

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

NOVEMBER 2021 SPECIAL MEETING ONLINE

November 12-16, 2021

CALL TO ORDER AND MISCELLANEOUS BUSINESS

CALL TO ORDER: The House of Delegates convened its 244th meeting at 7 p.m. Central Standard Time, Friday, November 12, using an online platform, Bruce A. Scott, MD, Speaker of the House of Delegates, presiding. The House convened again online on Monday, November 15 and Tuesday, November 16. The meeting adjourned on Tuesday afternoon. Reference committee hearings were conducted online on Saturday and Sunday. The House was not in session on those two days.

INVOCATION: The invocation was delivered by Father Expedito Muwonge, the Catholic chaplain at Gorton Hospitals in Louisville, Kentucky. Father Expedito is originally from Uganda and was ordained in Rwanda. He ministered to the many sick and dying from AIDS in Africa. In 1998, forced to flee for his life, he came to the United States and took up hospital ministry.

Greetings from Norton Pastoral Care Department. I want to thank you from the bottom of my heart for what you do to serve your patients, especially during these hard times of COVID-19. You have endured many silent fears and worries, but you kept on working regardless of the scares and dangers entailed. Sadly, some of you have lost relatives, friends, and colleagues to this pandemic. Please accept my sincere condolences. I can only imagine what you face day, each day at your work when at the back of your mind you know what can happen to you. You are true heroes. I salute you for such courage and determination. Thank you. Please allow me to do what I do best as a priest, to pray:

Great Spirit, Light of all Brightness, we come into your presence humbled by our fears, pain, sorrows, and the unknowns. We have gone through hard times in the past year and a half. Our burden of pain is deep and our anxiety is consuming. Most of us are at the edge of burnout. Compassionate fatigue has become our daily companion. Left to our own strength and imaginations, we despair. Thank you for your support.

We suffer from the loss of our loved ones and colleagues to a pandemic COVID-19 that is relentless. At times we are scared of doing what we are trained to do. We need your protection and assurance. Help us to work towards the end of this pandemic.

We have converged through this media to find a way forward during these challenging times. Our efforts need guidance from your creative powers. We implore your light to shine on our path.

As created beings, we are empowered with brains that lead us to discover some of the wonders you, the Great Spirit, placed in all creation. We implore your light to shine on our path. We want that light of wisdom to help us reach concrete decisions at this our virtual meeting. Thank you for your permeating presence.

Great Spirit, we implore you to guide our searches, igniting in us the curiosity that will lead to more innovations. Furthermore, give us a spirit of trusting in each other's abilities and a genuine sharing of new ways you show us. By trusting in you, the Great Spirit of Light, we lose nothing, for in your light we see light itself. Thank you for who you are to all of us.

And let all say Amen.

REPORTS OF THE COMMITTEE ON RULES AND CREDENTIALS: The following reports were presented by Tripti Kataria, MD, Chair:

CREDENTIALS: The Committee on Rules and Credentials reported that on Friday, November 12, 483 out of 691 delegates (69.9%) had been accredited, thus constituting a quorum; on Monday, November 15, 469 (67.9%) delegates

were online at the start of the session and on Tuesday, November 16, 475 (68.7%) were present at the start of the session.

RULES REPORT - Friday, November 12

HOUSE ACTION: ADOPTED

1. **Special Meeting of the House of Delegates (HOD)**
In accordance with the official “Call for the Special Meeting” dated September 13, 2021, the AMA House of Delegates will convene via a virtual platform on November 12-16, 2021 to conduct priority business of the Association.
2. **House of Delegates Security**
Maximum security shall be maintained at all times to prevent disruptions of the House, and only those individuals who have been properly credentialed shall be permitted to vote or comment.
3. **Credentials**
The registration record of the Committee on Rules and Credentials shall constitute the official roll call at this Special Meeting of the House. Delegates have been issued a unique Business Credential for use during the virtual meeting and should guard it carefully. If the credential is compromised, it should be reported immediately to HOD@ama-assn.org. Recredentialing can be accomplished by notifying the HOD office electronically, in which case a new credential shall be issued and the previous credential made void. Only delegates or their alternate may vote on business before the House.
4. **Business of the House of Delegates**
The order of business as published shall be the official order of business for this Special Meeting. This may be varied by the Speaker, subject to any objection sustained by the House. Under the bylaws, business is restricted to that for which this Special Meeting has been called. The House of Delegates will determine which resolutions meet the criteria for consideration at this Special Meeting. No further business shall be entertained.
5. **Privilege of the Floor**
Delegates may request the privilege of the floor via the virtual platform. An alternate may request the privilege of the floor when “seated” for his/her delegate. The Speaker may grant the privilege of the floor to such persons as may be presented by the President, or Chair of the Board of Trustees, or others who may expedite the business of the House, subject to objections sustained by the House.
6. **Procedures of the House of Delegates**
As per the official “Call for the Special Meeting” and per the Bylaws governing the Special Meeting, discretion shall be given to the Speaker to conduct the business before the AMA House of Delegates.
7. **Limitation on Debate**
There will be a 90-second limit on debate per presentation, subject to waiver by the presiding officer for just cause, on any oral presentation.
8. **No Second Required**
To expedite consideration of motions before the House, motions shall be assumed to have a second unless an objection to the assumption of a second for a specific motion is expressed.
9. **Conflict of Interest**
Members of the House of Delegates who have a substantial financial interest in a commercial enterprise, whose interest will be materially affected by a matter before the House of Delegates, must publicly disclose that interest.
10. **Respectful Behavior**
Courteous and respectful dealings in all interactions with others, including delegates, AMA and Federation staff, and other parties, are expected of all attendees at House of Delegates meetings.

Mister Speaker, This concludes the Report of the Committee on Rules and Credentials, and we recommend its adoption

SUPPLEMENTARY REPORT – Friday, November 12

HOUSE ACTION: LATE RESOLUTION 1001 NOT ACCEPTED

LATE RESOLUTIONS

Mister Speaker, Members of the House of Delegates:

The Committee on Rules and Credentials met on Thursday, November 11, to discuss Late Resolution 1001. The sponsor of the late resolution was given the opportunity to present for the committee's consideration the reason the resolution could not be submitted in a timely fashion and the urgency of consideration by the House of Delegates at this meeting.

Recommended not be accepted:

- Late 1001 - Appeals and Denials – CPT Codes for Fair Compensation

Your Committee understands that the section's proposed resolution raised legal concerns and was delayed at least in part for that reason. The sponsor also wavered in their efforts to address the legal concerns, not submitting the resolution until Wednesday, thereby adding to the delay. Your Committee on Rules and Credentials is not persuaded that the legal issues could not have been resolved in a more timely fashion. Moreover, this is not a new concern for physicians and our AMA has considerable policy on this issue, which will allow advocacy on the matter even without this resolution. For these reasons, the Committee recommends that the resolution not be accepted.

Mister Speaker, this concludes the Supplementary Report of the Committee on Rules and Credentials.

CLOSING REPORT

HOUSE ACTION: ADOPTED

Mister Speaker, Members of the House of Delegates:

Your Committee on Rules and Credentials wishes to thank our speakers, Dr Scott and Dr Egbert, for leading us through our deliberations and to commend the members of the House for expediting the business.

The Committee submits the following resolution:

Whereas, This Special Meeting of the House of Delegates has been most valuable in developing AMA policy; be it

RESOLVED, That expressions of deep appreciation be made to our Speakers and to our American Medical Association staff for planning and conducting this Special Meeting of the House of Delegates.

Mister Speaker, This concludes the Report of the Committee on Rules and Credentials, and we recommend its adoption.

**FINAL REPORT OF THE RESOLUTION COMMITTEE
November 2021 Special Meeting of the House of Delegates**

HOUSE ACTION: RECOMMENDATIONS ADOPTED

This is the Final Report of the Resolutions Committee. By the midnight November 10 deadline, 28 resolutions had been extracted from the list of those not meeting the priority threshold.

The resolutions are listed below in three groups:

- Resolutions meeting the priority threshold,
- Resolutions not meeting the priority threshold and not extracted, and
- Extracted resolutions, which will be presented to the House for a decision regarding their consideration.

The Final Report will be handled as a consent calendar on Friday evening, November 12, during the Opening Session. Each extracted item will be put to a vote to either sustain the recommendation of the Resolution Committee or to overrule its recommendation, without further debate. The House by majority vote will decide which items become the business of the HOD.

For extracted items, the Committee's report includes the name of the extractor and their extraction statement, the Resolution Committee's score (the average across 31 individuals), and the resolution sponsor's original ranking. The Committee's second report, which includes background from reference committee staff, is included as an attachment (starting on page 14); it has been modified only to move the extracted items to the top of the report.

RESOLUTIONS MEETING THE PRIORITY THRESHOLD

1. 002 - Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent
2. 008 - Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
3. 009 - Banning the Practice of Virginity Testing
4. 018 - Support for Safe and Equitable Access to Voting
5. 019 - Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent
6. 020 - Recognizing and Remediating "Structural Urbanism" Bias as a Factor in Rural Health Disparities
7. 021 - Free Speech and Civil Discourse in the American Medical Association
8. 022 - Prohibition of Racist Characterization Based on Personal Attributes
9. 023 - AMA Council on Ethical and Judicial Affairs Report on Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2
10. 101 - Standardized Coding for Telehealth Services
11. 113 - Supporting Medicare Drug Price Negotiation
12. 203 - Poverty-Level Wages and Health
13. 207 - Authority to Grant Vaccine Exemptions
14. 209 - Increasing Access to Hygiene and Menstrual Products
15. 212 - Sequestration
16. 221 - Promoting Sustainability in Medicare Physician Payments
17. 224 - Improve Physician Payments
18. 225 - End Budget Neutrality
19. 226 - Addressing Adolescent Telehealth Confidentiality Concerns
20. 229 - CMS Administrative Requirements
21. 234 - Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients
22. 240 - Ransomware Prevention and Recovery
23. 301 - Equitable Reporting of USMLE Step 1 Scores
24. 305 - Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status
25. 309 - Protecting Medical Student Access to Abortion Education and Training
26. 408 - Ensuring Affordability and Equity in COVID-19 Vaccine Boosters
27. 410 - Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers
28. 411 - Addressing Public Health Disinformation
29. 412 - Health Professional Disinformation During a Public Health Crisis
30. 414 - Advocacy on the US Department of Education's Spring 2022 Title IX Rules on Sexual Harassment and Assault in Education Programs
31. 502 - Advocating for Heat Exposure Protections for Outdoor Workers
32. 505 - Representation of Dermatological Pathologies in Varying Skin Tones
33. 506 - Enhancing Harm Reduction for People Who Use Drugs
34. 601 - "Virtual Water Cooler" for our AMA

35. 605 - Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates
36. 606 - Increasing the Effectiveness of Online Reference Committee Testimony
37. 614 - Insurance Industry Behaviors
38. 615 - Employed Physicians
39. 701 - Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid

RESOLUTIONS NOT MEETING THE PRIORITY THRESHOLD BUT NOT EXTRACTED

1. 004 - Guidelines on Chaperones for Sensitive Exams
2. 006 - Evaluating Scientific Journal Articles for Racial and Ethnic Bias
3. 007 - Exclusion of Race and Ethnicity in the First Sentence of Case Reports
4. 010 - Improving the Health and Safety of Sex Workers
5. 011 - Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions
6. 012 - Increased Recognition and Treatment of Eating Disorders in Minority Populations
7. 013 - Equal Access to Adoption for the LGBTQ Community
8. 014 - (Now 415)
9. 015 - Using X-Ray and Dental Records for Assessing Immigrant Age
10. 016 - Student-Centered Approaches for Reforming School Disciplinary Policies
11. 017 - Gender Equity and Female Physician Work Patterns During the Epidemic
12. 024 - Organ Transplant Equity for Persons with Disabilities
13. 025 - Opposition to Discriminatory Treatment of Haitian Asylum Seekers
14. 103 - Oral Healthcare Is Healthcare
15. 104 - Improving Access to Vaccinations for Patients
16. 105 - Fertility Preservation Insurance Coverage for Women in Medicine
17. 106 - Reimbursement of School-Based Health Centers
18. 107 - Expanding Medicaid Transportation to Include Healthy Grocery Destinations
19. 108 - Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes
20. 109 - Amending D-440.985, Health Care Payment for Undocumented Persons, to Study Methods to Increase Health Care Access for Undocumented Immigrants
21. 111 - Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System
22. 114 - Medicare and Private Health Insurance for Hearing Aids
23. 115 - Bundled Payments and Medically Necessary Care
24. 116 - Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance
25. 117 - Implant-Associated Anaplastic Large Cell Lymphoma
26. 118 - Expanding Site-of-Service Neutrality
27. 119 - Bundling Physician Fees with Hospital Fees
28. 120 - COBRA for College Students
29. 121 - Medicaid Tax Benefits
30. 123 - Support for Easy Enrollment Federal Legislation
31. 124 - Medicare Coverage of Dental, Vision, and Hearing Services
32. 204 - Supporting Collection of Data on Medical Repatriation
33. 206 - Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises
34. 210 - Advocating for the Amendment of Chronic Nuisance Ordinances
35. 211 - Support for Mental Health Courts
36. 213 - Eliminating Unfunded or Unproven Mandates and Regulations
37. 214 - Stakeholder Engagement in Medicare Administrative Contractor Policy
38. 215 - Pharmacy Benefit Manager Reform as a State Legislative Priority
39. 216 - Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers
40. 217 - Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education

41. 218 - Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care
42. 219 - The Impact of Midlevel Providers on Medical Education
43. 220 - Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use
44. 222 - Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act
45. 223 - Paying Physicians for Services According to the Physician Fee Schedule
46. 227 - Medication for Opioid Use Disorder in Physician Health Programs
47. 228 - Resentencing for Individuals Convicted of Marijuana-Based Offenses
48. 230 - Medicare Advantage Plan Mandates
49. 231 - Prohibit Ghost Guns
50. 232 - Ban the Gay/Trans (LGBTQ+) Panic Defense
51. 233 - Insurers and Vertical Integration
52. 235 - Vital Nature of Board-Certified Physician in Aerospace Medicine
53. 237 - Universal Good Samaritan Statute
54. 238 - Increasing Residency Positions for Primary Care
55. 239 - Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research
56. 241 - Enforcement of Administrative Simplification Requirements - CMS
57. 303 - Decreasing Bias in Evaluations of Medical Student Performance
58. 304 - Reducing Complexity in the Public Service Loan Forgiveness Program
59. 306 - Support for Standardized Interpreter Training
60. 308 - Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program
61. 311 - Improving Access to Physician Health Programs for Physician Trainees
62. 313 - Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training
63. 314 - Updating Current Wellness Policies and improving Implementation
64. 315 - Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs
65. 316 - Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic
66. 317 - Creating a More Accurate Accounting of Medical Education Financial Costs
67. 318 - The Medical Student Match Mismatch
68. 401 - Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome
69. 402 - Expansion on Comprehensive Sexual Health Education
70. 404 - Increase Employment Services Funding for People with Disabilities
71. 407 - Traumatic Brain Injury and Access to Firearms
72. 409 - Screening for HPV-Related Anal Cancer
73. 415 - (was 014) Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis for HIV
74. 501 - Ensuring Continued Access to Equitable Take-Home Methadone Treatment
75. 503 - Marketing Guardrails for the "Over-Medicalization" of Cannabis Use and Abuse
76. 504 - Air Pollution and COVID: A Call to Tighten Regulatory Standards
77. 507 - Healthy Air Quality
78. 508 - Personal Care Products Safety
79. 509 - Wireless Devices and Cell Tower Health and Safety
80. 510 - Opposition to Sobriety Requirement for Hepatitis C Treatment
81. 602 - Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings
82. 603 - Abolishment of the Resolution Committee
83. 604 - The Critical Role of Physicians in the COVID-10 Pandemic
84. 607 - AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels
85. 610 - Creation of Employed Physician Section
86. 611 - September 11th as a National Holiday
87. 612 - UN International Radionuclide Therapy Day Recognition
88. 616 - Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System

89. 702 - System Wide Prior and Post-Authorization Delays and Effects on Patients
90. 704 - Expanding the AMA's Study on the Economic Impact of COVID-19
91. 705 - Advocating for Program Stability in the Merit-Based Incentive Payment System
92. 706 - Support for State Medical Record Retention Laws
93. 707 - Fifteen Month Lab Standing Orders
94. 708 - Insurance Coverage for Scalp Cooling (Cold Cap) Therapy
95. 709 - Prior Authorization - CPT Codes for Fair Compensation
96. 710 - Physician Burnout is an OSHA Issue
97. 711 - Hospital System Consolidation
98. 712 - Advocacy of Private Practice Options for Health Care Operations in Large Corporations

RESOLUTIONS NOT MEETING THE PRIORITY THRESHOLD BUT EXTRACTED
FOR DECISION BY THE HOUSE

Resolution 001 - Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
Resolutions Committee composite score: 2.48 (2 = low priority)
Sponsor's ranking of resolution among their submitted resolutions: 49 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

In the Resolutions Committee report, staff noted that resolution 003 is important and timely. This item is indeed urgent, given pending legislative discussions in Congress. It asks our AMA to support a Congressional commission to make recommendations on reparations, for which federal legislation has been introduced (HR 40, Commission to Study and Develop Reparation Proposals for African Americans Act). This makes now an ideal time for the AMA to act. This resolution also asks the AMA to study the feasibility of economic and healthcare reparations for undoing the deep health disparities that hold our nation back, providing our AMA an opportunity to lead the way toward timely racial justice initiatives. Given that the AMA has called for research on how to prevent or repair the damages of racism (H-65.952, D-350.995), resolution 003 is a vital next step if the AMA truly intends to advance racial justice in medicine.

Resolution 003 - Supporting the Study of Reparations as a Means to Reduce Racial Inequalities
Resolutions Committee composite score: 1.97 (1 = not a priority at this time)
Sponsor's ranking of resolution among their submitted resolutions: 6 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

At any time, around 60,000 people are being held in solitary confinement in the United States. This problem has become worse during the COVID-19 pandemic, with prisons isolating more people for longer periods of time. The mental health effects of solitary confinement are long-lasting, causing long-term harm to our patients without the benefit of actually improving the prison environment. This resolution is important and urgent. This problem has gotten worse during the pandemic, and the longer we allow solitary confinement, which has been deemed a cruel and unusual punishment by other international agencies, to continue, we continue to allow irreparable harm to those who have the least ability to advocate for themselves.

Resolution 005 - Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism
Resolutions Committee composite score: 2.45 (2 = low priority)
Sponsor's ranking of resolution among their submitted resolutions: 10 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

In 2017, the 11th Circuit ruled against the EEOC when it effectively held that refusing to hire someone because of their dreadlocks is legal. In response, 14 states, 33 cities, and the American Academy of Pediatrics passed policy protecting natural hair and cultural headwear from workplace discrimination. Twenty-five other states considered but did not pass the same protections in 2020. However, current AMA and federal policy is notably lacking in such protections.

The COVID-19 pandemic has amplified the gross racial inequities in healthcare. Our AMA became a leader in the national conversation on issues of race when we committed to recognizing racism as a public health crisis. Medical students, residents, and physicians with natural hair or cultural headwear continue to be marginalized and penalized daily by archaic and Eurocentric professionalism guidelines. The time is now to demonstrate our commitment to racial justice by advocating for protections against race-based hair discrimination.

Resolution 026 - Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates

Resolutions Committee composite score: 2.61 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 1 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

Though we fervently hope we will return to normal meetings in June 2022, the reality is that there is no guarantee when the pandemic will have abated enough to safely return to normal meetings. We are concerned that two years of AMA meetings have been governed by the sparse Special Meeting bylaws in AMA Bylaw 2.12.2, and after four meetings held under this bylaw it is time to update it, especially while the lessons of the recent Special Meetings are fresh in our memories.

Knowing that even the next meeting for our AMA could be a Special Meeting, we believe it is timely, urgent, and a high priority to request an update in our Special Meeting bylaws.

Resolution 102 - Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation

Resolutions Committee composite score: 2.24 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 1 out of 4

Extracted by Louise B Andrew, Delegate, Senior Physicians Section

We Respectfully Request EXTRACTION of "Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation." SPS submitted #102 as High priority, specifically informed and guided by the Special Meeting Prioritization Matrix. Each enumerated point was carefully addressed in our Prioritization statement, resulting in our ranking.

Filling important policy GAPS (promoting awareness of, and research into the importance of early screening AND connection between hearing loss and cognitive impairment) were key NEW asks of #102.

Prior policies H-185.929 and Council Report 6-I-15 (adduced apparently to support REaffirmation [sic] over consideration) solely concern payment for remediation, and DO NOT address the critical new asks of this resolution.

One cannot REaffirm [sic] something never previously affirmed/considered. We fear incomplete comprehension of the breadth of this resolution caused premature closure.

Further, immediately pending Congressional action on secondary payment aspects of this issue makes timely consideration at THIS traditional advocacy meeting critically important.

Thanks for your [truncated at 150 words].

Resolution 110 - Caps on Insulin Co-Payments for Patients with Insurance

Resolutions Committee composite score: 2.14 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 37 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

Over 7 million Americans currently rely on insulin as a life-saving medication. Despite the fact that insulin was first used to treat diabetes almost 100 years ago, its cost has become exorbitant in the past two decades and is unaffordable for millions of patients. Over 25% of patients prescribed insulin reporting cost-related underuse, risking diabetic ketoacidosis, chronic kidney disease, lower limb amputations, and other sequela. At this moment, Congress is poised to act on legislation included within the reconciliation package that would cap insulin co-payments at \$35 per month for all Medicare Part D beneficiaries, which is projected to lower out-of-pocket costs by 28%. We must join diabetes advocates now in advocating to improve insulin affordability for all patients. This resolution is immensely timely and urgent, and could help positively change the lives of millions of struggling patients.

Resolution 112 - Expanding Coverage for and Access to Pulmonary Rehabilitation

Resolutions Committee composite score: 2.60 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: only resolution

Extracted by Christopher Worsham, Delegate, American Thoracic Society

This item should be considered at N21. While we deeply appreciate the difficult work of the Resolution Committee, contrary to the report's conclusion, issues of access to pulmonary rehabilitation affects many potential patients--the number of which remains unknown as the pandemic rages on. Millions of Americans have been infected with COVID-19 and are at substantial risk of prolonged symptoms that could be addressed with pulmonary rehabilitation; current HOD policy does not specifically address rehabilitation services, much less pulmonary rehabilitation. There remain acute needs for this care, substantial barriers to coverage and access to care, yet our AMA currently provide minimal guidance in this area to health systems, insurers, and policymakers. Given the importance of this issue at this time, and what I would anticipate would be minimal debate, considering this resolution at this meeting has the potential to provide strong leadership from AMA during the pandemic with minimal time [*truncated at 150 words*].

Resolution 122 - Increase Funding, Research and Education for Post-Intensive Care Syndrome

Resolutions Committee composite score: 2.61 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: only resolution

Extracted by Kathleen Doo, Delegate, Society of Critical Care Medicine

Resolution 122 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. While the physical and cognitive symptoms of PICS have long-been areas of interest for the critical care community, the explosion of COVID survivors in the past year and a half has transformed PICS into a system-wide, and particularly primary care priority. As the wave of patients are here now, we need to learn quickly about the best management of this syndrome, and only with specific ICD-10 codes can primary care physicians and health systems be adequately recognized through risk adjustment for taking care of this population with increased needs. Resolution 122 is timely, and we urge support for consideration.

Resolution 125 - Medicare Coverage of Dental, Vision and Hearing Services

Resolutions Committee composite score: 1.98 (1 = not a priority at this time)

Sponsor's ranking of resolution among their submitted resolutions: 2 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

Resolution 125 is incredibly timely as proposals to expand Medicare to cover dental, hearing, and vision services are being hotly debated throughout Congress. Millions of Medicare beneficiaries lack affordable access to these services and suffer from the resultant negative health repercussions, with hearing impairment recognized as among the most important modifiable risk factors for dementia as just one example. Much has changed since the AMA last examined the issues of Medicare coverage of hearing aids and dental services. In fact, a Viewpoint published in JAMA on September 27, 2021 astutely observed that "The Window of Opportunity is Open" to expand Medicare coverage of these benefits. The time is now for the AMA to stand with the National Dental Association on the right side of history, right a historical wrong in excluding basic oral, eye, and ear care from Medicare coverage, and improve the health of all Medicare beneficiaries.

Resolution 201 - Protection of Peer-Review Process

Resolutions Committee composite score: 2.32 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: only resolution

Extracted by Ann Stroink, Delegate, Congress of Neurological Surgeons

Although the AMA has clear and reaffirmed policy that protects the peer review process, as pointed out in a "whereas clause," the U.S. Senate Oversight Committee is investigating the United Network for Organ Sharing and has subpoenaed "all relevant materials to include peer-review related materials." Thus, instances such as this committee inquiry are a present and ongoing threat to the effectiveness of meaningful peer review. The AMA must take additional action to thwart such efforts that could open the door to destroying the peer review

process for all physicians. Therefore, the neurosurgery delegation believes this “directive to take action” is timely and necessary to ensure immediate AMA action on this issue.

Resolution 205 - Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits

Resolutions Committee composite score: 2.52 (2 = low priority)

Sponsor’s ranking of resolution among their submitted resolutions: 18 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

Resolution 205 is EXTREMELY URGENT AND TIMELY. Hundreds of thousands of forensic sexual assault evidence kits (“rape kits”) that use DNA evidence to identify serial rapists are backlogged in warehouses across America. These “backlogged” rape kits could be tested, and jurisdictions that have unilaterally done so have been remarkably successful at solving sexual assault cases and preventing rapes. Federal and state legislation to 1) end the backlog, 2) mandate all new rape kits be tested, and 3) provide additional funding for rape kit testing would be INCREDIBLY IMPACTFUL at reducing the prevalence of sexual assault nationwide. Pending Congressional legislation and the fact that rape kits expire due to statutes of limitations mean this item is INCREDIBLY URGENT and will benefit from IMMEDIATE INTERVENTION from our AMA. PLEASE VOTE TO EXTRACT THIS ITEM.

Resolution 208 - Protections for Incarcerated Mothers in the Perinatal Period

Resolutions Committee composite score: 2.21 (2 = low priority)

Sponsor’s ranking of resolution among their submitted resolutions: 24 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

Legislation is currently pending in multiple states on breastfeeding protections for incarcerated mothers. The [2017 recommendations](#) of the National Commission on Correctional Health Care, which call for breastfeeding protections for incarcerated mothers, have STILL not been uniformly adopted. The AMA has a chance to support these initiatives, making this issue EXTREMELY URGENT AND TIMELY. This resolution would improve the health of both incarcerated mothers AND their children. Furthermore, because incarceration occurs more in communities already experiencing significant health disparities, addressing this core health equity issue will promote optimal health for communities experiencing high rates of incarceration. The resolution is a timely step towards achieving the [Healthy People 2030 initiative](#) goal to “increase the proportion of infants who are breastfed exclusively through six months and infants who are breastfed at one year by the year 2030.”

Resolution 236 - Repeal or Modification of the Medicare Appropriate Use Criteria

Resolutions Committee composite score: 2.63 (2 = low priority)

Sponsor’s ranking of resolution among their submitted resolutions: only resolution

Extracted by Ann Stroink, Delegate, Congress of Neurological Surgeons

While CMS delayed implementing the AUC program until Jan. 1, 2023, the agency has stated it cannot delay the program again and must implement it as best as possible by this date (assuming the PHE ends). Furthermore, CMS has repeatedly stated that it does not have the legal authority to change the program, which requires an act of Congress. To have any real chance of passing legislation, we need our AMA to work on an appropriate legislative solution—either repeal or modification of the existing law—well in advance of the 2023 implementation date. Ideally, this could happen this year in a year-end omnibus spending package. However, if Congress fails to take action this year, medicine needs to advocate for legislative change in the first half of next year to have any real chance of success. Therefore, we cannot wait to consider this resolution until the June 2022 HOD meeting.

Resolution 302 - University Land Grant Status in Medical School Admissions

Resolutions Committee composite score: 2.21 (2 = low priority)

Sponsor’s ranking of resolution among their submitted resolutions: 11 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

This timely and urgent resolution was described in the Resolution Committee report as important, but not a priority to hear in November. We disagree. November is Native American Heritage Month. Native Americans face tremendous and increasing challenges in K-12 education, undergraduate studies, and extending well into

graduate and professional studies. This resolution directs our AMA to engage with the Land-Grant University System, AAMC, and Association of American Indian Physicians to (1) strengthen admissions practices for Native American applicants interested in serving Tribes, (2) bolster preclinical and clinical education relating to Native American health, and (3) reconcile land-grant university land expropriation from Tribes. This resolution is the first of many as we recognize not just our moral, but our legal obligation to promote equity for our 574 Tribal Nations. We cannot wait another admissions cycle for this resolution to become policy. The time is now to act on this important matter.

Resolution 307 - Support for Institutional Policies for Personal Days for Undergraduate Medical Students

Resolutions Committee composite score: 1.84 (1 = not a priority at this time)

Sponsor's ranking of resolution among their submitted resolutions: 41 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

Medical students experience burnout, depression, and suicidal ideation at much higher rates than the general population. The pandemic has acutely exacerbated these issues and further revealed how pervasive and devastating they are. Stigma, administrative barriers, and a lack of guaranteed, "personal days" off prevent students from accessing care. Implementing personal days (defined as no-questions-asked excused absences) in medical schools in a standardized fashion would allow students to access the care or resources they need without requiring them to face the stigma involved in disclosing private matters. We ask the House to stand with our MSS in prioritizing the mental and physical wellbeing of our fellow students, especially as it remains under urgent threat during this pandemic.

Resolution 310 - Resident and Fellow Access to Fertility Preservation

Resolutions Committee composite score: 2.13 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 6 out of 22

Extracted by Ray Lorenzoni, Delegate, Resident and Fellow Section

This policy applies to most current trainees and future physicians. Every extra year of training is a sacrifice when it comes to fertility for so many of our fellow physicians. Recent news stories, including in the New York Times, have highlighted the many physical and emotional trials affecting our colleagues.

As policies are changing around the country regarding trainee benefits, bills of rights, and compensation, a discussion of this resolution by the HOD would be timely and guide the AMA with trainee fertility policy it does not currently have.

Resolution 312 - Accountable Organizations for Resident and Fellow Trainees – Resident and Fellow Access to Fertility Preservation

Resolutions Committee composite score: 2.00 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 8 out of 22

Extracted by Ray Lorenzoni, Delegate, Resident and Fellow Section

The closure of the Hahnemann University Hospital and its residencies highlighted the vulnerability of residents and fellows, particularly for completing training, financial wellbeing, and legal rights.

While many organizations stepped in to support these residents (we thank the AMA for being a primary one), there is no central independent organization accountable to resident and fellow interests. This resolution asks the AMA to take a leadership role in supporting residents and fellows by identifying an existing organization to take on this role and recommend strategies to prevent future trainee disenfranchisement.

Resolution 403 - Providing Reduced Parking Fees for Patients

Resolutions Committee composite score: 2.12 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 46 out of 54

Extracted by Robert Dannenhoffer, Delegate, Oregon Medical Association

Resolution 403 addresses the additional transportation costs for our patients, a real barrier to care for those with limited or fixed incomes. This issue calls for AMA advocacy, is important, timely and deserving of discussion and consideration by our House of Delegates.

Resolution 405 - Formal Transitional Care Program for Children and Youth with Special Health Care Needs

Resolutions Committee composite score: 2.57 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 48 out of 54

Extracted by Robert Dannenhoffer, Delegate, Oregon Medical Association

Resolution 405 addresses a critical issue for patients with special health care needs and the physicians who care for them as advances in care have prolonged these patients' lives into adulthood. As children and youth with special health care (CYSHCN) needs become adults, AMA policy on children and youth with disabilities do not apply to all CYSCHN, although they and their families face similar challenges. Existing AMA policy H-60.974 needs to be broadened. The term CYSCHN is widely recognized by the federal government and pediatric community and defined as "those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. They also require health and related services of a type or amount beyond that required by children generally." AMA policy should be updated to be inclusive of patients in this definition.

Resolution 406 - Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer

Resolutions Committee composite score: 2.17 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 22 out of 22

Extracted by Robert Dannenhoffer, Delegate, Oregon Medical Association

We are experiencing a crisis in vaccine misinformation, and even as COVID spreads, HPV continues to cause preventable cancers in women and men. As the rate of routine vaccinations has fallen during the pandemic, it is urgent that the AMA update its policy on the benefits of HPV vaccination in preventing certain oropharyngeal cancers as well as cervical cancer to encourage uptake of HPV vaccination for both boys and girls. Resolution 406 is timely, amends AMA policy to more fully reflect the science, and should be non-controversial among physicians. The AMA House should not delay adopting a scientific stance on preventing cancer.

Resolution 413 - Universal Childcare and Preschool

Resolutions Committee composite score: 2.64 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 3 out of 54

Extracted by Anna Heffron, Delegate, Medical Student Section

This issue is CURRENTLY IN CONGRESS with an imminent vote. Major provisions to increase childcare and preschool access are included in the reconciliation plan, but are still subject to ongoing negotiation and agreement between the House and Senate.

Even the mere news that our AMA passed this could ensure that these provisions remain in the plan and are not reduced or cut in the final days of legislation--as so many other pieces have been deleted in the last two weeks. Additionally, this resolution will allow our AMA to actively engage in the development of HHS regulations starting in spring 2022 and ongoing implementation.

Passage is essential for giving all our children a great head start with lifelong benefits. Furthermore, this policy is crucial for supporting the careers of physicians with children--especially students, residents, fellows, early-career physicians, and women in medicine--as well as other healthcare workers on whom *[truncated at 150 words]*

Resolution 608 - Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

Resolutions Committee composite score: 2.32 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 12 out of 22

Extracted by Ray Lorenzoni, Delegate, Resident and Fellow Section

As international climate negotiations are presently taking place, we ask that the HOD permit a single resolution about climate change to be heard at this advocacy-focused meeting. A group of organizations representing 45 million healthcare professionals signed on to the Healthy Climate Prescription letter acknowledging the health risks linked to climate change, which was recently delivered to the COP26 climate negotiations.

Our AMA was not included on this letter, while medical societies of American states and specialty societies were. Our AMA already has policy that recognizes the well-established links between climate change and health and this resolution provides an opportunity discuss how we might best disseminate these policies.

Resolution 609 - Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency
Resolutions Committee composite score: 2.34 (2 = low priority)
Sponsor's ranking of resolution among their submitted resolutions: 2 out of 2

Extracted by Jerry Abraham, Delegate, California Medical Association

With the COVID-19 Pandemic, Our AMA heeded the call to action that the science and moment demanded. We must take an active role in the time-sensitive health emergency of Global Warming in order to fulfill Medicine's Social Contract with Humanity -- Resolution 609 is where we must start.

At the start of COVID-19, the science didn't give us the luxury of postponing taking measures to flatten the curve. Climate Change is a health risk-multiplier. Science doesn't give us the luxury of postponing advocacy for measures to flatten the climate curve anymore -- it is an emergency.

This past Monday, HHS announced their Climate Action Plan to: 1) Decarbonize the US healthcare sector (which contributes 10% of America's carbon pollution), and 2) Enhance health sector climate resilience.

Our AMA's existing (8) climate policies have major gaps. The HHS announcement will change the Practice of Medicine -- we need Resolution 609 now [*truncated at 150 words*]

Resolution 613 - Due Process at our AMA

Resolutions Committee composite score: 2.64 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: only resolution

Extracted by Stephen Imbeau, Delegate, South Carolina Medical Association

Resolution 613 is Timely and VERY Important; the AMA Hotline is ACTIVE right NOW. Due Process is in the fabric of the US and the AMA, by Constitution, by Culture and by Tradition. Due Process protects the weak from the strong, protects the common from the Elite and protects everybody from false accusation. This Resolution protects the AMA member from misuse of the AMA Hotline, from misunderstanding, from misinformation and from falsehood. It also allows for a quiet, confidential preliminary investigation by AMA OGC. We believe it is important to not only Extract R#613, but also to Approve at this November 2021 Virtual Interim Meeting of the AMA.

Resolution 617 - Together We are Stronger Marketing Campaign

Resolutions Committee composite score: 1.87 (1 = not a priority at this time)

Sponsor's ranking of resolution among their submitted resolutions: 3 out of 3

Extracted by Floyd Buras, Delegate, Louisiana State Medical Society

I wish to extract resolution 617 from the resolution committee report.

Resolution 618 - Dissolution of the Resolution Committee

Resolutions Committee composite score: 2.37 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: 1 out of 22

Extracted by Ray Lorenzoni, Delegate, Resident and Fellow Section

If a single extraction from the RFS is accepted for business, we kindly request that it be this one. Currently accepted business for the House of Delegates includes a resolution about bylaws changes to make the

Resolution Committee permanent, which would require passage of both this policy and the corresponding bylaws at a future date. Our resolution regarding the exact same subject but with the opposite stance should theoretically have received similar treatment by the Resolution Committee, but it did not. Even if you disagree with the content, we hope the HOD rectifies the discrepancy.

By limiting the business heard at each meeting to an unprecedented extent, the democratic process parliamentary procedures of the HOD have been undermined. Numerous relevant, time-sensitive resolutions have not been heard while many reaffirmations have occurred. This harms efforts to improve priority issues and address the large backlog of resolutions from our states and sections.

Resolution 619 - Continuing Equity Education

Resolutions Committee composite score: 2.69 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: only resolution

Extracted by Luis Seija, Delegate, Minority Affairs Section

On May 11, 2021, the AMA committed itself to "...push upstream to address all determinants of health and root causes of inequities by strengthening, empowering, and equipping physicians with the knowledge of and tools for dismantling structural and social drivers of health inequities."

In response to member requests to expand and deepen their understanding of health equity and racial justice, then BoT Chair, Dr. Kridel, communicated to our HOD, "...to be a leader in medicine and fulfill our mission requires us to be humble enough to admit we don't know everything but are committed to finding out."

For that reason, our Speakers organized the Health Equity Forum where members can do their part by "gaining knowledge and learning skills to advance equity across the health system."

Resolution 619 reflects our AMA's investment in the betterment of its membership, facilitating opportunities for life-long learning and recognizing prioritizing equity starts with us.

Resolution 703 - Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes

Resolutions Committee composite score: 2.08 (2 = low priority)

Sponsor's ranking of resolution among their submitted resolutions: only resolution

Extracted by Melissa Garretson, Delegate, American Academy of Pediatrics

The intent of this resolution is the compilation of data to enhance and support policy of the HOD. The absence of anything but anecdotal data regarding insurer compliance (and non-compliance) with CPT E/M coding and payment, especially given the recent updates to RVUs for 2021 undermines CPT. There is also no national compilation of such data to approach insurers on the national level. This robust and credible data will allow the AMA and Federation members to tackle egregious coding decisions from an evidence-based standpoint, and can also be helpful with policymakers regarding payer behavior out of compliance with payment agreements and laws. Consideration of this item would give our HOD an opportunity to give direction to staff regarding implementation of existing policy that opposes the incorrect use of CPT and arbitrary, unilateral downcoding and recoding by payers.

APPENDIX - Second Report of the Resolutions Committee

Note: This report has been modified to move information on extracted resolutions to the top of the report. The content has not otherwise been changed.

001	Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers Resolutions Committee composite score: 2.48 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 49 out of 54 Background Information provided by AMA staff to RC: None
003	Supporting the Study of Reparations as a Means to Reduce Racial Inequalities Resolutions Committee composite score: 1.97 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 6 out of 54

	Background Information provided by AMA staff to RC: While this resolution is important and timely, the Center for Health Equity, who would be writing the report if this were adopted, does not have policy staff on board until the end of 2021. If this were adopted at N21, CHE would have to hire an external subject matter expert to conduct this research (see fiscal note). Given the time it takes to vet and hire such an individual, it seems more appropriate for this resolution to be submitted at the June 2022 Meeting of the HOD when the CHE has their own in-house policy staff to write this report. The issue of reparations is unlikely to change between now and then in a way that would impact the outcome of the report.
005	Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism Resolutions Committee composite score: 2.45 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 10 out of 54 Background Information provided by AMA staff to RC: None
026	Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates Resolutions Committee composite score: 2.61 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 1 out of 54 Background Information provided by AMA staff to RC: None
102	Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation Resolutions Committee composite score: 2.24 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 1 out of 4 Background Information provided by AMA staff to RC: Policy H-185.929 supports coverage of hearing loss tests and policies that increase access to hearing aids, other technologies, and services that alleviate hearing loss and its consequences. Additionally, this topic was addressed by the Council on Medical Service in 2015 (Council Report 6-I-15) and was discussed by House of Delegates most recently at the 2019 Annual Meeting when additional policy was adopted.
110	Caps on Insulin Co-Payments for Patients with Insurance Resolutions Committee composite score: 2.14 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 37 out of 54 Background Information provided by AMA staff to RC: Resolution 110 is addressed by current AMA policy, and by the Council on Medical Service in 2018 (Council Report 7-A-18). Policy H-155.960 encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. The policy stipulates that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. AMA policy also supports value-based pricing for pharmaceuticals (Policy H-110.986). The policy specifically calls for value-based pricing processes that incorporate affordability criteria and that include cost-effectiveness analyses in comparative effectiveness research. Similarly, Policy H-110.990 states that cost-sharing requirements for prescription drugs should be based on considerations such as the unit cost of medication, availability of therapeutic alternatives, medical condition being treated, personal income, and other factors known to affect patient compliance. Finally, Policy H-125.977 advocates for economic assistance, including coupons and other discounts for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured.
112	Expanding Coverage for and Access to Pulmonary Rehabilitation Resolutions Committee composite score: 2.60 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: The resolution affects a smaller group or subgroup of physicians (by mode of practice, specialty, or geography) and/or their patients. Policy H-165.856 sets forth principles to guide health insurance market regulation and states that the regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements, and that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.
122	Increase Funding, Research and Education for Post-Intensive Care Syndrome Resolutions Committee composite score: 2.61 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: None
125	Medicare Coverage of Dental, Vision, and Hearing Services Resolutions Committee composite score: 1.98 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 2 out of 54 Background Information provided by AMA staff to RC: This resolution is already addressed by numerous AMA policies and has been the subject of two recent Council on Medical Service reports. <ul style="list-style-type: none"> Dental: A 2019 report of the Council on Medical Service addressed the issue of Medicare coverage of dental services. Policy D-160.925 recognizes the importance of managing oral health and access to dental care as a part of optimal patient care. Policy H-330.872 supports continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and

	<p>prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.</p> <ul style="list-style-type: none"> • Vision: Policy D-185.978 supports insurance coverage for and increased access to low vision aids for patients with visual disabilities. Policy H-25.990 encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients. • Hearing: Policy H-185.929 supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences and encourages health plans to offer optional riders that allow members to add hearing benefits to existing policies. Notably, coverage of and access to hearing aids was deliberated by the House of Delegates most recently at the 2019 Annual Meeting when additional policy was adopted. Furthermore, the FDA recently ruled that hearing aids can be made available OTC for mild to moderate hearing loss, and the Build Back Better Act, if enacted into law, would provide coverage for hearing aids for Medicare enrollees with certain degrees of hearing loss. Hearing aid coverage was the topic of Council on Medical Service Report 6-I-15.
201	<p>Protection of Peer-Review Process Resolutions Committee composite score: 2.32 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: Resolution 201 is not a priority or urgent. Nothing new has happened regarding the subpoena since it was issued in February of 2021. (Concerns have been raised about the fairness of the organ donation process). But most importantly, we have strong policy protecting peer review documents, in both state and federal venues, which we could affirm, and the AMA Litigation Center is extremely active in arguing for peer review protections on the federal and state levels. Any Federation member, through their respective state medical associations, may already request that the AMA argue for peer review protections in any instance where a subpoena or other attempt to discovery peer review materials is involved.</p>
205	<p>Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits Resolutions Committee composite score: 2.52 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 18 out of 54 Background Information provided by AMA staff to RC: Although the number of sexual assault evidence kits that remain untested is troubling, the problem is not new, nor have there been any recent developments or events that push the issue to the forefront of public policy and necessitate urgent consideration by the House of Delegates.</p>
208	<p>Protections for Incarcerated Mothers in the Perinatal Period Resolutions Committee composite score: 2.21 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 24 out of 54 Background Information provided by AMA staff to RC: Our AMA has been very active in advocating for improvements in maternal health, and specifically, the maternal mortality and morbidity rates in the U.S. Our AMA has strong policy supporting these efforts. Although we hope to obtain more pregnant inmate data, our AMA also has policy protecting the privacy of such individuals from discrimination by the use of such data by U.S. Immigration and Customs Enforcement (ICE) or other agencies. Additionally, we adopted policy at the last meeting that directs our AMA to "encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates while ensuring appropriate nondiscrimination and privacy safeguards; and (2) support legislation requiring all correctional facilities, including those that are privately-owned, to collect and publicly report pregnancy-related healthcare statistics with transparency in the data collection process while ensuring appropriate nondiscrimination and privacy safeguards." (Classification and Surveillance of Maternal Mortality H-420.948). As such, this proposed resolution is duplicative, and not urgent.</p>
236	<p>Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program Resolutions Committee composite score: 2.63 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: Resolution 236 is not urgent or a priority. The AMA has been very active in advocating on the AUC, most recently submitting comments for the proposed Physician Fee Schedule (PFS) asking for delayed implementation of the AUC. Per the final PFS Rule CMS (in line with what the AMA advocated for) delayed implementation of the payment penalty phase of the AUC program to being on the later of January 1, 2023, or the January 1 that follows the declared end of the PHE for COVID-19. This flexible effective date is intended to take into account the impact that the PHE for COVID-19 has had and may continue to have on practitioners, providers and beneficiaries. Previously, the payment penalty phase of the AUC program was set to begin January 1, 2022.</p>
302	<p>University Land Grant Status in Medical School Admissions Resolutions Committee composite score: 2.21 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 11 out of 54 Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November.</p>
307	<p>Support for Institutional Policies for Personal Days for Undergraduate Medical Students Resolutions Committee composite score: 1.84 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 41 out of 54</p>

	Background Information provided by AMA staff to RC: Not urgent. LCME standards hold that medical schools have policies and procedures in place that permit students to be excused from these experiences to seek needed care. It would be difficult to require a defined number of personal days per academic periods across schools, because schools have highly variable lengths of academic periods, courses, structures, etc. This issue may be more of a priority now as medical students, in particular those from marginalized groups, seek flexibility during COVID.
310	Resident and Fellow Access to Fertility Preservation Resolutions Committee composite score: 2.13 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 6 out of 22 Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November. AMA policy already supports education for those who may benefit from fertility preservation (H-425.967) and insurance coverage for fertility treatments (H-185.926, H-185.990), as well as support of medical and sick leave as listed below.
312	Accountable Organizations for Resident and Fellow Trainees Resolutions Committee composite score: 2.00 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 8 out of 22 Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November. The AMA has ample policy advocating for the rights and wellbeing of residents and fellows, and actively engages with key stakeholders, such as the ACGME, on their behalf. Policy H-310.943 encourages the ACGME and key stakeholders to address the problem of non-educational closing or downsizing of residency training programs and identify a process by which displaced residents and fellows, and for CMS to establish regulations that offer protections. The AMA's searchable residency and fellowship database, FREIDA™, contains information on more than 12,000 accredited programs; related information is shared through various communication channels.
403	Providing Reduced Parking Fees for Patients Resolutions Committee composite score: 2.12 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 46 out of 54 Background Information provided by AMA staff to RC: This resolution calls on the AMA to recognize parking fees as a burden of care for patients and to implement mechanisms for reducing parking costs. The AMA does not have existing policy on patient parking fees.
405	Formal Transitional Care Program for Children and Youth with Special Health Care Needs Resolutions Committee composite score: 2.57 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 48 out of 54 Background Information provided by AMA staff to RC: This resolution amends existing policy on children and youth with disabilities to also include children and youth with special health care needs, which is defined to include those whose health care needs are more complex and require specialized care for their physical, behavioral, or emotional development beyond that required by children generally.
406	Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer Resolutions Committee composite score: 2.17 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 22 out of 22 Background Information provided by AMA staff to RC: None
413	Universal Childcare and Preschool Resolutions Committee composite score: 2.64 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 3 out of 54 Background Information provided by AMA staff to RC: None
608	Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis Resolutions Committee composite score: 2.32 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 12 out of 22 Background Information provided by AMA staff to RC: None
609	Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Emergency Resolutions Committee composite score: 2.34 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 2 out of 2 Background Information provided by AMA staff to RC: AMA currently has myriad policies related to climate change and is actively engaged in advocacy activities related to the topic, including H-135.923 which supports initiatives to promote environmental sustainability and other efforts to halt global climate change and incorporating principles of environmental sustainability within its business operations and H-135.938 supports several components of climate change mitigation. Existing AMA policy also supports federal legislation and regulations that meaningfully reduce major power plant emissions: as well as efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

	<p>The AMA is addressing climate change, in part, through the Medical Society Consortium on Climate and Health. The consortium members support educating the public and policymakers in government and industry about the harmful human health effects of global climate change, and about the immediate and long-term health benefits associated with reducing greenhouse gas emissions (i.e., heat-trapping pollution) and taking other preventive and protective measures that contribute to sustainability. The consortium also supports actions by physicians and hospitals within their workplaces to adopt sustainable practices and reduce the carbon footprint of the health delivery system. In 2019, the AMA joined more than 70 health organization in signing a U.S. Call to Action on Climate, Health, and Equity: A Policy Action Agenda. The policy action agenda notes that climate change is one of the greatest threats to health America has ever faced—it is a true public health emergency. The health, safety and wellbeing of millions of people in the U.S. have already been harmed by human-caused climate change, and health risks in the future are dire without urgent action to fight climate change. We have called on government, business, and civil society leaders, elected officials, and candidates for office to recognize climate change as a health emergency and to work across government agencies and with communities and businesses to prioritize action on this Climate, Health and Equity Policy Action Agenda.</p> <p>In addition, the AMA is a part of the newly formed National Academy of Medicine Action Collaborative on Decarbonizing the U.S. Health Sector; Dr. Madara is on the steering committee for the group.</p>
613	<p>Due Process at our AMA Resolutions Committee composite score: 2.64 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: None</p>
617	<p>Together We are Stronger Marketing Campaign Resolutions Committee composite score: 1.87 (1 = not a priority at this time) Sponsor’s ranking of resolution among their submitted resolutions: 3 out of 3 Background Information provided by AMA staff to RC: None</p>
618	<p>Dissolution of the Resolution Committee Resolutions Committee composite score: 2.37 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 1 out of 22 Background Information provided by AMA staff to RC: None</p>
619	<p>Continuing Equity Education Resolutions Committee composite score: 2.69 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: None</p>
703	<p>Clear Statement Regarding the Use of CPT E/M Outpatient Visit Codes Resolutions Committee composite score: 2.08 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: Current policy satisfies the request in Resolution 703 and therefore should not be considered. Policy H-70.954 states that our AMA continues to seek endorsement of Current Procedural Terminology (CPT) as the national coding standard for physician services; in collaboration with state and specialty societies, will urge the Secretary of HHS and CMS and all other payers to adopt CPT as the single uniform coding standard for physician services in all practice settings; and will oppose the incorrect use of CPT by insurers and others, taking necessary actions to insure compliance with licensing agreements, which include provisions for termination of the agreement; will work with the American Academy of Pediatrics and other specialty societies to support state and federal legislation requiring insurers to follow the coding as defined in the Current Procedural Terminology Manual and interpreted by the CPT Assistant for all contracts in both the public and private sectors, as long as the CPT process is simple, user friendly, and does not undergo frequent changes; and seek legislation and/or regulation to ensure that all insurance companies and group payers recognize all published CPT codes including modifiers. Moreover, a high fiscal note is anticipated to correspond to Resolution 703 and does not appear to be a prudent use of limited AMA resources.</p>

Your Resolutions Committee presents its Second Report on the prioritization of resolutions. The Committee’s purpose, as delineated in the [Prioritization Process](#), is to implement the bylaws requirement that Special Meeting business comport with the reason for the call to the meeting, which was to “conduct priority business of the Association.”

The Committee wishes to state clearly that items not meeting the priority threshold should not be labelled or considered unimportant or irrelevant. The Committee noted that many resolutions on what might be considered priority issues were already adequately covered by existing AMA policy. Resolutions that reaffirmed or made minor additions to current policy were generally scored lower than those which introduced new policy or proposed substantive change to policy. In other cases, the requested activity may be underway or ongoing or may include a request for study of a topic for future directives.

This Second Report of the Resolutions Committee lists resolutions in two groups: those considered to have met the threshold of priority for this Special Meeting and those thought not to have met the priority threshold. The Committee has recommended for consideration ALL resolutions for which the Committee's composite score exceeded 2.72, which means a number of resolutions scoring lower than 3 or "medium priority" were included in those accepted for consideration at this meeting. While any cut point is arbitrary, this figure is consistent with our earlier Special Meetings and yields 39 resolutions. That volume is also consistent with our prior Special Meetings:

- November 2020 - 44 reports and 36 resolutions (out of 99 submitted)
- June 2021 - 51 reports and 64 resolutions (out of 150 submitted)

For the current meeting, 166 resolutions were considered by the Committee, including two since withdrawn. Forty-five reports will also be presented.

Any resolution from the second group, those not meeting the priority threshold, may be extracted for consideration by the House of Delegates, which will determine, by majority vote, those items that will be considered as business. There is no need to extract items that have been listed by the Committee as meeting the priority threshold, as they will be considered during the meeting.

Any delegate may extract an item by sending an email to HOD@ama-assn.org with a request for extraction. The email should specify the resolution number and title (to avoid any confusion) and may include an extraction statement of up to 150 words noting why the item should be considered a priority item at the Special Meeting. **Requests for extraction must be received no later than midnight, Central Standard Time, Wednesday, November 10 (ie, Wednesday evening).** No extractions will be accepted after that deadline, and no extractions will be accepted by any other method. Informational reports may also be extracted by the same deadline.

The Final Report from the Committee will be issued Thursday, November 11 and list resolutions in three groups:

- items recommended for consideration,
- items that have not met the priority threshold and have not been extracted, and
- extracted items, which will be presented to the House for a decision regarding their consideration.

The Final Report will be handled as a consent calendar on Friday evening, November 12, during the Opening Session. Each extracted item will be put to a vote to either sustain the recommendation of the Resolutions Committee or to overrule its recommendation, without further debate. Additional comments, pro and con, regarding the priority may be posted in the Online Forum. The House by majority vote will decide which items become the business of the HOD.

RESOLUTIONS MEETING THE PRIORITY THRESHOLD

1. 002 - Disaggregation of Race Data for Individuals of Middle Eastern and North African (MENA) Descent
2. 008 - Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954
3. 009 - Banning the Practice of Virginity Testing
4. 018 - Support for Safe and Equitable Access to Voting
5. 019 - Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent
6. 020 - Recognizing and Remediating "Structural Urbanism" Bias as a Factor in Rural Health Disparities
7. 021 - Free Speech and Civil Discourse in the American Medical Association
8. 022 - Prohibition of Racist Characterization Based on Personal Attributes
9. 023 - AMA Council on Ethical and Judicial Affairs Report on Physician Responsibilities to Impaired Colleagues: CEJA E-9.3.2
10. 025 - Ransomware Prevention and Recovery
11. 101 - Standardized Coding for Telehealth Services
12. 113 - Supporting Medicare Drug Price Negotiation
13. 203 - Poverty-Level Wages and Health
14. 207 - Authority to Grant Vaccine Exemptions
15. 209 - Increasing Access to Hygiene and Menstrual Products
16. 212 - Sequestration
17. 221 - Promoting Sustainability in Medicare Physician Payments
18. 224 - Improve Physician Payments
19. 225 - End Budget Neutrality
20. 226 - Addressing Adolescent Telehealth Confidentiality Concerns
21. 229 - CMS Administrative Requirements
22. 234 - Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients
23. 301 - Equitable Reporting of USMLE Step 1 Scores
24. 305 - Increase Awareness Among Residency, Fellowship, and Academic Programs on the United States-Puerto Rico Relationship Status

25. 309 - Protecting Medical Student Access to Abortion Education and Training
26. 408 - Ensuring Affordability and Equity in COVID-19 Vaccine Boosters
27. 410 - Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers
28. 411 - Addressing Public Health Disinformation
29. 412 - Health Professional Disinformation During a Public Health Crisis
30. 414 - Advocacy on the US Department of Education's Spring 2022 Title IX Rules on Sexual Harassment and Assault in Education Programs
31. 502 - Advocating for Heat Exposure Protections for Outdoor Workers
32. 505 - Representation of Dermatological Pathologies in Varying Skin Tones
33. 506 - Enhancing Harm Reduction for People Who Use Drugs
34. 601 - "Virtual Water Cooler" for our AMA
35. 605 - Formalization of the Resolution Committee as a Standing Committee of the American Medical Association House of Delegates
36. 606 - Increasing the Effectiveness of Online Reference Committee Testimony
37. 614 - Insurance Industry Behaviors
38. 615 - Employed Physicians
39. 701 - Coverage of Pregnancy-Associated Healthcare for 12 Months Postpartum for Uninsured Patients who are Ineligible for Medicaid

RECOMMENDED AGAINST CONSIDERATION

For each resolution, the Resolutions Committee's composite score is provided along with the sponsor's rank. Also included are comments provided to the Committee by reference committee staff. The sponsor's corresponding comments on the item's priority appear with the resolution in the handbook, addendum, or Friday tote. They are not duplicated here for reasons of space.

004	<p>Guidelines on Chaperones for Sensitive Exams Resolutions Committee composite score: 2.02 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 54 out of 54 Background Information provided by AMA staff to RC: This resolution asks for the Council on Ethical and Judicial Affairs to amend E-1.2.4, "Use of Chaperones," first by addressing opting out of using chaperones for sensitive exams, which is covered by current language in that opinion. The opinion does not state that chaperones must be used, but that physicians should adopt a policy that patients are free to request a chaperone, that the policy is communicated to patients, and to always honor a patient's request for a chaperone. This language sufficiently and clearly allows for a patient to opt in or out of using a chaperone. The other points the resolution asks CEJA to consider are documentation of the use (or not-use) of a chaperone, chaperones for patients without capacity, and to ask the patient if there is a gender preference for the chaperone, where possible. Because it is unclear why near-term action on this topic is needed, this item does not meet the urgency/priority standard of the Special Meeting.</p>
006	<p>Evaluating Scientific Journal Articles for Racial and Ethnic Bias Resolutions Committee composite score: 2.43 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 14 out of 54 Background Information provided by AMA staff to RC: None</p>
007	<p>Exclusion of Race and Ethnicity in the First Sentence of Case Reports Resolutions Committee composite score: 2.22 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 15 out of 54 Background Information provided by AMA staff to RC: None</p>
010	<p>Improving the Health and Safety of Sex Workers Resolutions Committee composite score: 1.76 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 28 out of 54 Background Information provided by AMA staff to RC: Existing policy H-515.958, "Promoting Compassionate Care and Alternatives for Individuals Who Exchange Sex for Money or Goods," states, in part, that "Our American Medical Association also supports legislation for programs that provide alternatives and resources for individuals who exchange sex for money or goods, and offer alternatives for those arrested on related charges rather than penalize them through criminal conviction and incarceration." Because the AMA already has policy supporting alternatives to criminal conviction and incarceration of sex workers, this resolution is not urgent and could be considered at the next in-person meeting.</p>
011	<p>Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions Resolutions Committee composite score: 1.53 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 29 out of 54 Background Information provided by AMA staff to RC: This resolution fails to make the argument as to how (2) in H-185.990 (the policy they propose to amend) does not address their concerns that infertility caused by gender-affirming interventions are not covered in AMA's existing efforts. It reads, "Our AMA supports payment for fertility preservation therapy service by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical</p>

	<p>treatments as determined by a licensed physician and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.”</p> <p>The amendments to H-185.950 contained in the second resolve don’t substantively change the meaning of the existing policy.</p> <p>Because existing policy sufficiently covers the concerns addressed in the resolution, this resolution is not urgent.</p>
012	<p>Increased Recognition and Treatment of Eating Disorders in Minority Populations</p> <p>Resolutions Committee composite score: 2.48 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 30 out of 54</p> <p>Background Information provided by AMA staff to RC: This resolution is in line with current policy on culturally sensitive care (H-295.897, “Enhancing the Cultural Competence of Physicians” and D-440.978, “Culturally Responsive Dietary and Nutritional Guidelines”).</p>
013	<p>Equal Access to Adoption for the LGBTQ Community</p> <p>Resolutions Committee composite score: 2.57 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 32 out of 54</p> <p>Background Information provided by AMA staff to RC: None</p>
014	<p>Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis for HIV</p> <p>Resolutions Committee composite score: 2.22 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 40 out of 54</p> <p>Background Information provided by AMA staff to RC: None</p>
015	<p>Using X-Ray and Dental Records for Assessing Immigrant Age</p> <p>Resolutions Committee composite score: 1.79 (1 = not a priority at this time)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 43 out of 54</p> <p>Background Information provided by AMA staff to RC: None</p>
016	<p>Student-Centered Approaches for Reforming School Disciplinary Policies</p> <p>Resolutions Committee composite score: 2.29 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 44 out of 54</p> <p>Background Information provided by AMA staff to RC: None</p>
017	<p>Gender Equity and Female Physician Work Patterns During the Epidemic</p> <p>Resolutions Committee composite score: 2.44 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 1 out of 2</p> <p>Background Information provided by AMA staff to RC: The resolves in this resolution are currently covered by the current scope of research efforts currently underway by the Physician Satisfaction & Practice Sustainability (PS2) group. Accepting this resolution as business would duplicate those efforts.</p>
024	<p>Organ Transplant Equity for Persons with Disabilities</p> <p>Resolutions Committee composite score: 2.40 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 4 out of 7</p> <p>Background Information provided by AMA staff to RC: None</p>
025	<p>Opposition to Discriminatory Treatment of Haitian Asylum Seekers</p> <p>Resolutions Committee composite score: 1.66 (1 = not a priority at this time)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 17 out of 17</p> <p>Background Information provided by AMA staff to RC: NY 17 Opposition to Discriminatory Treatment of Haitian Asylum Seekers is neither urgent nor a priority. Firstly, the AMA has already sent a letter urging the U.S. Department of Homeland Security (DHS) to ensure the health and well-being of all individuals and their families seeking asylum in the United States, including the Haitian refugees currently at the U.S. southern border. Additionally, the immigration policies currently in place are not discriminatory towards Haitians. Due to a culmination of environmental and political issues thousands of Haitian refugees (beyond the normal inflow) have gathered at the Southern border. This unfortunately, is not exclusive to Haitians. Many countries have experienced recent natural disasters that have pushed immigrants to the border making this one of the largest years ever for attempted migration. Due to Title 42 restrictions put in place due to COVID many individuals have been turned away without due process (due to the PHE). This is happening to all asylum seekers right now and will end as soon as the PHE does. Moreover, this summer, the Administration granted Temporary Protected Status to Haitians who were already in the United States illegally, citing the current situation in Haiti; the status however does not apply to migrants currently seeking entrance to the US.</p> <p>See: https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-9-23-Letter-to-Mayorkas-re-Haitian-Asylum-Health-v2.pdf</p>
103	<p>Oral Healthcare Is Healthcare</p> <p>Resolutions Committee composite score: 2.32 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 2 out of 4</p> <p>Background Information provided by AMA staff to RC: Resolution 103 is addressed by current AMA policy, and by the Council on Medical Service in 2019 (Council Report 3-A-19). Policy D-160.925 recognizes the importance of</p>

	managing oral health and access to dental care as a part of optimal patient care. Policy H-330.872 supports continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.
104	<p>Improving Access to Vaccinations for Patients</p> <p>Resolutions Committee composite score: 2.50 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 1 out of 2</p> <p>Background Information provided by AMA staff to RC: This resolution is addressed by current AMA policy, and by the Council on Medical Service in 2020 (Council Report 3-N-20). Policy H-440.860 supports easing federally imposed immunization burdens by, for example, covering all vaccines in Medicare under Part B and simplifying the reimbursement process to eliminate payment-related barriers to immunization; and urges the Centers for Medicare & Medicaid Services (CMS) to raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations. Policy D-440.981 supports adequate reimbursement for vaccines and their administration from all public and private payers; encourages health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; and advocates that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care. Policy H-440.875 states that our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the Advisory Committee on Immunization Practices, the US Preventive Services Task Force, or based on prevailing preventive clinical health guidelines.</p>
105	<p>Fertility Preservation Insurance Coverage for Women in Medicine</p> <p>Resolutions Committee composite score: 2.13 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 2 out of 2</p> <p>Background Information provided by AMA staff to RC: Resolution 105 is not a priority resolution, as it is addressed by current AMA policy. Policy H-185.990 directs the AMA to encourage insurers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility. This policy further advocates for payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused by medical treatments.</p>
106	<p>Reimbursement of School-Based Health Centers</p> <p>Resolutions Committee composite score: 2.09 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 33 out of 54</p> <p>Background Information provided by AMA staff to RC: The AMA has strong policy on increasing health coverage for children and adolescents (Policy H-165.877) and working with community groups and schools to transform schools into health-enhancing institutions (Policy H-60.981). Existing policy (Policy H-60.921) specifically supports school-based health centers. Because current policy exists on this topic, and only a small subgroup of physicians (if any) would be impacted, this resolution does not meet the urgency/priority standard of the Special Meeting.</p>
107	<p>Expanding Medicaid Transportation to Include Healthy Grocery Destinations</p> <p>Resolutions Committee composite score: 1.72 (1 = not a priority at this time)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 34 out of 54</p> <p>Background Information provided by AMA staff to RC: This is addressed by current AMA policy, and by the Council on Medical Service in 2020 (Council Report 7-N-20). Policy H-165.822 supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs.</p>
108	<p>Medicaid and CHIP Coverage of Glucose Monitoring Devices for Patients with Diabetes</p> <p>Resolutions Committee composite score: 2.29 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 35 out of 54</p> <p>Background Information provided by AMA staff to RC: States have flexibility in determining which benefits are covered under Medicaid; they are not required by federal rules to provide continuous glucose monitors as a state Medicaid benefit. Policy H-120.990 supports the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with the AMA's ethical guidelines. A decision by the HOD on whether the AMA should expand Policy H-330.885 to include Medicaid and CHIP coverage is not urgent and could be considered at the next in-person meeting.</p>
109	<p>Amending D-440.985, "Health Care Payment for Undocumented Persons," to Study Methods to Increase Health Care Access for Undocumented Immigrants</p> <p>Resolutions Committee composite score: 2.53 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 36 out of 54</p> <p>Background Information provided by AMA staff to RC: None</p>
111	<p>Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System</p> <p>Resolutions Committee composite score: 1.67 (1 = not a priority at this time)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 38 out of 54</p>

	<p>Background Information provided by AMA staff to RC: Existing AMA policy (Policy H-60.910) advocates for health care for youth in foster care. Furthermore, legislation enacted in 2018 (Public Law 115-271) included a provision that makes Medicaid to 26 available to all former foster youth. Because it is unclear why near-term action on this topic is needed, and few physicians would be impacted, this item does not meet the urgency/priority standard of the Special Meeting.</p>
114	<p>Medicare and Private Health Insurance for Hearing Aids Resolutions Committee composite score: 2.27 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: Resolution 114 is not a priority resolution, as it is addressed by current AMA policy and was studied by the Council on Medical Service in 2015 (Council Report 6-I-15). Policy H-185.929 supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences. Notably, coverage of and access to hearing aids was deliberated by the House of Delegates most recently at the 2019 Annual Meeting when additional policy was adopted. Furthermore, the FDA recently ruled that hearing aids can be made available OTC.</p>
115	<p>Bundled Payments and Medically Necessary Care Resolutions Committee composite score: 2.40 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 3 out of 3 Background Information provided by AMA staff to RC: The resolution does not meet the priority standard of the Special Meeting, as it asks for a non-urgent study, as opposed to immediate action, and can wait to be considered at the next in-person meeting. Additionally, the topic of the requested study is already addressed by numerous AMA policies. Policies D-70.983, H-70.980, H-70.962 and H-70.949 address, oppose, or call for action on inappropriate bundling of medical services. Policy H-390.849 opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.</p>
116	<p>Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance Resolutions Committee composite score: 2.17 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 11 out of 22 Background Information provided by AMA staff to RC: Resolution 116 is not a priority resolution, as it is a reaffirmation of current policy with little to no change. AMA policy has long recognized the importance of providing avenues for affordable health insurance coverage to patients who do not have employer-sponsored health insurance, or for whom employer-sponsored health insurance does not meet their needs. Based principally on recommendations developed by the Council on Medical Service, beginning in 1998, the AMA proposal for covering the uninsured and expanding choice advocates for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes will receive the largest credits (Policies H-165.920 and H-165.865). Policy H-165.920 also supports and advocates a system where individually purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it. Policy H-165.824 states that premium tax credits would be available to individuals <u>without an offer of "affordable" employer coverage</u>, with no upper income limit. Policy H-165.828 states that individuals currently caught in the "family glitch" and <u>unable to afford coverage offered through their employers for their families</u> would become eligible for ACA financial assistance based on the premium for family coverage of their employer plan. Policy H-165.828 also states that, to help employees currently having difficulties affording coverage, the threshold used to determine the affordability of employer coverage would be lowered, which would make more people eligible for ACA financial assistance based on income. For more details on AMA's plan to cover the uninsured and expand choice, please go to https://www.ama-assn.org/system/files/2021-01/2021-ama-plan-to-cover-uninsured.pdf.</p>
117	<p>Implant-Associated Anaplastic Large Cell Lymphoma Resolutions Committee composite score: 1.57 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 20 out of 22 Background Information provided by AMA staff to RC: Resolution 117 is not a priority resolution, as it is a reaffirmation of current policy with little to no change. Policy H-55.973 recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments.</p>
118	<p>Expanding Site-of-Service Neutrality Resolutions Committee composite score: 2.22 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 5 out of 9 Background Information provided by AMA staff to RC: Resolution 118 is not a priority resolution as it is already addressed by numerous AMA policies and has been studied several times by the Council on Medical Service (Council Report 4-I-18, Council Report 3-A-14, and Council Report 3-A-13). Among other policies, the site-of-service differential is addressed by Policies H-330.925, D-330.997, H-400.957, and H-240.979. Policy D-330.902 supports Medicare payment policies for outpatient services that are site-neutral without lowering total Medicare payments (RESOLVE 1). This policy further supports Medicare payments for the same service routinely provided in multiple outpatient settings that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting (RESOLVE 2). Policy D-240.994 advocates that third party payers be required to assess equal or lower</p>

	facility coinsurance for lower-cost sites of service and allow their plan's participating physicians to perform outpatient procedures at an appropriate site of service as chosen by the physician and the patient (RESOLVE 3).
119	<p>Bundling Physician Fees with Hospital Fees Resolutions Committee composite score: 2.18 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 10 out of 17 Background Information provided by AMA staff to RC: Several AMA policies address payment reforms and bundled payments, including Policies D-390.961, H-165.837 and D-385.963. The resolution's intent is explicitly addressed by Policy D-390.961[6], which directs the AMA to work to ensure that bundled payments do not lead to hospital-controlled payments to physicians.</p>
120	<p>COBRA for College Students Resolutions Committee composite score: 1.87 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 14 out of 17 Background Information provided by AMA staff to RC: Graduating college students already have access to four avenues for accessing health insurance coverage, making the asks of the resolution neither urgent nor of a high priority. First, they can stay on their parents' health plan up to age 26 (supported by Policy H-180.964); they can qualify for premium tax credits to purchase coverage on ACA marketplaces (supported by numerous AMA policies); they can secure coverage through new employment; or they can qualify for Medicaid based on their income and state of residence.</p>
121	<p>Medicaid Tax Benefits Resolutions Committee composite score: 2.16 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 13 out of 17 Background Information provided by AMA staff to RC: Resolution 121 is addressed by current AMA policy. Policy H-290.982 supports innovative methods of increasing physician participation in the Medicaid program, such as plans for deferred compensation for Medicaid providers that would allow physicians to tax defer a specified percentage of their Medicaid income. Policies H-160.969 and H-180.965 state that the AMA will not seek special tax deductions for providing medical care as requested by Resolution 121.</p>
123	<p>Support for Easy Enrollment Federal Legislation Resolutions Committee composite score: 2.05 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: This resolution is not a priority resolution, as the action called for in this resolution is important but current policy on the issue is adequate. A 2020 report of the Council on Medical Service addressed and established new policy on facilitated and automatic enrollment in health insurance coverage. The resulting policy, Policy H-165.823, states that our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards: (a) Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations. (b) Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage. (c) Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled. (d) Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment. (e) Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values. (f) Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees. (g) Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans. (h) There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.</p>
124	<p>Medicare Coverage of Dental, Vision, and Hearing Services Resolutions Committee composite score: 2.20 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 2 out of 22 Background Information provided by AMA staff to RC: This is not a priority resolution as it is already addressed by numerous AMA policies and has been the subject of two recent Council on Medical Service reports.</p> <ul style="list-style-type: none"> Dental: A 2019 report of the Council on Medical Service addressed the issue of Medicare coverage of dental services. Policy D-160.925 recognizes the importance of managing oral health and access to dental care as a part of optimal patient care. Policy H-330.872 supports continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

	<ul style="list-style-type: none"> • Vision: Policy D-185.978 supports insurance coverage for and increased access to low vision aids for patients with visual disabilities. Policy H-25.990 encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients. • Hearing: Policy H-185.929 supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences and encourages health plans to offer optional riders that allow members to add hearing benefits to existing policies. Notably, coverage of and access to hearing aids was deliberated by the House of Delegates most recently at the 2019 Annual Meeting when additional policy was adopted. Furthermore, the FDA recently ruled that hearing aids can be made available OTC for mild to moderate hearing loss, and the Build Back Better Act, if enacted into law, would provide coverage for hearing aids for Medicare enrollees with certain degrees of hearing loss. Hearing aid coverage was the topic of Council on Medical Service Report 6-I-15.
204	<p>Supporting Collection of Data on Medical Repatriation Resolutions Committee composite score: 1.97 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 13 out of 54 Background Information provided by AMA staff to RC: This resolution asks the AMA to oppose the act of forced medical repatriation defined as "the transfer of undocumented patients in need of chronic care to their country of origin" as well as request data from HHS on the prevalence and impact of this practice. It is unclear how widespread this issue of medical repatriation actually is, however, it is not an urgent matter at this time. With the government continuing to enact Title 42 (the law that allows the government to turn away immigrants without any sort of due process/in most cases no hearing) there is likely very little or no medical repatriation happening during this time because we are failing to allow individuals into the country, and the ones that we do allow in, we place in the asylum process or they go through the professional visa process meaning that medical repatriation will not impact them. There are many time-sensitive immigration issues that currently exist but medical repatriation does not rise to that level.</p>
206	<p>Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises Resolutions Committee composite score: 2.12 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 22 out of 54 Background Information provided by AMA staff to RC: Rules, Legislation, and Health Disparities to Better Address National Crises Resolution T18 is not urgent or a priority. This resolution looks to prioritize the needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic and opposes policies that would force immigrants to choose between health care or future lawful residency status. The AMA already does this advocacy with existing policy. We currently actively oppose the public charge rule, which would force immigrants to choose between health care or future lawful residency status. We are in the process of drafting a letter on the public charge right now and have filed amicus briefs and other advocacy material on this topic in the past. We also support alternatives to detention and support the extension/reauthorization of visas. Below are just a few examples of our work in this area.</p> <p>AMA Policy: Care of Women and Children in Family Immigration Detention H-350.955 Impact of Immigration Barriers on the Nation's Health D-255.980 Visa Complications for IMGs in GME D-255.991 Health, In All Its Dimensions, Is a Basic Right H-65.960 Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927</p> <p>Asylum letters: 2021-7-15-Letter-to-Mayorkas-and-Miller-re-Preferential-Use-of-Alternatives-to-Detention 2021-4-9-Letter-to-Mayorkas-Garland-and-Johnson-re-National-Security-and-Contagious-Disease-Immigration 2020-8-5-Letter-to-Wolf-Albence-Barr-re-National-Security-and-Contagious-Disease-Immigration 2020-7-14-Letter-to-Wolf-and-Albence-re-Asylum-Rule</p> <p>Visa letters: 2020-3-24-AMA-Letter-to-USCIS-re-COVID 2020-3-24-AMA-Letter-to-DoS-and-DHS-re-COVID-19 2020-4-14-Letter-Cuccinelli-USCIS Re-COVID-19-and-H-1Bs 2020-5-4-Letter-to-Pence-re-Presidential-Proclamation-Non-Immigrants 2020-6-26-Letter-to-Wolf-and-Pompeo-re-Presidential-EO-Entry-Ban 2020-7-8-AMA-Sign-On-Letter-re-H-1B-IMG</p>
210	<p>Advocating for the Amendment of Chronic Nuisance Ordinances Resolutions Committee composite score: 1.31 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 45 out of 54 Background Information provided by AMA staff to RC: This resolution asks for the AMA to advocate for changes to municipal-level nuisance and property ordinances. There are nearly 20,000 municipalities in the US. AMA Advocacy focuses on state and federal issues and has neither expertise in the complexity of local nuisance and property ordinances nor or the bandwidth to advocate at the municipal level.</p>

211	<p>Support for Mental Health Courts Resolutions Committee composite score: 1.78 (1 = not a priority at this time) Sponsor’s ranking of resolution among their submitted resolutions: 50 out of 54 Background Information provided by AMA staff to RC: Support for Mental Health Courts is not urgent or a priority. The AMA already has broader policy on mental health treatment rather than incarceration, including H-345.975, which supports “state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations.” AMA policy D-95.962 also predicates support for funding for drug courts on “evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder.” And Support for Justice Reinvestment Initiatives, H-95.931, supports “screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.” AMA also has excellent Ethics guidance for treatment of those with a mental illness and those who may lack capacity. Taken together, current policy more than addresses the substance and intent of the proposed MSS resolution.</p> <p>In addition, using “mental health courts” as the umbrella term could create conflicts in AMA policy as states have different names for different courts. The above discussion, moreover, emphasizes treatment, not “sobriety.” Thus, even if the MSS resolution moves forward, it would need significant amendment to align with AMA policy. In sum, it is not a priority to move forward with a resolution that would conflict with current AMA policy as well as one that is already covered in greater depth by current AMA policy.</p>
213	<p>Eliminating Unfunded or Unproven Mandates and Regulations Resolutions Committee composite score: 2.70 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 1 out of 3 Background Information provided by AMA staff to RC: Eliminating Unfunded or Unproven Mandates and Regulations is not urgent or a priority. It is unclear what technology or practice guidelines the resolution is referring to, but the AMA is not aware of CMS mandating the use of augmented intelligence in imaging studies.</p>
214	<p>Stakeholder Engagement in Medicare Administrative Contractor Policy Resolutions Committee composite score: 2.47 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 1 out of 2 Background Information provided by AMA staff to RC: Stakeholder Engagement in Medicare Administrative Contractor Policy is not of urgency/priority. While the resolution as written is well intended and promotes fair and equitable payment policy, as indicated in the resolution, the AMA already has strong policy on point in support of robust MAC processes for transparency and stakeholder engagement, including engagement of CACs, in reviewing Local Coverage Determinations (LCDs), and in support of local Medicare CACs in their role as policy advisers. As such, the AMA is actively working on addressing inadequate and inappropriate payor policies that were not informed by proper data and will work with stakeholders to address LCAs that it identifies as potentially restricting coverage or access to care.</p>
215	<p>Pharmacy Benefit Manager Reform as a State Legislative Priority Resolutions Committee composite score: 2.56 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 2 out of 2 Background Information provided by AMA staff to RC: Resolution 215 is not a priority or urgent given existing policy and ongoing AMA work. D-110.987 already highlights the importance of the AMA addressing PBM issues and directs the AMA to develop model legislation on state regulation of PBMs. The AMA has developed model legislation addressing several types of PBM activities (utilization management requirements, gag clauses, clawbacks, price transparency, co-pay accumulators, etc.) and have engaged with national policy making organizations (e.g. NAIC, NCOIL) in national-level policy conversations and in the development of model legislation. Up until early year, legal challenges by the Pharmaceutical Care Management Association to state laws regulating PBMs put into question the scope and reach of such state laws, but the Supreme Court’s decision in <i>Rutledge v. PCMA</i> appears to have broadened the ability of states to address PBM activity via regulation. The NAIC is in the process of developing additional resources to reflect this SCOTUS decision, and AMA staff is beginning the process of developing additional model legislation on PBM issues not yet addressed with AMA model bills and to better reflect the expanded authority of states. Additionally, the AMA continues to work with stakeholders to develop national standards for point-of-care drug pricing information and other drug pricing transparency priorities, as well as advocate for broad prior authorization and step-therapy reforms in private and public insurance. See fixpriorauth.org for additional resources.</p> <p>Existing policy: The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987</p> <ol style="list-style-type: none"> 1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. 3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.

	<p>4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.</p> <p>5. Our AMA supports improved transparency of PBM operations, including disclosing:</p> <ul style="list-style-type: none"> - Utilization information; - Rebate and discount information; - Financial incentive information; - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee’s formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy; - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records; - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and - Percentage of sole source contracts awarded annually. <p>6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.</p>
216	<p>Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers Resolutions Committee composite score: 2.48 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 10 out of 22 Background Information provided by AMA staff to RC: Resolution 216 should not be considered urgent or priority as our AMA has extensive policy on these issues, including AMA Principles for Physician Employment H.225.950, Coerced Employment of Physicians H-160.927, Physician and Medical Staff Member Bill of Rights H-225.942, Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950, Models / Guidelines for Medical Health Care Teams H-160.906, Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987, Physician Assistants H-35.989, Physician Assistants and Nurse Practitioners H-160.947, Status and Utilization of New or Expanding Health Professionals in Hospitals H-35.996, Regulation of Physician Assistants H-35.965. This policy covers both the employment and scope of practice concerns raised in Resolution 7. Moreover, as noted above, AMA has extensive longstanding policy supporting and advocating for physician supervision of non-physicians. Adopting policy that simultaneously places limits on physician supervision, seems at odds with this policy and could be used by non-physicians to support independent practice.</p>
217	<p>Studying Physician Supervision of Allied Health Professionals Outside of their Fields of Graduate Medical Education Resolutions Committee composite score: 2.02 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 14 out of 22 Background Information provided by AMA staff to RC: Resolution 217 should not be considered urgent or priority and should be reaffirmed based on existing policy. The issue of physicians supervising non-physicians “in fields which are not a core part of those physicians’ completed residencies and fellowships” is adequately addressed by existing AMA policy requiring “appropriate physician supervision” of non-physicians: Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio H-35.969, Scopes of Practice of Physician Extenders H-35.973, and Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978. Resolution 207 is also not a priority for this meeting as the data sought for the resolution is likely not available or would be extremely expensive to collect. Moreover, there are instances where it is appropriate for a physician to supervise a non-physician outside the physicians’ specialty. Findings from a study as proposed in this resolution would speak more to how physicians view their supervisory role over non-physicians as opposed to how non-physicians are practicing and could be counter-productive to our ongoing advocacy on scope of practice. Of note, this resolution was determined not a priority at J-21.</p>
218	<p>Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care Resolutions Committee composite score: 2.71 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 15 out of 22 Background Information provided by AMA staff to RC: The authors state, “This policy is lower priority.”</p>
219	<p>The Impact of Midlevel Providers on Medical Education Resolutions Committee composite score: 1.87 (1 = not a priority at this time) Sponsor’s ranking of resolution among their submitted resolutions: 1 out of 22 Background Information provided by AMA staff to RC: Resolution 219 should not be considered urgent or priority. Our AMA has extensive resources on the differences in the education and training of physicians and non-physicians, including the ability of non-physicians (nurse practitioners and physician assistants) to practice in specialties outside their certification. This information is integral to and utilized extensively in our advocacy to oppose inappropriate scope expansions of nurse practitioners and physician assistants. The AMA is also currently working with a coalition of state medical and specialty societies to address issues related to post-graduate education of non-physicians. In addition, the data sought in these recommendations is likely not available or would be extremely expensive to collect and such findings may not result in actionable conclusions.</p>

220	<p>Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use Resolutions Committee composite score: 1.70 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 21 out of 22 Background Information provided by AMA staff to RC: Given the limited calendar of the Special Meeting, and the lack of congressional or regulatory activity on this issue, it does not appear to be urgent.</p>
222	<p>Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act Resolutions Committee composite score: 2.28 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 2 out of 9 Background Information provided by AMA staff to RC: Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act is neither urgent nor a priority. The AMA already opposes the Ninth Amendment to the PREP Act (as we have opposed the other amendments that have occurred over the course of the pandemic) this includes through releasing statements of opposition to the PREP Act amendments and a request to rescind the amendments (see link below). In addition, we already oppose expansion under the declaration of the scope of authority for state-licensed pharmacists to order and administer, and certain pharmacy technicians and pharmacy interns to administer, COVID-19 therapeutics subcutaneously, intramuscularly, or orally. We also oppose any preemption of state scope of practice law including the PREP Act amendments. The AMA consistently advocates for legislation that prevents the federal government from preempting state scope of licensure laws. Additionally, we already have policy on point which would make this policy mostly redundant.</p>
223	<p>Paying Physicians for Services According to the Physician Fee Schedule Resolutions Committee composite score: 2.59 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 4 out of 9 Background Information provided by AMA staff to RC: Although this resolution is well intended given the current COVID-19 PHE, the AMA already has strong and clear policy including COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963 which asks for the continued advocacy efforts for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams during and post pandemic. In addition, CMS has passed strong rulemaking that expands telehealth until at least the end of the pandemic which is expected to last until well into 2022. As such, the AMA has current policy specifically on point and thus, this resolution is already actively being worked on and should not be considered.</p>
227	<p>Medication for Opioid Use Disorder in Physician Health Programs Resolutions Committee composite score: 2.14 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 3 out of 4 Background Information provided by AMA staff to RC: Medication for Opioid Use Disorder in Physician Health Programs is not urgent or a priority. This resolution raises the urgent issue to help physicians who may have a need for medical and other assistance regarding treatment for a substance use disorder, mental illness, burnout or wellness. However, the AMA is already working with the FSPHP and other stakeholders on all of the issues in the resolved clauses, including physician health programs, safe-haven policies, wellness programs, and the need for confidentiality protections. All of the AMA's current efforts are supported by current policy, making the actual resolution non-urgent. As such, the adoption of this policy would be redundant and thus is not urgent or a priority.</p>
228	<p>Resentencing for Individuals Convicted of Marijuana-Based Offenses Resolutions Committee composite score: 1.56 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 4 out of 4 Background Information provided by AMA staff to RC: This resolution is not urgent or a priority for multiple reasons, including:</p> <ul style="list-style-type: none"> • This would be redundant to a report that is due at A-22 on this issue; • The complicated issues raised by the resolution are the same as will be discussed in the report due at A-22, including studying the legal and public health effects of state laws allowing for expungement of criminal records related to cannabis; that is—there is a very strong likelihood this resolution would get referred.
230	<p>Medicare Advantage Plan Mandates Resolutions Committee composite score: 2.21 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 9 out of 17 Background Information provided by AMA staff to RC: Resolution 230 Medicare Advantage Plan Mandates is neither urgent nor a priority. This resolution was brought for a very limited purpose (certain New York retirees are being required to change their health insurance or pay more for their plan due to city finances). Additionally, we already have a policy directly on point, and as such this resolution is not needed.</p> <p>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.</p>

231	<p>Prohibit Ghost Guns</p> <p>Resolutions Committee composite score: 1.60 (1 = not a priority at this time)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 16 out of 17</p> <p>Background Information provided by AMA staff to RC: Resolution 231 Although the resolve uses the word weapons, this resolution is specific to “ghost guns” i.e., homemade firearms. The AMA already has strong and clear policy including Firearm Availability H-145.996, which would apply to all firearm purchasers and registration. As such, the AMA has current policy specifically on point and thus, this resolution is already actively being worked on. On August 19, 2021, the AMA submitted comments supporting the proposed rulemaking issued by the Bureau of Alcohol, Tobacco, Firearms, and Explosives in the Department of Justice that would specifically regulate ghost guns. This resolution is a re-submission (June 2021 Res. 202; November 2020 Res. 210). In June, the Resolution Committee determined it did not meet the priority threshold. It was extracted, but the House of Delegates voted to sustain the recommendation of the Resolution Committee. This resolution is still not urgent.</p>
232	<p>Ban the Gay/Trans (LGBTQ+) Panic Defense</p> <p>Resolutions Committee composite score: 2.00 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 3 out of 17</p> <p>Background Information provided by AMA staff to RC: Resolution 232, Ban the Gay/Trans (LGBTQ+) Panic Defense is a re-submission (June 2021 Res. 203). In June, the Resolution Committee determined it did not meet the priority threshold with a score of 1.87. It was extracted, but the House of Delegates voted to sustain the recommendation of the Resolution Committee.</p> <p>We continue to think that this resolution is not urgent or a priority. No state recognizes the so-called “gay and trans panic defense” an affirmative defense. A 2020 study found the defense was a strategy employed in 104 cases across 35 states over the past 50 years and the defense was used successfully to reduce charges for defendants about one-third of the time. In addition, the UCLA Williams Institute, a well-respected research organization focused on LGBTQ+ rights, has developed model legislation barring its use and other advocacy resources for use by other stakeholders. While violence and discrimination against LGBTQ+ individuals is a pressing concern to the AMA, the legal issue that this resolution seeks to address is uncommon, the AMA does not have the requisite expertise in criminal law to credibly address the matter, and other organizations have already developed the resources requested by the resolution.</p> <p>Relevant policies: Support of Human Rights and Freedom H-65.965 Preventing Anti-Transgender Violence H-65.957</p>
233	<p>Insurers and Vertical Integration</p> <p>Resolutions Committee composite score: 1.95 (1 = not a priority at this time)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 11 out of 17</p> <p>Background Information provided by AMA staff to RC: Resolution 233 -- Insurers and Vertical Integration is not urgent or a priority. This same resolution was presented at the J-21 meeting and was not found to be urgent or a priority at that time. This resolution calls for the American Medical Association to seek legislation and regulation to prevent health payers (except non-profit HMO’s) from owning or operating other entities in the health care supply chain. There is no way any such legislation or regulation would ever pass—at least in the foreseeable future. The anticompetitive effects of vertical mergers are not nearly as well understood as horizontal mergers, which is why antitrust enforcers rarely challenge vertical mergers. In 2019 the DOJ lost very badly when it challenged a vertical merger between AT&T and Time Warner—and both are huge companies. Prior to that loss, the last time the DOJ challenged a vertical merger was in 1977, which it also lost. Further, under the resolution, all vertical mergers involving health insurers, even small regional health insurers (except for non-profit HMOs), would be unlawful—mergers that would have little, if any, negative competitive impact. Note that it is possible that some of these smaller regional health insurers might be sponsored by physician-led health systems that are part of IPPS. Geisinger has its own health plan, for example—so does Scott and White. Also, physicians might want to have an option of being employed by a health insurers, as a competitive option of having to be employed by a hospital. Whether or not a merger, vertical or horizontal or otherwise, is on balance bad for competition has always been judged on a case-by-case basis under existing antitrust law. Finally, the AMA is already very much on top of this issue, as the resolution notes. For example, as recently as April 6, 2021, the AMA sent a letter to the DOJ concerning Optum’s proposed acquisition of Change HealthCare. In this letter, which addressed the AMA identified potential antitrust concerns with the proposed merger, including its vertical aspects, and urged the DOJ to conduct a thorough written examination of significant competitive concerns that require DOJ’s investigation</p>
235	<p>Vital Nature of Board-Certified Physicians in Aerospace Medicine</p> <p>Resolutions Committee composite score: 1.71 (1 = not a priority at this time)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: only resolution</p> <p>Background Information provided by AMA staff to RC: Resolution 235, Vital Nature of Board-Certified Physician in Aerospace Medicine, is neither urgent nor a priority. The AMA has ample policy on the importance of physician led teams in all settings, not just within the aerospace industry. The AMA continues to zealously advocate for physician lead care and for appropriate oversight and scope restrictions for mid-level providers. The AMA continues to engage in its scope of practice work for all physicians, including aerospace physicians, and as such, the work that is being</p>

	<p>requested within this resolution is already within the purview of existing policy and as a result this resolution is not urgent or a priority.</p> <p>See: In-flight Medical Emergencies H-45.978 Air Travel Safety H-45.979 Need for Active Medical Board Oversight of Medical Scope-of-Practice Activities by Mid-Level Practitioners H-270.958 Support for Physician Led, Team Based Care D-35.985 Scopes of Practice of Physician Extenders H-35.973 Models / Guidelines for Medical Health Care Teams H-160.906</p>
237	<p>Universal Good Samaritan Statute Resolutions Committee composite score: 1.95 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: Resolution 237 is not urgent or a priority. The AMA has robust advocacy supporting federal legislation on both Good Samaritan laws and provider immunity during the COVID-19 public health emergency and during national emergencies in general. We have joined recent letters in support of The Good Samaritan Health Professionals Act of 2021 in both the House and Senate as well as in our own letter to House and Senate leadership in 2020. In addition, the AMA has strong policy supporting provider immunity during State or National Emergencies and, in line with our policy, supports federal liability protection for suits arising from care related to COVID-19, and advocates for liability immunity for treatment during a declared public health emergency.</p>
238	<p>Increasing Residency Positions for Primary Care Resolutions Committee composite score: 2.42 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 2 out of 7 Background Information provided by AMA staff to RC: Resolution 238, Increasing Residency Positions for Primary Care, is not urgent or a priority. This resolution asks for the AMA to seek to increase the cap of Medicare support for graduate medical education and prioritize the number of accredited residency positions with a goal of increasing the number of physicians in the primary care workforce specifically. Increasing the number of residency slots has been one of the top priorities of our organization. The AMA has been working with both federal agencies, coalitions, and leaders of Congress on solutions to bolster our physician workforce including the removal of the Medicare funding cap for federal funding of residency slots. Moreover, we have recently had a victory in this area, for the first time since 1996 1,000 new Medicare GME slots were added in the Appropriations Act and we commented on the details of the distribution of these slots in the IPPS rule. Additionally, we already have comprehensive policy on strengthening the primary care workforce. Therefore, this resolution is not urgent.</p> <p>See: The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967 US Physician Shortage H-200.954 Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958 Securing Funding for Graduate Medical Education H-310.917 Revisions to AMA Policy on the Physician Workforce H-200.955 Principles of and Actions to Address Primary Care Workforce H-200.949</p>
239	<p>Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research Resolutions Committee composite score: 1.79 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 7 out of 7 Background Information provided by AMA staff to RC: Resolution 239, Making State Health Care Cost Containment Datasets Free of Cost and Readily Available for Academic Research, is not urgent or a priority given existing policy, ongoing work, and a lack of timeliness. This resolution would require AMA advocacy to make APCD data available to academic researchers at little to no cost. The AMA has long supported the development of APCDs and the use of independent claims data that they house for a multitude of purposes, including research. It seems an extension of this existing advocacy to ensure affordability of the data for research purposes. However, the impact of making access to the data free for academic research could potentially have a negative effect on the ability of APCDs to survive, as such fees tend to be a source of funding. Recently passed federal legislation provides additional funding for APCDs and once that funding is provided over the coming years, perhaps advocacy to ensure free access would be more appropriate and well received.</p>
241	<p>Enforcement of Administrative Simplification Requirements - CMS Resolutions Committee composite score: 2.66 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 1 out of 3 Background Information provided by AMA staff to RC: Enforcement of Administrative Simplification Requirements – CMS is not urgent. The Centers for Medicare & Medicaid Services (CMS) National Standards Group (NSG), on behalf of the Department of Health and Human Services (HHS), enforces Health Insurance Portability and Accountability Act</p>

	of 1996 (HIPAA) Administrative Simplification requirements. HHS uses a two-pronged approach to enforce the rules: Reactive enforcement, where HHS continues the existing informal process for investigating complaints that are filed against covered entities and Proactive enforcement through the Compliance Review Program, where HHS randomly selects health plans and clearinghouses for Compliance Reviews. For the last seven years, the AMA has been actively advocating to CMS for enforcement of the HIPAA Administrative Simplification requirements for health plans and will continue to do so.
303	<p>Decreasing Bias in Evaluations of Medical Student Performance</p> <p>Resolutions Committee composite score: 1.76 (1 = not a priority at this time)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 12 out of 54</p> <p>Background Information provided by AMA staff to RC: Not urgent. The LCME has looked at requests to require implicit bias training and judged that this was too specific to include in standards. Implementing "blinded" assessment of professionalism would be difficult to implement, since professionalism/behavior is typically observed in-person in the preclinical and clinical phases of the curriculum. The Council on Medical Education has a forthcoming report on Reforms to Mitigate Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process which will address Policy D-295.963.</p>
304	<p>Reducing Complexity in the Public Service Loan Forgiveness Program</p> <p>Resolutions Committee composite score: 2.50 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 20 out of 54</p> <p>Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November. The Council on Medical Education has a forthcoming report on Medical Student Debt and Career Choice that will have related recommendations.</p>
306	<p>Support for Standardized Interpreter Training</p> <p>Resolutions Committee composite score: 1.52 (1 = not a priority at this time)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 39 out of 54</p> <p>Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November. First two resolves are addressed in current policy. Third resolve asks for new CME module.</p>
308	<p>Modifying Eligibility Criteria for Association of American Medical Colleges' Financial Assistance Program</p> <p>Resolutions Committee composite score: 2.00 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 42 out of 54</p> <p>Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November. AMA staff are in close communications with AAMC and can accomplish this goal through that mechanism.</p>
311	<p>Improving Access to Physician Health Programs for Physician Trainees</p> <p>Resolutions Committee composite score: 2.12 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 7 out of 22</p> <p>Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November. Recognizing that COVID-19 has taken a toll on the medical workforce, the AMA already has abundant policy on physician health to include its Code of Medical Ethics (9.3.2). Policy affirms the importance of physician health and the need for ongoing education of all physicians and medical students (H-405.961); supports collaboration with the Federation of State Physician Health Programs (FSPHP) to provide information on the availability and services of state physician health programs (D-405.990); recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services. (H-295.993). AMA's strategic focus on enhancing professional satisfaction and practice sustainability has been actively engaged in such efforts.</p>
313	<p>Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training</p> <p>Resolutions Committee composite score: 2.30 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 13 out of 22</p> <p>Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November. AMA policy already encourages employers to offer and/or expand paid parental leave policies (H-405.954) and urges medical schools, residency training programs, medical specialty boards, the ACGME, and medical group practices to incorporate and/or encourage development of parental leave policies (H-405.960).</p>
314	<p>Updating Current Wellness Policies and improving Implementation</p> <p>Resolutions Committee composite score: 1.92 (1 = not a priority at this time)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 16 out of 22</p> <p>Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November. Recognizing that COVID-19 has taken a toll on the medical workforce, the AMA already has ample policy on wellness and burnout to include its Code of Medical Ethics (9.3.1). Policy affirms the importance of physician health and the need for ongoing education of all physicians and medical students (H-405.961); recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and</p>

	<p>advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; (H-295.993); and encourage partnerships and collaborations with accrediting bodies (e.g., the ACGME, LCME) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty. (D-310.968). AMA's strategic focus on enhancing professional satisfaction and practice sustainability has actively engaged in to support physicians and residents including ample resources available on the AMA Ed Hub™.</p>
315	<p>Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs Resolutions Committee composite score: 2.32 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 18 out of 22 Background Information provided by AMA staff to RC: Not urgent. While important, it is not imperative that this issue be addressed in November. AMA has policy in support of IMGs, to include encouraging the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match (D-310.977) and does support uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools (H-255.966); however, policy does not specifically address cost parity.</p>
316	<p>Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic Resolutions Committee composite score: 2.14 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 15 out of 17 Background Information provided by AMA staff to RC: Comment: Not urgent. This issue has been recently studied, with the Council on Medical Education preparing Report 4-N-21, "Medical Student Debt and Career Choice," for the November meeting. The AMA also offers medical school debt management solutions for medical students and physicians through Laurel Road as well as other loans and financial services.</p>
317	<p>Creating a More Accurate Accounting of Medical Education Financial Costs Resolutions Committee composite score: 1.73 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 1 out of 2 Background Information provided by AMA staff to RC: Comment: Not urgent. This issue has been recently studied, with the Council on Medical Education preparing Report 4-N-21, "Medical Student Debt and Career Choice," for the November Meeting. The AMA also offers medical school debt management solutions for medical students and physicians through Laurel Road as well as other loans and financial services.</p>
318	<p>The Medical Student Match Mismatch Resolutions Committee composite score: 2.12 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: Not urgent. It is not imperative that this item be discussed at November meeting. The AMA has ample policy in support of GME funding as well as match reform. FREIDA™, the AMA's searchable residency and fellowship database, contains information on more than 12,000 accredited programs; related information is shared through various communication channels. The authors/delegations had shared with the Council on Medical Education an earlier draft of this resolution. While the Council shares the concerns regarding the growing bottleneck of unmatched students, other factors need to be considered in identifying solutions to the problem. In addition,</p> <ul style="list-style-type: none"> ○ The AMA opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program or have not completed at least one year of accredited graduate medical education in the U.S.) due to the potential risks and harm that may be experienced by both trainees and patients. ○ The Coalition for Physician Accountability, of which our AMA is a member, has made recent efforts to improve the entire UME-GME transition. Several of the recommendations call for greater transparency of data and improved advising, as described in a recent report from their UME-GME review committee. ○ Recent reports from the National Resident Matching Program provide current data. <ul style="list-style-type: none"> ▪ Results and Data: 2021 Main Residency Match ▪ 2021 NRMP Main Residency Match®: Match Rates by Specialty and State ▪ NRMP Program Results 2017-2021 Main Residency Match® ▪ Impact of Length of Rank Order List on Match Results: 2002-2021 Main Residency Match
401	<p>Endorsement of Public Health Measures to End the COVID-19 Pandemic and Promotion of Research and Insurance Coverage to Define and Delimit the Emerging Issue of Post-Acute Covid Syndrome Resolutions Committee composite score: 2.45 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 3 out of 4 Background Information provided by AMA staff to RC: Resolution 401 asks the AMA through advocacy and public relations to promote public health recommendations related to the COVID-19 emergency that are consistent with science and AMA policy. This is exactly what the AMA has been doing throughout the COVID-19 pandemic. The Whereas clauses point to the AMA's press statement on President's Biden's "Path out of the Pandemic" plan as the impetus for this resolution. The AMA issued a statement in support of President Biden's plan. The AMA did not comment specifically on the anticipated OSHA employer COVID-19 vaccine mandate as the AMA does not comment on anticipated rules until we have had the opportunity to review the details of the rule to ensure consistency with AMA</p>

	policy. That rule has yet to be released. This directive is unnecessary and asks the AMA to do something we are already doing.
402	<p>Expansion on Comprehensive Sexual Health Education</p> <p>Resolutions Committee composite score: 2.26 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 31 out of 54</p> <p>Background Information provided by AMA staff to RC: This resolution proposes minor amendments to existing AMA policy.</p>
404	<p>Increase Employment Services Funding for People with Disabilities</p> <p>Resolutions Committee composite score: 2.67 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 47 out of 54</p> <p>Background Information provided by AMA staff to RC: This resolution calls on the AMA to support increased resources for employment services to reduce health disparities for people with disabilities. Existing policy focuses on medical graduates with disabilities and challenges to employment after training.</p>
407	<p>Traumatic Brain Injury and Access to Firearms</p> <p>Resolutions Committee composite score: 1.97 (1 = not a priority at this time)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 19 out of 22</p> <p>Background Information provided by AMA staff to RC: Author cites relevant policy.</p>
409	<p>Screening for HPV-Related Anal Cancer</p> <p>Resolutions Committee composite score: 1.68 (1 = not a priority at this time)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 5 out of 7</p> <p>Background Information provided by AMA staff to RC: According to the CDC's 2021 STI Treatment Guidelines, data are insufficient to recommend routine anal cancer screening with anal cytology in persons with HIV infection, MSM without HIV infection, and the general population. An annual digital anorectal examination (DARE) might be useful to detect masses on palpation in persons with HIV infection and possibly in MSM without HIV with a history of receptive anal intercourse. More evidence is needed concerning the natural history of anal intraepithelial neoplasia, the best screening methods and target populations, the safety and response to treatments, and other programmatic considerations before screening can be routinely recommended.</p> <p>Data are insufficient to recommend routine anal cancer screening with anal cytology among populations at risk for anal cancer. Certain clinical centers perform anal cytology to screen for anal cancer among populations at high risk (e.g., persons with HIV infection, MSM, and those having receptive anal intercourse), followed by high-resolution anoscopy (HRA) for those with abnormal cytologic results (e.g., ACS-US, LSIL, or HSIL). Sensitivity and specificity of anal cytology to detect HSIL are limited (sensitivity 55%–89% and specificity 40%–67%). Data are insufficient to conclude whether use of HRA leads to reductions in anal cancer incidence or improves anal cancer morbidity and mortality. An ongoing clinical trial is investigating whether treatment of HSIL is effective in reducing the incidence of anal cancer among persons with HIV infection (NCT02135419).</p> <p>Existing AMA policy calls for continued research on the diagnosis and treatment of anal cancer and its precursor lesions.</p>
501	<p>Ensuring Continued Access to Equitable Take-Home Methadone Treatment</p> <p>Resolutions Committee composite score: 2.68 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 1 out of 2</p> <p>Background Information provided by AMA staff to RC: While this Resolution is a very important topic, AMA staff are already currently involved in advocacy activities related to continued access to methadone and all treatments for opioid use disorder (OUD). A continued focus on access to OUD treatment was made clear in recent recommendations released by the AMA Substance Use and Pain Care Task Force and AMA staff continue efforts related to this specific issue.</p>
503	<p>Marketing Guardrails for the "Over-Medicalization" of Cannabis Use and Abuse</p> <p>Resolutions Committee composite score: 2.42 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 3 out of 3</p> <p>Background Information provided by AMA staff to RC: At the current time, this Resolution is low priority because the AMA Cannabis Task Force is working to accomplish goals related to cannabis evidence and education as directed by the HOD. The Cannabis Task Force is focused on reviewing the available scientific evidence published subsequent to the 2017 National Academies of Sciences, Engineering, and Medicine report on the health effects of cannabis, synthesizing the information, and making it available, through the development of a series of educational opportunities, focused on varying topics, for health care providers, which includes patient resources.</p>
504	<p>Air Pollution and COVID: A Call to Tighten Regulatory Standards</p> <p>Resolutions Committee composite score: 2.05 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 2 out of 2</p> <p>Background Information provided by AMA staff to RC: While climate, pollution, and environmental health issues are important, this particular resolution is not urgent at this time. AMA currently has myriad policies related to these issues and specifically has policy related to air quality and particulate matter. Policy H-135.946 "supports more stringent air quality standards for particulate matter" and Policy H-135.998 "urges that maximum feasible reduction of all forms of</p>

	air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.”
507	<p>Healthy Air Quality</p> <p>Resolutions Committee composite score: 2.13 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: only resolution</p> <p>Background Information provided by AMA staff to RC: While climate, pollution, and environmental health issues are important, this particular resolution is not urgent at this time. AMA currently has myriad policies related to these issues and specifically has policy related to air quality and particulate matter. Policy H-135.946 addresses fine particulate matter (PM 2.5) and “supports more stringent air quality standards for particulate matter,” Policy D-135.978 notes that Our AMA will review any new air quality standards proposals for particulate matter and offer comments, and Policy H-135.998 “urges that maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.”</p>
508	<p>Personal Care Products Safety</p> <p>Resolutions Committee composite score: 1.87 (1 = not a priority at this time)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 3 out of 7</p> <p>Background Information provided by AMA staff to RC: This Resolution is not high priority. AMA currently has policy in place that allows for appropriate advocacy related to FDA regulations on cosmetics. This policy includes: 1. Calls for an adequately funded FDA to ensure safe and effective products are made available to the American public as efficiently as possible; 2. Notes that AMA will continue to monitor and respond to legislation that affects FDA regulations; 3. Notes that AMA will continue to work with FDA on controversial issues; 4. Supports and adequate budget for FDA (H-100.980, “Food and Drug Administration”); 5. Supports a cosmetic registry and providing FDA sufficient authority to recall cosmetic products (H-440.855, “National Cosmetics Registry and Regulation”); and 6. Calls for elimination of lead use in cosmetics (H-60.924, “Reducing Lead Poisoning”).</p>
509	<p>Wireless Devices and Cell Tower Health and Safety</p> <p>Resolutions Committee composite score: 1.47 (1 = not a priority at this time)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 6 out of 7</p> <p>Background Information provided by AMA staff to RC: This Resolution is low priority at this time and is noted as such from the sponsor. While not directly related to cellular tower placement, AMA currently has policy on this topic that calls for the continued monitoring of developments and issues related to the effects of electric and magnetic fields, encourages research efforts to continue on exposures to electromagnetic fields and their effects, average public exposures, occupational exposures, and the effects of field surges and harmonics, and supports broad dissemination of findings and recommendations of authoritative, multidisciplinary committees (H-460.938, “Effects of Electric and Magnetic Fields”).</p>
510	<p>Opposition to Sobriety Requirement for Hepatitis C Treatment</p> <p>Resolutions Committee composite score: 2.25 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 52 out of 54</p> <p>Background Information provided by AMA staff to RC: This resolution addresses an important issue. As the Resolution sponsors point out, the introduction of direct-acting antiviral medications (DAAs) has changed the treatment and prognosis of patient with active Hepatitis C virus (HCV). Restrictions should be addressed so that socioeconomic status and insurance status are not barriers to this evidence-based treatment and stigma against patients with substance use disorders is not perpetuated. The proposed amendments to expand AMA policy will assist in advocacy efforts related to this issue.</p>
602	<p>Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings</p> <p>Resolutions Committee composite score: 2.10 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 16 out of 54</p> <p>Background Information provided by AMA staff to RC: None</p>
603	<p>Abolishment of the Resolution Committee</p> <p>Resolutions Committee composite score: 2.21 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 9 out of 54</p> <p>Background Information provided by AMA staff to RC: None</p>
604	<p>The Critical Role of Physicians in the COVID-19 Pandemic</p> <p>Resolutions Committee composite score: 2.66 (2 = low priority)</p> <p>Sponsor’s ranking of resolution among their submitted resolutions: 3 out of 9</p> <p>Background Information provided by AMA staff to RC: The intent of this resolution is already being implemented. The AMA has created best-in-class resources, content, and social media marketing targeting physicians, resident physicians, and medical students as part of our COVID-19 Response Strategy. These efforts have resulted in significant increases in website traffic, and other key digital engagement metrics. With an aim at ensuring appropriate support for our target audiences as they deliver care throughout this pandemic, specific focus areas of AMA COVID-19 content include elevating the voice of physicians and science, combating misinformation, creating burnout resources, and supporting national campaigns with strategic partners, e.g., #MaskUp.</p>

	<p>The initial phase of the strategy spurred:</p> <ul style="list-style-type: none"> • Launch of COVID-19 Vaccine Resource Center that curates clinical vaccine guidance from the FDA, CDC and other health organizations, which includes: <ul style="list-style-type: none"> - COVID-19 Vaccine: Physician FAQs - COVID-19 Vaccine: Patient FAQs - COVID-19 TRANSMISSION: PATIENT-FACING INFORMATION - WHAT PATIENTS NEED TO KNOW ABOUT WEARING FACE MASKS • Launch of multi-channel #VaccinesWork campaign to provide physicians and patients with education and tools on the science and safety of vaccines
607	<p>AMA Urges Health and Life Insurers to Divest From Investments in Fossil Fuels Resolutions Committee composite score: 2.05 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: only resolution Background Information provided by AMA staff to RC: None</p>
610	<p>Creation of Employed Physician Section Resolutions Committee composite score: 2.68 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 3 out of 3 Background Information provided by AMA staff to RC: None</p>
611	<p>September 11th as a National Holiday Resolutions Committee composite score: 1.69 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 7 out of 17 Background Information provided by AMA staff to RC: None</p>
612	<p>UN International Radionuclide Therapy Day Recognition Resolutions Committee composite score: 1.55 (1 = not a priority at this time) Sponsor's ranking of resolution among their submitted resolutions: 8 out of 17 Background Information provided by AMA staff to RC: None</p>
616	<p>Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System Resolutions Committee composite score: 2.71 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 2 out of 4 Background Information provided by AMA staff to RC: None</p>
702	<p>System Wide Prior and Post-Authorization Delays and Effects on Patients Resolutions Committee composite score: 2.07 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 2 out of 3 Background Information provided by AMA staff to RC: Though the author's resolution concerns an important issue in the practice of medicine, existing AMA policy, PA Principles, and AMA advocacy address all of the author's concerns. Therefore, this resolution would not be a valuable addition to AMA policy and should not be considered.</p> <p>The AMA's PA Principles have served as the foundation for an extensive, multi-pronged advocacy campaign to reform and improve UM programs. The AMA directly advocates with health plans, benefit managers, and other UM entities to voluntarily adopt these principles; urge accreditation organizations, such as the National Committee for Quality Assurance and the Utilization Review Accreditation Commission, to include these concepts in criteria for utilization review programs; introduce bills based on these principles to state legislatures; encourage technological standards organizations to support improved UM processes; and launch a media campaign to raise awareness of the principles and requested reforms.</p> <p>Regarding Resolution 702, PA Principle #3 states that utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as a toll-free number, to a provider of the same training and specialty/subspecialty for discussion of medical necessity issues.</p> <p>PA Principle #8 addresses simplification of website navigation stating that utilization review entities should publicly disclose, in a searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering providers what supporting documentation is needed to complete every prior authorization and step therapy override request.</p> <p>Regarding expedient decision for authorizations PA Principle #15 states that, if a utilization review entity requires prior authorization for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information. AMA Policy also states that D-320.979 our AMA will advocate that all insurance companies</p>

	<p>and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends</p> <p>Regarding immediate response with confirmation of submission, the AMA has policy supporting the adoption of electronic transactions, including acknowledgements. Policy H-190.978 states that vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products. Additionally, Policy D-190.974 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. Further, it states that our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers and that 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. Finally, Policy D-320.982 states that 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.</p>
704	<p>Expanding the AMA's Study on the Economic Impact of COVID-19 Resolutions Committee composite score: 2.10 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 9 out of 22 Background Information provided by AMA staff to RC: This resolution is not a priority at this time and a delay in consideration would not cause harm, as extensive work is already underway across the AMA that addresses this resolution. The AMA continues to track employment in physician offices and the revenue received by physician offices using monthly data from the Bureau of Labor Statistics and Bureau of Economic Analysis. Similarly, using quarterly Medicare claims data, the AMA is also tracking changes in Medicare Fee Schedule Spending at the aggregate level but also by specialty, place of service, and type of service. Part of that latter work also examines the shares of spending (and visits) that are provided by telehealth in the aggregate but again, also by specialty and type of service. Additionally, ongoing AMA efforts on physician payment reform and digital innovation, "Return on Health," take into account the economic impact of COVID-19 and are focused on economic recovery, so a separate study would be unnecessary. Moreover, it would be premature to study the long-term impacts or implications for recovery while still in the midst of the pandemic. Finally, the studies specifically requested in the resolution would be large and complex. Accordingly, a high fiscal note is anticipated, and this would not be a prudent use of limited AMA resources.</p>
705	<p>Advocating for Program Stability in the Merit-Based Incentive Payment System Resolutions Committee composite score: 2.31 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 6 out of 9 Background Information provided by AMA staff to RC: The AMA's recent comments on the 2022 Physician Fee Schedule and Quality Payment Program proposed rule satisfies the request of Resolution 705 and therefore Resolution 705 should not be considered. Specifically, in the AMA's comments, it "strongly urges CMS to automatically apply the Extreme and Uncontrollable Circumstances Hardship Exception for the 2021 MIPS Performance Period, so physicians are held harmless from the nine percent MIPS penalty due to the significant, ongoing disruptions that the COVID-19 PHE is having on physician practices."</p>
706	<p>Support for State Medical Record Retention Laws Resolutions Committee composite score: 2.22 (2 = low priority) Sponsor's ranking of resolution among their submitted resolutions: 9 out of 9 Background Information provided by AMA staff to RC: The AMA's recent comments on the 2022 Physician Fee Schedule and Quality Payment Program proposed rule satisfies the request of Resolution 706 and therefore Resolution 706 should not be considered. As the resolution states, <i>CMS is proposing to modify the Provide Patients Electronic Access to Their Health Information measure to establish a data availability requirement beginning with encounters with a date of service on or after January 1, 2016, beginning with the EHR reporting period in FY 2022.</i> The AMA commented that, it "appreciates CMS' objective to expand the timeframe for electronic health information availability to patients. We recognize CMS' intent of aligning its information access policies between providers and payers and to reduce the friction patients may face when accessing their medical information. While more can be done, the AMA is concerned there could be unintended consequences with requiring patient health information with encounter start date of January 1, 2016, be made immediately available starting with the CY 2022 EHR reporting period. Many physicians and health systems have digitized old medical records using digital imaging or PDF-style formats. These formats make</p>

	<p>it challenging to search for or protect specific information in EHRs that, by state or federal law, must be withheld upon request or when sending information to other individuals or entities. For instance, California state law requires physicians to withhold information about child abuse from being released. This information is often intermixed with other medical information inside various “notes” electronically contained within an EHR. CMS’ policy to make all information available would require physicians and health systems to manually review and redact certain information prior to the release of these notes. Due to the limitations of imaging or PDF-style formats used to document many of these notes, this process can be extremely time-consuming and costly. We are aware of a health system in California that has estimated it would take 60,000 workhours to manually go through EHR charts and to label or mark notes to prevent this information from being released. The AMA urges CMS to consider the limitations of EHR technology to support physicians and health systems’ compliance with this proposed policy. The AMA recommends CMS create flexibility that allows physicians to provide most of the information requested but still allows leeway for health information management personnel or a physician’s professional judgment to determine when it is impractical for certain information to be made available in a “timely” manner. For instance, CMS should provide no less than a 48-hour window for physicians and health systems to review the patient’s request for health information to determine whether the release will require manual redaction or extraordinary technical effort to accommodate state or federal law.”</p>
707	<p>Fifteen Month Lab Standing Orders Resolutions Committee composite score: 1.91 (1 = not a priority at this time) Sponsor’s ranking of resolution among their submitted resolutions: 4 out of 17 Background Information provided by AMA staff to RC: This resolution is not a priority at this time and does not satisfy the urgency criteria. Also, though new orders every 6 months may be burdensome and unnecessary for patients with long-standing chronic conditions with established therapy/testing, there is concern is that the flexibility offered by standing orders could allow for testing at a frequency/quantity beyond what is medically necessary, which is why payers have limits on the number of tests covered for a certain period of time (e.g., Medicare NCD/LCD limits on the number of thyroid tests per year, etc.).</p>
708	<p>Insurance Coverage for Scalp Cooling (Cold Cap) Therapy Resolutions Committee composite score: 1.69 (1 = not a priority at this time) Sponsor’s ranking of resolution among their submitted resolutions: 2 out of 17 Background Information provided by AMA staff to RC: This resolution is not a priority at this time. Additionally, this resolution is a reaffirmation of some AMA policy and is inconsistent with other policy, and a delay in consideration would not cause harm. Specifically, the goal of the first resolved could be accomplished via Policies H-155.960 and D-185.979. Policy H-155.960 supports value-based decision-making and encourages third-party payers to use targeted benefit design, whereby patient cost-sharing is determined based on the clinical value of a service or treatment, with consideration given to tailoring cost-sharing to patient income and other factors known to impact compliance. Related, Policy D-185.979 encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. However, the specific ask of the first Resolved, that our AMA advocate for universal insurance coverage for Scalp Cooling (Cold Cap) Therapy, is inconsistent with Policy H-165.856, which states that the regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements, and that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.</p> <p>The second Resolved is a reaffirmation, as the AMA has significant policy on medical necessity determinations. (See Policies H-320.942, H-320.995, H-285.998, H-185.942, H-320.982, H-335.996, and H-320.952, among others). Notably, Policy H-320.942 supports efforts to ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care. Policy H-285.998 states that all health plans conducting utilization management or review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and have the right to review any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. Moreover, Policy H-320.995 urges health insurance carriers, government financing agencies, physicians and medical societies to explore ways of improving communications, including regarding third party methodologies for determining medical necessity and opportunities for treating physicians to provide additional medical evidence before a final decision regarding medical necessity is made.</p>
709	<p>Prior Authorization-CPT - Codes for Fair Compensation Resolutions Committee composite score: 2.32 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 5 out of 17 Background Information provided by AMA staff to RC: The AMA has an abundance of policy on reducing the prior authorization burden and undertaken significant advocacy efforts on the issue. Specifically, Policy H-385.951 states that 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. It goes on to state that insurers pay physicians fair</p>

	<p>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. Policy H-320.968 states that our AMA supports the development of draft state and federal legislation to require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review. Policy H-320.968 also states that our AMA supports the development of draft state and federal legislation to require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms.</p> <p>Importantly, Resolution 709 incorrectly requests that the AMA’s HOD establish CPT codes. Per Policy H-70.919, the AMA reinforces that the independent and well-established CPT editorial panel is the only proper forum for developing new and revised CPT codes.</p> <p>In addition, prior authorization and utilization management programs are a high-priority advocacy target for the AMA. The AMA regularly works with state medical associations and national medical specialty societies to address issues with prior authorization. Moreover, in 2017, the AMA partnered with 16 other organizations representing physicians, hospitals, pharmacists, and patients to develop the Prior Authorization and Utilization Management Reform Principles. In response, the AMA has undertaken an extensive advocacy campaign based on the Principles and ongoing research on prior authorization to further support this work. The work includes the Annual Survey of physicians, grassroots activities like FixPriorAuth.org for patient and physician involvement, robust participation in various standards organizations looking to streamline process, consistent advocacy with the Centers for Medicare and Medicaid, supporting legislative reforms, social media advocacy, and the creation of and support for model state legislation throughout federation advocacy efforts. As summarized, the AMA is committed to continuing its extensive advocacy campaign based on the Principles and ongoing research on prior authorization burdens to further support this work.</p>
710	<p>Physician Burnout is an OSHA Issue Resolutions Committee composite score: 2.45 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 12 out of 17 Background Information provided by AMA staff to RC: As outlined in Board of Trustees Report 15 presented at the 2019 Annual Meeting, the AMA recognizes the importance of addressing and supporting physician satisfaction, as well as the impact physician burnout may have on patient safety, health outcomes and overall costs of health care. This commitment to physician satisfaction and well-being is evidenced by AMA’s ongoing development of targeted policies and tools to help physicians, residents and medical students, and its recognition of professional satisfaction and practice sustainability as one of its three strategic pillars. In fact, the AMA has a dedicated unit, the Professional Satisfaction and Practice Sustainability (PS2) unit, which is focused on institutional and system level solutions that aim to resolve root causes of burnout and demoralization. The PS2 unit is actively engaged in various approaches to ameliorating physician burnout, including: publishing research in leading peer-reviewed journals to build the evidence base for the factors that cause physician dissatisfaction and burnout and their impacts; convening members of the research and physician practice communities to improve burnout; launching a free online STEPS Forward practice transformation platform that provides resources designed to help physicians, practices, and health systems; partnering with health systems, large practices, state medical societies, state hospital associations, and graduate medical programs to deploy and assess physician burnout utilizing the Mini-Z Burnout Assessment; and developing the AMA Practice Transformation Initiative: Solutions to Increase Joy in Medicine that will build the evidence base for private and public investment in clinician well-being as a means of achieving the Quadruple Aim. Examples of the AMA’s extensive policy dedicated to ameliorating physician burnout include: Policy H-405.955 - Support for the Quadruple Aim, Policy D-310.968 - Physician and Medical Student Burnout, Policy H-405.957- Programs on Managing Physician Stress and Burnout, Policy H-170.986 - Health Information and Education, Policy H-405.961 - Physician Health Programs, Policy D-405.990 - Educating Physicians About Physician Health Programs, Policy H-295.858 -Access to Confidential Health Services for Medical Students and Physicians, and Code of Ethics 9.3.1 - Physician Health & Wellness.</p>
711	<p>Health System Consolidation Resolutions Committee composite score: 2.48 (2 = low priority) Sponsor’s ranking of resolution among their submitted resolutions: 3 out of 3 Background Information provided by AMA staff to RC: This resolution is not a priority at this time and a delay in consideration would not cause harm, as this resolution is addressed by strong AMA policy and extensive work across the AMA. The Council on Medical Service keeps abreast of consolidation as evidenced by the three Council reports presented in recent years, CMS 7-A-19 and CMS 5-A-17 on Hospital Consolidation, and CMS 11-A-19 on Corporate Investors. Moreover, although the AMA’s most visible health care consolidation efforts have focused on health insurance markets, the AMA has studied and continues to monitor hospital market concentration. Finally, Policy H-215.960 - Hospital Consolidation addresses the goals of this resolution. The Policy underscores that antitrust relief for physicians remains a top AMA priority. The policy also states that the AMA strongly supports and encourages competition in all health care markets, supports rigorous review and scrutiny of proposed mergers to determine their</p>

	effects on patients and providers, will continue to support actions that promote competition and choice, and will work with interested state medical associations to monitor hospital markets, including rural, state, and regional markets, and review the impact of horizontal and vertical health system integration on patients, physicians and hospital prices.
712	<p>Advocacy of Private Practice Options for Healthcare Operations in Large Corporations</p> <p>Resolutions Committee composite score: 2.54 (2 = low priority)</p> <p>Sponsor's ranking of resolution among their submitted resolutions: 2 out of 3</p> <p>Background Information provided by AMA staff to RC: This resolution is not urgent and should not be considered at this meeting. The AMA's Council on Medical Service recently drafted a report on Corporate Investors in 2019, touches on some of the issues raised in this resolution. In its report, the Council noted that long-standing policy states that physicians are free to choose their mode of practice and enter into contractual arrangements as they see fit, and it is essential that the AMA maintain a leadership role that is uniting and supportive of all physicians and care delivery models. And, because physicians appear to be looking for guidance and solutions, the Council recommended a series of guidelines that it believes should be considered by physicians who are contemplating corporate partnerships.</p> <p>Importantly, it is also AMA policy encouraging national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and physicians. Additionally, the AMA has many resources available to help physicians navigate the arrangements at issue in this resolution. For example, the AMA has a resource titled "Venture Capital and Private Equity Investment: How to Evaluate Contractual Agreements." Also, the AMA has a Venture Capital and Private Equity Investment Model Checklist. Moreover, the AMA has a model bill intended to address situations where a physician organization is contracting with another entity, including an employer. This focuses on "clinical care organizations" which might encompass the kinds of arrangements that the resolution envisions.</p>

EMERGENCY RESOLUTION

HOUSE ACTION: RESOLUTION NOT ACCEPTED

The following emergency resolution was submitted for the consideration of the House of Delegates on Monday, November 15. The House voted not to accept the resolution as business.

RESOLVED, That our American Medical Association urgently prepare a strategic plan to address the current health care workforce shortage crisis that disproportionately affects rural areas and underserved urban areas and the potential worsening of this crisis upon implementation of the CMS Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule; and be it further

RESOLVED, That our AMA urgently collaborate with appropriate stakeholders to protect health care delivery in underserved, rural communities, and preserve the economic viability of rural sole community hospitals as primary lines of defense in the COVID-19 pandemic; and be it further

RESOLVED, That our AMA reaffirm policies H-465.979, H-200.972, H-465.990, and H-465.994.

APPROVAL OF MINUTES: The Proceedings of the June 2021 Special Meeting of the House of Delegates, conducted online June 11-16, 2021, were approved.

ADDRESS OF THE PRESIDENT: AMA President Gerald E. Harmon, MD, delivered the following address to the House of Delegates on Friday, Nov. 12.

Mr. Speaker, officers, delegates, physician colleagues, distinguished guests, had enough of these virtual meetings yet? This is our fourth in a row, but who's counting?

First, let me thank each and every one of you who has responded to the pandemic. Physicians have shown great courage in the face of difficulty over the past many months, even up until this very day as the battle goes on. My physician colleagues—my battle partners, indeed my fellow COVID veterans—soldier on answering the call.

Even as this Delta surge wanes, we anticipate entering a third calendar year of this global pandemic and have surpassed 750,000 lives lost to COVID in the United States alone, just a staggering and heartbreaking milestone to reach. And

yet questions remain. Are we near the end? Will there be another surge? Will vaccinations hold up against future mutations? We don't have those answers yet.

I want you to imagine a small community hospital in a rural area of a southern state a year and a half into the pandemic. The COVID Delta variant's surging, and the vaccination rate lags. A hospital and ICU have been operating well above 100 percent capacity for more than a month. The ICU is filled with COVID patients, 90 percent of whom are unvaccinated, and two-thirds of them under age 60. Inpatient beds are overflowing into the hospital hallways. Emergency room and the PACU beds double as critical care beds as patients struggle to breathe.

With these younger, sicker patients comes a new dynamic for many doctors and nurses. They're now witnessing young families and their children watching through barriers or covered in PPE as their loved ones succumb to a devastating virus. Healthcare workers are taking extra shifts and giving it their all, but they're showing signs of exhaustion as they deal with the physical and emotional trauma. Young clinicians in particular appear shell-shocked, and seem to be even questioning their career choices.

To many of you, this might sound all too familiar. In fact, the scenario I just described took place at my community hospital in Georgetown County, South Carolina, during a grueling seven-day, 100-hour teaching rotation that I led. The fear and the weariness in young clinicians' faces was not unlike what I witnessed in the medical arena in Iraqi Freedom and Enduring Freedom after 9/11. I'd call it battle fatigue. Like combat, the unrelenting demands of responding to COVID patients has led to physical and emotional exhaustion and pushed physicians and our entire healthcare workforce nearly to the breaking point.

What will be the lasting effects of this pandemic on young doctors? Will they leave their chosen specialties, or even the profession? What will it mean for the future of healthcare? We don't have those answers yet. And it's a difficult feeling to live with day after day.

Our psychiatry friends will tell you that the human brain is challenged by uncertain situations and outcomes. And faced with uncertainty, we may feel threatened, unable to concentrate, and less capable of solving problems. During such uncertain times, it's critical that we find support and social connection. Where will physicians, and especially young doctors and those in training, find that support?

I'd submit that we must be their support. We at the AMA, and all the state and specialty medical societies who comprise the House of Medicine, we must be the allies of our physician colleagues that we need right now. A few months ago, one of our federation partners, the West Virginia State Medical Association, asked me to speak to the question, "Do we still need organized medicine?" You might think the answer is obvious: "Heck, yeah!" But here's why.

Throughout this pandemic, the AMA and our state and specialty medical associations have stepped up and bridged many gaps. We've gotten doctors and other healthcare workers their information, the personal protective equipment, and other resources they needed, even as the state and federal governments struggled in a deficient public health system.

And when I use the term "organized medicine," I don't mean an abstract concept. I mean our people, our purpose, our actions in support of a profession built on ethics and science, and that is focused on providing the best possible care for patients in ways that also strengthen our communities. "Organized medicine" means hundreds of thousands of physicians, students, trainees from every state and specialty in the United States; gifted and talented practitioners, researchers, and academics. "Organized medicine" means our common purpose, which is "to promote the art and science of medicine and the betterment of public health," the AMA Mission Statement. And "organized medicine" refers to those specific actions we must do to help physicians meet the challenges of this pandemic and beyond. When we first encountered the novel coronavirus in early 2020, the AMA and our partners in organized medicine responded:

- We fought for the PPE
- We fought for financial resources
- We were a reliable source of evidence-based information on COVID that physicians needed during a time of mixed messaging
- We talked with CMS to expand telehealth and to pause the regulations that were standing in the way

- We pushed insurers to drop prior–authorization requirements
- And, most importantly, we fought against misinformation and disinformation at every step

We continue now to call out half–truths and lies. We’re educating those who are open to science–based information.

Colleagues, don’t believe the myth that all who are unvaccinated are hardened in that position. In fact, research shows that if we as doctors, if we recommend vaccines to our patients, they’re inclined to take them.

My state only has a little over half its population vaccinated right now. And last month I spoke to a group of maybe 50 employees about vaccines, and I used the point that many in the community had either trusted me personally or their families had trusted me with their medical care, from sprained ankles to heart attacks to cancer. And yet they had some hesitations and questions about the COVID vaccine that were largely prompted due to nonstop misinformation and half–truths. I reminded them they had sought my advice for decades. So my advice remained to “take my advice: take the vaccine.”

Afterwards, many of these vaccine–hesitants stepped up and thanked me, and they said, “You know, I’m convinced now, Dr. Harmon. Where can I get my shot?”

You know, my story, multiplied by those from colleagues across the country, speaks to the power that we have as individual doctors, and, in turn, the power, the reach, and the impact we can have as organized medicine, as purveyors of truth on the side of science.

As this audience knows, the value of organized medicine is much broader than the pandemic response. Challenges in medicine existed long before COVID–19, and they’re going to continue long after the worst is over.

Physicians face bureaucratic and regulatory obstacles to care that contribute to burnout. Organized medicine has not lost sight of those battles. In fact, the pandemic has shined a spotlight on the breadth of challenges we face:

- Dysfunctional Medicare physician payment system
- Scope of practice expansion
- Electronic records/data transparency
- Chronic disease management
- Prior authorization
- Health disparities
- Equity concerns

We’ve committed teams at the AMA working on each of these healthcare challenges—and many, many more—and I’m so very grateful for their efforts and appreciate them. Let me highlight three issues that are of utmost importance to us right now.

First, we need the strength of organized medicine in the battle against Medicare payment cuts, a battle that is going to have to be refought again this year. You know, we’re facing potential Medicare cuts of nearly 10 percent beginning in January of 2022. It’s about time Congress passed a permanent solution to end these annual battles that threaten the solvency of physician practices. Congress must address physician budget neutrality and inadequate annual payment updates as the root causes.

We also need the strength of organized medicine to fight aggravating payer policies that really hurt rather than help our patients.

Now, I want to keep this speech in the PG–rating mode, but I’ve got to use that dirty word “prior authorization”. Recently a friend and a patient, a former patient of mine, presented with some ill–defined symptoms. He had kinds of slight cognitive impairments, intermittent complaints of difficulty walking, especially when he was on the golf course. Now, he was over 70. He had hypertension, he had diabetes. He was being followed by an endocrinologist, a physician assistant who was working with him, and less often seeing his primary–care doctor. He had had a benign CAT scan of his head, and the feeling by many of his providers was tending towards the diagnosis of vascular dementia or Parkinson’s.

I wondered about Normal Pressure Hydrocephalus, or an NPH, and so ordered an MRI of his brain. Now, his Medicare Advantage Plan benefits manager pushed back on the study and said, “We’re going to deny it.” I disagreed. I spent a half an hour on the phone arguing, and finally prevailed. Sure enough, that MRI was consistent with Normal Pressure Hydrocephalus. And my neurosurgeon colleagues are now taking him to surgery.

Now, if I had not fought this decision, if we had not fought it, the delay in care would likely have resulted in the patient’s condition deteriorating. It could’ve caused certainly greater disability, and possibly even death down the road. That’s just foolish. When an insurance company is making the decision rather than a doctor, it’s probably going to be in favor of the short-term financial gain. That’s why the AMA is pushing for legislative action on prior authorization and step therapy reforms at the federal and the state levels.

And finally, we also need the strength of organized medicine when it comes to correcting the past wrongs of our profession and creating a healthcare system that is responsive to the needs of all patients. The impact of systemic racism in medicine, past and present, is real. The pandemic and social unrest of the past 20 months has shown all too clearly how policies such as segregation, mass incarceration, police brutality, and redlining continue to adversely affect the health of black and brown communities and individuals.

We’re committed to our strategic plan to embed health equity and racial justice within the AMA and within the larger healthcare system. The plan is ambitious and far reaching. It will be the subject of an educational session during this meeting, and I encourage everyone to attend to learn more. Our work to date has been earnest. It has noble ambitions, and it is critical to the health of our nation.

The point is, a single physician cannot bring about the legislative or regulatory changes needed to improve the practice environment. But membership in organized medicine multiplies our power, our resources, and our voices by hundreds of thousands of physicians.

I was a big fan of the late General Colin Powell, who famously said, “Perpetual optimism is a force multiplier.” I’ve been accused of being pathologically optimistic, and I want us to remain focused on all that we face. But I can assure you that we haven’t lost the fight, whether we are talking about COVID-19 or burnout or any other challenge.

The AMA and its federation partners are strong. We’re an army against the virus. We’re an army against injustice, an army against an unresponsive bureaucracy and distracted legislators. We’re strong in support of our colleagues, both individually and collectively. We’re strong in envisioning the end to this pandemic and a brighter age for healthcare.

There’ll be yet uncertain times ahead, but we can walk with confidence into this future, because through organized medicine we know we are not walking alone. It’s been a long couple of years. I encourage you to persevere through what remains a consequential time in the nation’s history and the history of medicine. I encourage us once more to act worthy of ourselves on behalf of future generations.

And I thank you.

REPORT OF THE EXECUTIVE VICE PRESIDENT: James L. Madara, MD, executive vice president of the Association, delivered the following report to the House of Delegates on Friday, Nov. 12.

Mr. Speaker, members of the board, delegates, and colleagues, seldom has trust in American institutions been tested as it has in the last 19 months. Surveys during the pandemic showed waning trust in the institutions of government, academia, science, media, and in our health system at large. But many of those same surveys also show strong public trust for individual physicians. In fact, trust in physicians was shown to be high among all groups, demographics, and political affiliations.

Trust in the care, expertise, and experience provided by physicians is an essential part of the patient-physician relationship, and that’s especially true in a crisis. And just as physicians are among the most trusted professions, our AMA is among the most trusted brands.

Physicians trust us to give voice to their concerns and to help mitigate the challenges they face, from PPE shortages, to financial stress, to increasing regulatory burdens. Trust in the AMA can be deduced from analysis of our engagements, engagements that continue to set new records, including with physicians.

This year we'll reach more than 26 million unique users on our AMA website. That's a 32 percent increase over last year. And by the way, that last year's result, which we will now sail by, was a dramatic increase from the previous year. Additionally, daily listens to our podcasts are up fivefold from last year, while our daily videos have already surpassed one million views. And the trust physicians place in us is evident in our dues-paying membership, which has increased each year over the last decade. In fact, dues-paying membership increased by more than one-third over the last 10 years.

Importantly, our membership growth is also revealed to extend to our increasing market share of physician members as well. So what's driving this increase? There are several likely elements. For example, APCO Worldwide again this year ranked the AMA among the nation's best and most effective associations, with high marks for being stewards of industry reputation. We were also lauded for our influence on health policy, and for speaking with a unified voice on issues that matter the most to physicians. This is a credit to our entire organization, and particularly to our strategic framework composed of the three arcs of removing obstacles to patient care, driving the future of medicine through advances in education, and leading the charge to prevent chronic disease.

These three arcs are each amplified by three accelerators: advocacy, equity, and innovation. This framework is based on the policies of our House of Delegates, and it brings our mission to life. As we developed this strategic framework, I recall one particular meeting I had with a well-known industrialist/entrepreneur to get his take on our approach. I highlighted our many innovations and investments, such as transforming medical education and physician training, as well as our expansive work across digital health, including Health2047 in Silicon Valley. I also summarized our recent work to advance equity in medicine by addressing social determinants of health aimed at improving outcomes in neighborhoods, challenged by decades of disinvestment and neglect. He thought the approach was innovative, but also expansive, so he asked what unifying concept tied it all together.

I told him that concept was our mission statement: "To promote the art and science of medicine and the betterment of public health." And that made it click for him. He looked at me and said, "Well, that makes it clear: the AMA is a public trust."

Now, here's how I interpret that comment. The AMA exists to benefit the public, but we do so in a very particular way: by being the physicians' powerful ally in patient care. We serve the public by serving those who care for the public.

Supporting physicians and improving our nation's health has been our focus since 1847. It's the reason, as one of our first actions then, we launched the field of clinical medical ethics, a field that still guides our profession to this day. It's why we fought to reduce smoking and right size opioid prescriptions, and why we continue to champion medical science and actively encourage vaccination against COVID-19.

Within our strategic framework, the crosscutting accelerator of health equity became particularly front and center in the pandemic. To see the human cost of inequities, we look no further than Chicago's West Side, a neighborhood where we participate to model real world solutions to complex challenges. The West Side is a place where life expectancy is at least 14 years lower than that for residents of our affluent neighborhoods. As one piece of our equity work, we partner with many on the West Side, including community groups and providers, to deal with the number one risk factor for death and disability: high blood pressure. This work will achieve more timely and accurate blood pressure control methods and incorporate holistic elements, requiring a better understanding of local needs and approaching our colleagues with humility and an empathic effort toward understanding. Through this work, we hope to define pathways for improved health outcomes that might be applied to similar neighborhoods nationally that have been economically and socially marginalized.

Additionally, through our federal advocacy efforts, we're making remote patient care a reality for more people, giving those struggling with chronic disease, such as hypertension, lifesaving touchpoints with their physicians regardless of geographic location. Part of this effort is in developing tools and training to make it easier to implement telehealth, a key to widespread adoption. These are features of a public trust.

We are also doing this work through our industry-leading AMA Ed Hub, which two years after its launch has grown to more than two million engagements in the current year, and now two dozen content collaborators ranging from specialty societies to universities to genetic institutes.

Here, too, we build our commitment to public health and equity, launching a groundbreaking series of CME modules this year to give physicians a deeper understanding of health inequities and identify their root causes, including structural racism and related social determinants of health. And we've created a committee of external experts dedicated to advising our organization on equitable structures and opportunities in digital health innovation, work that would benefit historically marginalized people and communities, as well as others.

Our innovation company, Health2047, continues to apply novel thinking and deep analysis toward addressing challenges we face. Two examples. One of the new companies launched this year, Emergence Healthcare Group, is developing turnkey practice solutions to allow physicians in private practice to offload burdens and paperwork, eliminate burdens so physicians can dedicate more of their time to patient care, and doing so without increasing practice cost. Another newly launched company seeks to improve real-world aspects of clinical trials by providing a pathway to make them inclusive and accessible. This startup, SiteBridge Research, is creating a novel trial-in-a-box platform that will allow small practices to participate in clinical trials without the high costs and administrative hassles that currently prevent these practices from participating.

If successful, this approach would constitute a major step toward solving the challenge of collecting real-world data from diverse populations, information that can aid our national response to the next great health crisis and at the same time provide more treatment options for physicians and contribute to financial stabilization of small practices.

Now, we don't know how many of these innovative approaches will ultimately deliver on their promise, but the exercise is to develop many possible solutions to help physicians over the longer term in addition to all the work we do to help physicians more immediately. All of our work, short-term and long-term, can be differentiated by the fact that we create the beginning problem definition at the patient-physician interface rather than first defining problems at the administrative level. That latter approach is often taken in nonphysician-led organizations, resulting in the hodgepodge of solutions thrown over the transom into our practices.

The AMA is committed to creating a health system that's accessible, efficient, and equitable. To get there, we need an environment that supports physicians, one that allows doctors to be doctors rather than scribes and box checkers. This is needed to fulfill our obligation as a public trust, a trust that serves the public by being the physicians' powerful ally in patient care.

Thank you.

REMARKS FROM THE CHAIR OF THE AMPAC BOARD: The following remarks were presented to the House of Delegates on Friday, Nov. 12 by Stephen Imbeau, MD, Chair of the AMPAC board.

I'm Stephen Imbeau, AMPAC Board Chair, from Florence, South Carolina. It's no secret that this Corona Virus pandemic has created a new normal for most of us. For AMPAC, it has altered our typical process of fundraising.

We can't travel to meet you in person, and we can't spend time together. We now have to rely on direct mail, email, and digital campaigns. But some things do remain constant: we still need the support of all of you in the House of Delegates to implement the AMA's advocacy mission through AMPAC. But we have only 53 percent participation within this House, so I want you all to join AMPAC. Please go to [AMPACOnline.org](https://ampaconline.org) to join, and let's get to at least 60 percent by the end of this meeting. Please also drop by our virtual booth during the hours listed on the website.

As board chair, I thank all of you who have given to AMPAC this year, particularly those at the Capital Club level, for your support and your dedication. We will once again hold a Capital Club virtual event on Monday at 12:00 noon Central, with a special guest speaker, Amy Walter. Amy is a renowned political analyst with unparalleled access to political campaigns. She is now the owner and the publisher of the Cook Political Report. We are excited to hear what she has to say next week.

Finally, while the pandemic has changed how we fundraise, political giving will not end. So we need the support of you all to be prepared for the 2022 election cycle. I look forward to seeing you at Monday's Capitol Club event and thank you again from our entire AMPAC board.

REPORT OF THE AMPAC BOARD: The following report was presented to the House on Friday, Nov. 12 by Stephen Imbeau, MD, Chair, AMPAC Board.

It is my privilege to present this report to the AMA House of Delegates on behalf of the AMPAC Board of Directors summarizing our 2021 activities as we prepare for yet another busy election year. Partisan gridlock in Washington, DC over infrastructure, tax policy and a host of other controversial issues has made it difficult for medicine's core priorities to break into the forefront. This harsh landscape becomes more treacherous when combined with the impact of a still lingering pandemic, making AMPAC's ability to ensure physicians have a seat at the policy-making table more critical now than ever. We achieve this by supporting federal candidates who will support organized medicine in the halls of Congress as well as political education programs that train physician advocates to work on campaigns for medicine-friendly candidates and to run for office themselves.

As this year marks AMPAC's 60th anniversary, we reflect on our achievements as America's oldest nonunion political action committee and leading the way on many political activities like strategic contributions to federal candidates, in-kind contributions, and independent expenditures. At the same time, we recognize that many physicians may not fully understand or appreciate AMPAC's core function, the scope of our work and why we need the support of all physicians. As a result, we've developed a short, educational video that will answer basic questions and aid our existing members in recruiting their colleagues to join the chorus of medicine's most powerful political voice: AMPAC. Click here to view the video: <https://vimeo.com/643850739/be114a948a>.

AMPAC Membership Fundraising

We would like to thank the House of Delegates members who contributed to AMPAC during this special 60th anniversary year, and especially those at the Capitol Club level.

AMPAC revenue through October 31 is \$685,661 and receipts are down by 7 percent compared to this same time last year. One of the most significant impacts on AMPAC's fundraising since the pandemic began has been that the AMA has not held any in-person meetings. This has led to a 75 percent decrease in what AMPAC raises during AMA meetings. Despite pivoting to virtual tactics to counter this, the support of the House of Delegates has diminished considerably in 2020 and 2021.

Currently HOD AMPAC participation is 52 percent, which is noticeably lower than the 76 percent participation achieved in 2019. As a leader, we ask for your support during AMPAC's special anniversary year. For those who have not had a chance to do so yet, we encourage you to visit our website <https://www.ampaonline.org/> and make an investment today to help increase overall AMPAC participation in the HOD. AMPAC is also hosting a virtual booth during this meeting, so visit AMPAC's website for additional details and to view the schedule.

Finally, AMPAC is hosting a virtual Capitol Club event for all current 2021 Capitol Club members on Monday, November 15 from 12:00 - 1:00 p.m. Central Time with special guest Amy Walter. Walter is the Editor and Publisher of The Cook Political Report and is one of the best political journalists in Washington, providing analysis of the issues and events that shape the political environment.

All current 2021 Capitol Club members received an invitation to register to attend this event and if you did not receive the invitation, please visit AMPAC's website for more information on how to register for this event.

Political Action

During the current, early giving period AMPAC has prioritized contributions to incumbents who are strong allies of medicine, members of their parties' leadership, on key committees or otherwise in an important position to advance medicine-friendly policies on Capitol Hill. Because 2022 is a redistricting year the AMPAC Board has also taken further steps to avoid early contributions to incumbents whose seats may be significantly impacted by the redrawing of new congressional district boundaries. The overall redistricting picture has gotten clearer as the end of the year

approaches and while uncertainty remains for some states/races, the added clarity should allow for contributions to members of Congress who fit the aforementioned criteria and where redistricting complications are no longer a concern.

The overall pace of AMPAC's early giving is expected to pick-up some as the 2022 elections are now a little less than a year away. This will continue to hue closely to the early giving criteria the Board established in June and as always, robust giving expanded to more rank-and-file incumbents as well as first-time candidates, will not happen until the AMPAC Board holds its Congressional Review Committee budgeting meeting in February.

Political Education Programs

Over the course of two weekends in December, physicians, medical students, physician spouses and state medical society staff from across the country will take part in the 2021 Campaign School which will be held virtually due to the ongoing COVID-19 pandemic. During the program, twenty-three participants will be placed into virtual campaign teams and with a hands-on approach our team of political experts will walk them through a simulated campaign, teaching each of them everything they need to know to run a successful race as either a candidate or campaign staff. Senator John Barrasso, MD (WY), a former program graduate, is scheduled to be the keynote speaker. AMPAC is happy to report that previous political education programs held virtually have received high marks from participants, many of whom are seriously considering a run for public office, and we are confident December's program will yield similar results. Dates and format have not been announced for the 2022 Candidate Workshop next spring. Due to the COVID-19 pandemic, AMPAC announced that the 2021 Candidate Workshop would also be held virtually this year. Building off the success of the virtual Campaign School, AMPAC staff worked with program trainers to convert the one-and-a-half-day in-person programming into a virtual format. Held over the course of two weekends in May, twenty-six physicians, medical students and state society staff participants learned the skills and strategic approach they will need as a candidate out on the campaign trail. During the one-and-a-half-day program, participants learned how and when to make the decision to run, the importance of a disciplined campaign plan and message, the secrets of effective fundraising, the role of spouse and family and much more. Senator Bill Cassidy, MD (LA) and Representative Ami Bera, MD (CA), both former program graduates, provided keynote addresses to the group. AMPAC is proud to report that the virtual program also received high marks from participants.

RETIRING AMA OFFICERS, DELEGATES AND MEDICAL EXECUTIVES

California Medical Association

Jim Hay, MD
Robert Margolin, MD

Connecticut State Medical Society

Ted Zanker, MD

Missouri State Medical Association

Warren Lovinger, MD

Medical Society of the State of New York

Abdul Rehman, MD
John J. Kennedy, MD

Texas Medical Association

Lyle Thorstenson, MD

Wisconsin Medical Society

Michael M. Miller, MD

REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES (N-21)

Reference Committee on Amendments to Constitution and Bylaws

Heidi Dunniway, MD, Indiana, Chair
 Abhishek Dharan, Texas, Regional Medical Student
 George A. Fouras, MD, California
 Tate Hinkle, MD, American Academy of Family Physicians
 Theodore Jones, MD, Michigan
 Candace E. Keller, MD, American Society of Anesthesiologists
 Robert Pantan, MD, Illinois

Reference Committee A (Medical Service)

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 Anjalee W. Galion, MD, California
 Barbara Hummel, MD, Wisconsin
 Rajadhar Reddy, Texas, Regional Medical Student
 Ezequiel Silva, III, MD, Texas
 Hugh Taylor, MD, American Academy of Family Physicians
 Shannon Trotter, DO, Ohio

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 Michael A. DellaVecchia, MD, Pennsylvania
 William Freeman, MD, Louisiana
 Ryan Hall, MD, Florida
 Nicole A. Henry-Dindial, MD, New Jersey
 Bryan G. Johnson, MD, Texas
 Janice Tildon-Burton, MD, Delaware

Reference Committee C (Medical Education)

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 Daniel Dent, MD, American College of Surgeons
 Betty M. Drees, MD, Missouri
 Alysa Edwards, Colorado, Regional Medical Student
 Douglas W. Martin, MD, Iowa
 Debra Perina, MD, American College of Emergency Physicians
 Kenath Shamir, MD, Massachusetts

Reference Committee D (Public Health)

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 Jack Gatti, Maryland, Regional Medical Student
 Woody Jenkins, MD, Oklahoma
 Sarah Marsicek, MD, American Academy of Pediatrics
 Eddie Patton, Jr., MD, Texas
 Donald Posner, MD, Louisiana
 Donald J. Swikert, MD, Kentucky

Reference Committee E (Science and Technology)

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 Jessica Adkins, MD, Kentucky, Sectional Resident
 Ricardo Correa, MD, American College of Physicians
 Oluwasegun Paul Emenogu, Ohio, Regional Medical Student
 Jeff Klingman, MD, California
 David Teuscher, MD, American Academy of Orthopaedic Surgeons
 Yasser Zeid, MD, Texas

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 Stuart J. Glassman, MD, American Academy of Physical Medicine and Rehabilitation
 Rebecca L. Johnson, MD, Florida
 Shilpen A. Patel, MD, American Society for Radiation Oncology
 William Reha, MD, Virginia

Reference Committee G (Medical Practice)

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 Michael Hanak, MD, American Academy of Family Physicians
 Niva Lubin-Johnson, MD, Illinois
 Justin Magrath, Louisiana
 Joshua Mammen, MD, International College of Surgeons - US Section
 Ashok Patel, MD, Minnesota
 Stephen J. Rockower, MD, Maryland

Committee on Rules and Credentials

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 Patricia L. Austin, MD, California
 Ariel Carpenter, MD, Kentucky, Sectional Resident
 Dale M. Mandel, MD, Pennsylvania
 Glen McClain, Ohio
 Laurel Ries, MD, Minnesota
 Jayesh B. Shah, MD, Texas

Chief Teller

Gary D. Thal, MD, American Society of Anesthesiologist

* Alternate delegate