistent with the Principles of Medical Ethics and the Current Opinions of Council on Ethical and Judicial Affairs.
2. Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians authorized to organize labor organizations under the National Labor Relations Act.
3. Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers.

Citation: Sub. Res. 901, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation A-08; Modified: BOT Rep. 09, A-18

Physician Collective Bargaining H-385.976

- Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.
- (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.
 - (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.
 - (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.
 - (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Citation: BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19

AMA Assistance for Members in Matters Pertaining to Physician-Hospital/Health System Relationships D-215.990

1. As a benefit of membership our AMA will provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

2. Our AMA encourages the Federation of Medicine and its members to provide assistance, such as information and advice (but not legal opinions or representation), as appropriate to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

Citation: Res. 826, I-11; Reaffirmed: BOT Action in response to referred for decision Res. 816, I-16

Employed Physician Bill of Rights and Basic Practice Professional Standards D-225.973

Our AMA will advocate that employed physicians should be provided sufficient administrative and clinical support to ensure that they can appropriately care for their patients.

Citation: BOT Rep. 13, A-19

Physician Independence and Self-Governance D-225.977

Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.

Citation: (Res. 801, I-11; Modified: BOT Rep. 6, I-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 616
(N-21)

Introduced by: Michigan

Subject: Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology® System

Referred to: Reference Committee F

1 Whereas, The COVID-19 pandemic and restrictions brought unprecedented financial strain
2 upon physicians, with the most recent Physician Foundation survey showing 12 percent of
3 physicians either closing or planning to close their practice within the next year (75 percent of
4 those physicians are in private practice), and nearly 75 percent of physicians reported lost
5 income; and

6
7 Whereas, During this time, physicians also had to implement the new Current Procedural
8 Terminology® (CPT®) Evaluation and Management (E/M) code revisions, which became
9 effective January 1, 2021; and

10
11 Whereas, This was the first major change to the codes and guidelines for office and other
12 outpatient evaluation and management (E/M) services in 24 years; and

13
14 Whereas, Although the Centers for Medicare and Medicaid Services (CMS) signaled its intent to
15 update E/M coding and documentation guidelines when it requested stakeholder feedback in
16 the proposed 2017 Medicare Physician Fee Schedule rules and continued to propose updates
17 in future rules, some stakeholders were hopeful for a delay as physicians were still reeling from
18 the pandemic; and

19
20 Whereas, Given that each patient encounter and experience is unique, medical coding system
21 to accurately reflect the care given within hundreds of specialties and thousands of patient visits
22 may be difficult or have a disparate impact on physicians in different specialties; and

23
24 Whereas, The AMA reported that when the revisions became effective, the AMA received
25 feedback on areas causing confusion, in response to which the CPT Editorial Panel issued
26 technical corrections to add clarity and answer questions concerning the E/M code revisions;
27 and

28
29 Whereas, The intent of these E/M coding changes - to modernize billing and documentation,
30 reduce administrative burdens on physicians, and recognize time spent evaluating and managing
31 patients' care - is commendable; however, actual experiences and consequences should be
32 studied and modified as necessary to further simplify E/M documentation and ease
33 administrative burdens and to fairly and accurately reflect the evaluation and management
34 services provided by private and employed physicians, reflective of the complexity of care within
35 all specialties, and respectful of uncompensated care by our specialist colleagues; therefore be it

- 1 RESOLVED, That our American Medical Association survey physicians about and study the
- 2 impact of the 2021 CPT® Evaluation and Management coding reform on physicians, among all
- 3 specialties, in private and employed practices and report the findings and any recommendations
- 4 at the June 2022 meeting of the House of Delegates. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

The 2021 American Medical Association (AMA) Current Procedural Terminology® (CPT®) Evaluation and Management code set went live on January 1, 2021. It is currently affecting physician reimbursement. Failure to address any potential harm in a timely manner will result in more practice closures and worsen patient access to physicians. This resolution asks the AMA to study an issue that is very pertinent to practicing physicians right now.

Source:

1. <http://physiciansfoundation.org/wp-content/uploads/2020/08/20-1278-Merritt-Hawkins-2020-Physicians-Foundation-Survey.6.pdf>

RELEVANT AMA POLICY

AMA CPT Editorial Panel and Process H-70.973

The AMA will continue (1) to work to improve the CPT process by encouraging specialty societies to participate fully in the CPT process; (2) to enhance communications with specialty societies concerning the CPT process and subsequent appeals process; and (3) to assist specialty societies, as requested, in the education of their members concerning CPT coding issues.

Citation: Sub. Res. 806, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmation: I-17

Preservation of Evaluation/Management CPT Codes H-70.985

It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services;

(2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes;

(3) seek feedback from its members on insurance practices that advocate bundling of procedures and laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members;

(4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and

(5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.

Citation: Sub. Res. 98, A-90; Reaffirmed by Res. 850, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20

Use of CPT Editorial Panel Process H-70.919

Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetical statements and modifiers.

Citation: BOT Rep. 4, A-06; Reaffirmation A-07; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation A-10; Reaffirmation A-11; Reaffirmation I-14; Reaffirmed: CMS Rep. 4, I-15; Reaffirmation A-16; Reaffirmed in lieu of: Res. 117, A-16; Reaffirmed in lieu of: Res. 121, A-17; Reaffirmation: A-18; Reaffirmation: I-18; Reaffirmed: Res. 816, I-19

CPT Coding System H-70.974

1. The AMA supports the use of CPT by all third party payers and urges them to implement yearly changes to CPT on a timely basis.
2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient's insurance.

Citation: Sub. Res. 809, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Appended: Res. 803, I-11; Reaffirmed: CMS Rep. 1, A-21

Physicians' Current Procedural Terminology H-70.972

The AMA (1) continues to seek ways to increase its efforts to communicate with specialty societies and state medical associations concerning the actions and deliberations of the CPT Maintenance process; (2) urges the national medical specialty societies to ensure that their representatives to the CPT process are fully informed as to their association's policies and coding preferences; and (3) urges those specialty societies that have not nominated individuals to serve on the CPT Advisory Committee to do so.

Citation: BOT Rep. MM, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 617
(N-21)

Introduced by: Louisiana

Subject: Together We are Stronger Marketing Campaign

Referred to: Reference Committee F

Whereas, The AMA unveiled a new brand marketing campaign in 2005 that included the tagline “Together We are Stronger”; and

Whereas, The “Together We are Stronger” campaign was abandoned at sometime during 2018 for a new campaign “Members Move Medicine”; and

Whereas, Since the “Together We are Stronger” campaign was replaced, our AMA has become fractured and often exclusive of some members; and

Whereas, Our AMA’s recent Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity highlights has further weakened our AMA’s reputation among many members; therefore be it

RESOLVED, That our American Medical Association consider readoption of the “Together We are Stronger” tagline as the main marketing slogan and campaign for the organization.
(Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

On June 1, 2021, Russ Kridel, MD, Chair, AMA Board of Trustees, issued a message to the members of the American Medical Association House of Delegates regarding certain recent events pertaining to the *AMA’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023*. As noted by Dr. Kridel, “Our House has always dealt with challenging topics with the same professionalism that we try to exhibit daily as practicing physicians”. However, many at recent meetings of the AMA House, particularly those held virtually, we have witnessed a loss of professionalism during comments regarding the Strategic Plan. Some members of our House are being personally attacked and threatened by others for their thoughts and ideas. Name calling, unsettling calls to family members, and other unprofessional communications have occurred. As the strategic plan will once again be discussed at the November 2021 meeting, the debate and hopefully the adoption of these policies and principles are paramount in order to have a professional and courteous conversation regarding the production and contents of the equity report. We believe the Speakers saw this firsthand during the June meeting.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(N-21)

Introduced by: New York

Subject: Fifteen Month Lab Standing Orders

Referred to: Reference Committee G

Whereas, Federal Medicaid rules limits a laboratory standing order's validity to six months which necessitates practitioners to reorder laboratory studies every six months for regular and routine laboratory studies that often are required for a patient's lifetime (such as standard of care monitoring of HemoglobinA1Cs every three to six months for diabetics); and

Whereas, There is no documented benefit to limiting laboratory orders to six months and expiration of standing lab orders has led to patient and physician dissatisfaction; and

Whereas, "Busywork" that is not perceived as meaningful contributes to burnout which is a harm negatively impacting the American medical work force and has deleterious implications on patient care quality, outcomes and patient satisfaction; and

Whereas, Reordering laboratory studies only for the sake of a regulation leads to unnecessary and not meaningful work, the kind of activity that contributes to burnout among practitioners and increases the cost of healthcare because of the time and labor required for each practice to reorder routine laboratory studies; therefore be it

RESOLVED, That our American Medical Association advocate the Centers for Medicare and Medicaid Services to allow standing laboratory orders to be active for fifteen (15) months.
(Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The current CMS regulation requiring lab orders to be renewed every six months with the concomitant review of results and reissue of prescriptions is unnecessary for patients who have been on maintenance medications for months and years. Many state regulations permit prescriptions to be valid for 12 months or more, therefore lab orders should be commensurate with that regulation. There is no benefit to the requirement of having patients be tested every 6 months especially in the case of patients who have been on longstanding maintenance medications and who have fared well. This would save patient, insurance and physician expense in addition to saving staff time and unnecessary paperwork and processing time. This change would also reduce administrative paperwork which contributes to physician burnout and stress.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(N-21)

Introduced by: New York

Subject: Insurance Coverage for Scalp Cooling (Cold Cap) Therapy

Referred to: Reference Committee G

1 Whereas, Scalp Cooling (Cold Cap Therapy) has been cleared by the FDA for use during
2 chemotherapy treatment to reduce the likelihood of chemotherapy-induced alopecia in cancer
3 patients with solid tumors such as ovarian, breast, colorectal, bowel, and prostate cancers; and
4

5 Whereas, The National Comprehensive Cancer Network® (NCCN) has given Scalp cooling a
6 Category 2A designation indicating uniform NCCN consensus that the intervention is
7 appropriate; and
8

9 Whereas, Peer-reviewed studies have shown Scalp Cooling (Cold Cap Therapy) prevented hair
10 loss in 53-66.3% of patients with breast cancer receiving adjuvant chemotherapy, compared to
11 a control group where all patients experienced significant hair loss; and
12

13 Whereas, Scalp cooling treatment (Cold Cap Therapy) in peer reviewed studies was well-
14 tolerated with no scalp metastases observed; and
15

16 Whereas, Minimizing hair loss during cancer treatment helps patients to preserve personal
17 identity and self-esteem and appear normal as opposed to sick; and
18

19 Whereas, Protecting privacy and gaining the ability to choose whether to disclose a cancer
20 diagnosis is significant to many patients; and
21

22 Whereas, Scalp cooling can give patients a sense of control in what can be an overwhelming
23 experience; and
24

25 Whereas, The American Medical Association (AMA) has issued two (2) separate Category III
26 CPT codes for "mechanical scalp cooling": 0662T and 0663T, effective July 1, 2020; and
27

28 Whereas, Aetna, issued a policy statement in 2017 stating that they consider scalp cooling
29 medically necessary as a means to prevent hair loss during chemotherapy but insurance
30 coverage for scalp cooling is not yet standard in the United States; and
31

32 Whereas, Reimbursement varies depending on plan, coverage, and location with some
33 insurance companies covering up to \$2,000 for wigs but denying coverage for scalp cooling in
34 similar price range (\$1,500-\$3,000); and
35

36 Whereas, Many patients have encountered the circumstance where their health insurance
37 carrier will not provide coverage for scalp cooling therapy, forcing patients to pay out of pocket
38 for this essential therapy; and
39

40 Whereas, This significant out of pocket expense puts this treatment out of range for many; and

Whereas, Our AMA advocates for health equity; therefore be it

RESOLVED, That our American Medical Association advocate for and seek through legislation and/or regulation, universal insurance coverage for Scalp Cooling (Cold Cap) Therapy (Directive to Take Action); and be it further

RESOLVED, That our AMA work with consumer and advocacy groups to challenge insurers on medical necessity denials for Scalp Cooling (Cold Cap) Therapy and encourage appeals to independent third-party reviewers. (Directive to Take Action)

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

Whether through personal experience or interactions with patients, physicians understand the devastating diagnosis of cancer. Patients requiring chemotherapy will undoubtedly experience hair loss as a result, adding to their misery. Scalp Cooling Therapy is proven to alleviate hair loss during chemo and would therefore improve a patient's self-image and positive outlook with regard to their cancer treatment. A positive response to chemo is not just about the treatments themselves, equally important is the patient's outlook and expectation that their health is improving from those treatments. Patients will not see (nor feel) improvement if the image in a mirror is one of themselves with no hair. Our sense of self is based in large part on physical appearance. Advocating for insurance coverage of Scalp Cooling Therapy would improve patient response to chemotherapy both physically and mentally. Because routine cancer screenings were in large part ignored during the COVID crisis, the expectation is that once resumed, the diagnoses of cancer will increase. Whereas Medicare and some health insurers will provide coverage for this therapy, other companies do not. An increase in cancer diagnoses makes this issue urgent and one that should be addressed with the insurance industry by the AMA as soon as possible.

1. NCCN scalp cooling recommendations from the [NCCN Clinical Practice Guidelines in Oncology \(NCCN Guidelines®\)](#). NCCN provides the following recommendations: breast cancer (Version 1.2019), ovarian cancer (Version 1.2020)

References

- [1] Trusson D, Pilnick A. The role of hair loss in cancer identity: perceptions of chemotherapy-induced alopecia among women treated for early-stage breast cancer or ductal carcinoma in situ. *Cancer Nurs* 2017;40:E9e16.
- [2] Rugo HS, Melin SA, Voigt J. Scalp cooling with adjuvant/neoadjuvant chemotherapy for breast cancer and the risk of scalp metastases: systematic review and meta-analysis. *Breast Cancer Res Treat* 2017;163:199e205.
- [3] Ludwig E. Classification of the types of androgenetic alopecia (common baldness) occurring in the female sex. *Br J Dermatol* 1977;97:247e54.
- [4] Nangia J, Wang T, Osborne C, Niravath P, Otte K, et al. Effect of a scalp cooling device on alopecia in women undergoing chemotherapy for breast cancer: the SCALP randomized clinical trial. *JAMA* 2017;317:596e605.
- [5] vandenHurkCJ, BreedWP, NortierJW. Shortpost-infusionscalpcoolingtime in the prevention of docetaxel-induced alopecia. *Support Care Cancer* 2012;20:3255e60.
- [6] RugoHS, KleinP, MelinSA, HurvitzSA, MeliskoME, et al. Association between use of a scalp cooling device and alopecia after chemotherapy for breast cancer. *JAMA* 2017;317:606e14.
- [7] Rugo HS, Voigt J. Scalp hypothermia for preventing alopecia during chemotherapy. A systematic review and meta-analysis of randomized controlled trials. *Clin Breast Cancer* 2018 Feb;18(1):19e28.
- [8] Shin H, Jo SJ, Kim DH, Kwon O, Myung SK. Efficacy of interventions for prevention of chemotherapy-induced alopecia: a systematic review and meta-analysis. *Int J Cancer* 2015;136:E442e54.
- [9] van den Hurk CJ, Peerbooms M, van de Poll-Franse LV, Nortier JW, Coebergh JW, et al. Scalp cooling for hair preservation and associated characteristics in 1411 chemotherapy patients - results of the Dutch Scalp Cooling Registry. *Acta Oncol* 2012;51:497e504.
- [10] KomenMM, SmorenburgCH, vandenHurkCJ, NortierJW. Factors influencing the effectiveness of scalp cooling in the prevention of chemotherapy-induced alopecia. *Oncologist* 2013;18:885e91.

Number: 0290

Policy Effective Date 10/13/1998

Last Review: 7/1/2021

Aetna considers scalp cooling (i.e., using ice-filled bags/bandages, cryogel packs, or specially designed products (e.g., Chemo Cold Cap, DigniCap, ElastoGel, Paxman Scalp Cooling System and Penguin Cold Cap)) medically necessary as a means to prevent hair loss during chemotherapy.

Note: Cooling caps and other products for scalp cooling are considered incidental to the chemotherapy administration and are not separately reimbursed. Cooling caps and other scalp cooling products purchased by the member are considered supplies that are generally excluded from coverage under plans that exclude supplies. See benefit plan descriptions.

RELEVANT AMA POLICY

Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate chemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

Citation: CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(N-21)

Introduced by: New York

Subject: Prior Authorization – CPT Codes for Fair Compensation

Referred to: Reference Committee G

1 Whereas, The American Medical Association (AMA) has previously affirmed that physicians and
2 physician practices should be fairly compensated for work involved in prior authorizations; and
3

4 Whereas, AMA CPT® Editorial Panel is authorized by the AMA Board of Trustees to revise,
5 update, or modify CPT codes, descriptors, rules and guidelines; and
6

7 Whereas, Studies have shown that wrongful adverse determinations by health plans are
8 common, including denial of prior authorization and denial of payment for previously provided
9 services; and
10

11 Whereas, Costs involved in prior authorizations provide perverse disincentives and lead to sub-
12 optimal healthcare outcomes, especially for marginalized and economically vulnerable
13 communities; and
14

15 Whereas, Good public and economic policy must align costs, benefits and incentives; currently,
16 all costs are incurred by physician practices, and all financial savings and benefits from prior
17 authorization accrue to health insurance plans leading to perverse incentives that disadvantage
18 patients and endanger their health; and
19

20 Whereas, Compensation for work performed by physician practices is accomplished via CPT
21 codes; therefore be it
22

23 RESOLVED, That our American Medical Association include in any model legislation and as a
24 basis for all advocacy, fair compensation based on CPT codes for appeal of wrongfully denied
25 services, including those for prior authorization reforms and that CPT codes must fully reflect
26 the aggregated time and effort expended by physician practices (Directive to Take Action); and
27 be it further
28

29 RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT®
30 Editorial Panel to account for administrative work involved in prior authorizations that reflects the
31 actual time expended by physician practices to advocate on behalf of patients and to comply
32 with insurer requirements (Directive to Take Action); and be it further
33

34 RESOLVED, That our AMA evaluate and propose a CPT code for consideration by the CPT®
35 Editorial Panel to account for administrative work that reflects the actual time expended by
36 physician practices and their billing vendors involved in successfully appealing wrongful pre-and
37 post-service denials. (Directive to Take Action)

Fiscal Note: Minimal - less than \$1,000
Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

The amount of time and effort physicians spend on administrative work rather than patient care continues to increase. Recognition of this burden and its contribution to physician burnout, career dissatisfaction, and patient dissatisfaction must be made. Repeated requests for documentation in order to pay denied claims, increased denial of claims, obtain pre-authorization for services continue to absorb more time in physician practices. These administrative tasks are not adequately compensated by the insurance industry. Physicians should not have to take time from patient care to deal with such matters. The AMA is the advocate for physicians in the United States and has a responsibility to address the issue of compensation for extensive administrative work. Appealing claim denials can drag on for months putting an additional burden on physician practices in terms of finances. Increased time spent on administrative work deserves compensation.

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests.

Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21 Appended: CMS Rep. 5, A-21

Remuneration for Physician Services H-385.951

1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.

Citation: Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res.

721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14; Reaffirmed: Res. 811, I-19

Prior Authorization Reform D-320.982

Our AMA will explore emerging technologies to automate the prior authorization process for medical services and evaluate their efficiency and scalability, while advocating for reduction in the overall volume of prior authorization requirements to ensure timely access to medically necessary care for patients and reduce practice administrative burdens.

Citation: Res. 704, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(N-21)

Introduced by: New York

Subject: Physician Burnout is an OSHA Issue

Referred to: Reference Committee G

Whereas, Repetitive Strain (Stress) Injury or RSI is defined as a category of injuries "to the musculoskeletal and nervous systems that may be caused by repetitive tasks, forceful exertions, vibrations, mechanical compression, or sustained or awkward positions; and

Whereas, RSI is a known work-related injury which falls under the purview of the Occupational Safety and Health Administration (OSHA); and

Whereas, Most RSI results from cumulative trauma rather than a single event; and

Whereas, Repeated exposure to work-related stressors can result in physician burnout; and

Whereas, Cerebral centers and activity are most certainly within the domain of the nervous system; and

Whereas, Physician burnout resulting from work-related stressors should be regarded as RSI and, as such, should fall under the aegis of OSHA; therefore be it

RESOLVED, That our American Medical Association seek legislation/regulation to add physician burnout as a Repetitive Strain (Stress) Injury and subject to Occupational Safety and Health Administration (OSHA) oversight. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

New York ranked this as vitally important – it has to do with physician health and well-being which has been sorely tested during the last year. Physicians are under enormous stress each and every day, and the COVID pandemic added immeasurably to that stress. The incidence of physician suicide increased during the last year – a clear indication of the added stress of COVID. Working without the necessary and proper equipment during the pandemic and watching colleagues die of COVID while doing their job has all added to the burden of being a physician. Physicians have few protections for their wellbeing and good health. Many feel that physicians should be “super-heroes” unaffected by the stress of providing health care in today’s very different environment. Adding physician burnout as an RSI subject to OSHA oversight would go a long way toward ensuring physicians work situation is monitored to ensure that they do not burnout.