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* Contained in the Handbook Addendum

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233* Insurers and Vertical Integration

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

* Contained in the Handbook Addendum

REPORT 02 OF THE BOARD OF TRUSTEES (N-21) Policing Reform
(Resolution 410-NOV-20)
(Reference Committee B)

EXECUTIVE SUMMARY

Because of structural racism, historically marginalized and minoritized communities in the United States, particularly Black and Native American populations, shoulder the unfair, unjust, and disproportionate burden of police violence, experiencing higher levels of mortality, morbidity, inequity, and intergenerational trauma. At the 2020 November Meeting, the House of Delegates referred the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, "Policing Reform," for a report back to the House of Delegates. These clauses recommend that the AMA support repeal of qualified immunity for law enforcement officers, termination of federal programs that provide military equipment to local law enforcement agencies, and the establishment of community-based oversight boards with disciplinary authority over law enforcement officers. This report provides background, discussion, and recommendations on each of these issues.

First, the qualified immunity doctrine grants civil immunity to individual government officials performing discretionary duties within the scope of their employment. Repeal of the doctrine has been advanced as a way of preventing excessive use-of-force by law enforcement officers. As it applies to law enforcement officers, supporters of qualified immunity believe it is necessary to give some deference to officers making "split-second judgments" about the amount of force that is necessary in a particular situation. The rationale for abolishing qualified immunity posits that the threat of personal liability will be so great that officers will curb their behavior. Second, the U.S. Department of Defense (DOD) 1033 Program (1033 Program) permits eligible federal, state, and local agencies, under certain circumstances, to obtain certain DOD personal property, including equipment, clothing, vehicles, aircraft, weapons, and ammunition. The 1033 Program is often charged with over militarizing local law enforcement agencies, particularly in communities of color. Supporters of sending excess military equipment argue that it helps to increase safety and is an efficient and wise use of tax dollars. Critics argue that such programs have led to a culture that leads to excess lethal force on suspects. Third, community oversight boards (COBs) empower members of the public to review, investigate, or discipline law enforcement officer wrongdoings. Proponents say that such boards improve public trust, ensure accessible complaint processes, ensure thorough investigations, increase transparency, and deter police misconduct. However, COBs have been found to be largely ineffective.

There is a lack of evidence that abolishing qualified immunity, terminating the 1033 Program, and/or establishing COBs would reduce police violence. Therefore, the AMA's contribution to the national conversation about policing would be better focused on a holistic approach to policing. In particular, procedurally just policing models and greater community involvement in policing policies and practices are promising, evidence-based means of decreasing use-of-force. In addition, because of the similarities between medicine and law enforcement—professionals in both fields are frequently placed in high-pressure situations in which they must make split second, life-or-death decisions—it may benefit law enforcement to borrow some of the strategies and practices that the medical profession uses to ensure that its members provide safe and effective care, such as establishing evidence-based standards and practices, implementing sentinel event reviews following an adverse event, and encouraging further research into the impact of law enforcement practices and programs.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-N-21

Subject: Policing Reform
(Resolution 410-NOV-20)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2020 November Meeting, the House of Delegates referred the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, "Policing Reform," introduced by the Medical Student Section, which asked:

> That our AMA advocate for the elimination or reform of qualified immunity, barriers to civilian oversight, and other measures that shield law enforcement officers from consequences for misconduct.
>
> That our AMA support efforts to demilitarize law enforcement agencies, including elimination of the controlled category of the United States Department of Defense 1033 Program and cessation of federal and state funding for civil law enforcement acquisition of military-grade weapons.
>
> That our AMA support the creation of independent, third-party community-based oversight committees with disciplinary power whose mission will be to oversee and decrease police-on-public violence.

The reference committee heard mixed testimony on these resolves, including significant support for referral to allow for a more thorough analysis. This Board report, therefore, addresses the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, specifically, and provides background, discussion, and recommendations.

BACKGROUND

Following the well-publicized deaths of Black Americans during police encounters—including George Floyd, Breonna Taylor, and too many others—as well as the widespread protests in their aftermath, our nation is engaging in a long-overdue conversation about police violence and excess force, and how racism and systemic and structural racial injustice manifest in over-policing of Brown and Black communities. While the AMA recognizes that many who serve in law enforcement are committed to social justice in their holistic view of justice, AMA policy acknowledges the need for changes at the federal, state, and local levels to end discriminatory practices and unnecessary or excessive use of police force. The AMA has been and continues to be engaged in advocating for such changes. As noted in an AMA Viewpoint by then-Immediate Past AMA Board Chair Jesse M. Ehrenfeld, MD, MPH, and then-Immediate Past President Patrice Harris, MD, MA:

> …the violence inflicted by police in the news headlines today must be understood in relation to the larger social and economic arrangements that put individuals and populations in harm's way, leading to both premature illness and death. Police violence is a striking reflection of our American legacy of racism—a system that assigns value and structures opportunity while unfairly advantaging some and disadvantaging others based on their skin color… Importantly, racism is detrimental to health in all its forms.[1]

Because of structural racism, historically marginalized and minoritized communities in the United States shoulder the unfair, unjust, and disproportionate burden of police violence, experiencing higher levels of mortality, morbidity, inequity, and intergenerational trauma. Police violence is a leading cause of death for young men in the United States.[2] Over their life course, about one in every 1,000 Black men can expect to be killed by police. The risk of being killed by police peaks between the ages of 20 years and 35 years for men and women and for all racial and ethnic groups. Black women and men and American Indian and Alaska Native women and men, however, are significantly more likely than white women and men to be killed by police. Latino men are also more likely to be killed by police than are white men.[3] According to the Mapping Police Violence database, Black people comprise 28 percent of those killed by police in 2020—despite being only 13 percent of the population.[4] It is important to note that the disproportionate exposure of communities of color to fatal police violence does not correlate to crime rates.[5] Police-related deaths have distinct causes, distributions, and consequences for population health from other forms of violence and currently number in the thousands every year.[6]

Beyond the increased rate of fatalities, research also shows that racially marginalized communities are disproportionally subject to police force, and there is a correlation between policing and adverse health outcomes. Studies have shown that, "Men, racial/ethnic minorities, young people, and those living in economically disadvantaged areas are particularly at risk, especially those at the intersection of these social stratifications."[7] Standardized policies, such as stop and frisk, normalize racial profiling and structural racism.[8] An increased prevalence of police encounters is linked to elevated stress and anxiety levels, along with increased rates of high blood pressure, diabetes, and asthma—and fatal complications of those comorbid conditions—for both the victim and the community, including children.[9,10] Racism as a driver of health inequity is also particularly evident in findings from a 2018 *Lancet* study showing that law enforcement-involved deaths of unarmed Black individuals were associated with adverse mental health consequences among Black American adults—regardless of whether the individual affected had a personal relationship with the victim or the incident was experienced vicariously. The trauma of violence in a person's life course is associated with chronic stress, higher rates of comorbidities, and lower life expectancy.[11]

QUALIFIED IMMUNITY

Qualified immunity is a judicially created legal principle that grants civil immunity to individual government officials performing discretionary duties within the scope of their employment. Only if a plaintiff demonstrates that the government official violated, "clearly established statutory or constitutional rights of which a reasonable person would have known" may a civil suit proceed.[12] It operates as an affirmative defense for individual government officials, barring damages even if an unlawful, unconstitutional act was committed. Though qualified immunity is often discussed as it applies to law enforcement officers, it also applies to most other executive branch officers. Importantly, qualified immunity is only applied in civil claims and only in suits against government officials individually. Criminal proceedings and suits against the government itself for damages caused by officials' actions do not trigger the qualified immunity doctrine.

The doctrine of qualified immunity was established in 1982 by the U.S. Supreme Court and was intended to, "protect officials who are required to exercise discretion and the related public interest in encouraging the vigorous exercise of official authority."[13] As it applies to law enforcement officers, supporters of qualified immunity believe it is necessary to give some deference to officers making "split-second judgments—in circumstances that are tense, uncertain, and rapidly evolving—about the amount of force that is necessary in a particular situation."[14]

The doctrine is often implicated in civil rights lawsuits against state and local police under 42 U.S.C. § 1983 (Section 1983), which creates an avenue to seek damages for civil rights violations in state or federal court. Over time, the Supreme Court has broadened qualified immunity and narrowed the path to proceed in a case against a government official, diminishing the protections of Section 1983. A *Reuters* analysis of appellate court records showed that lower courts have increasingly granted immunity in cases alleging excessive use of force by law enforcement officers.[15]

Qualified immunity is a federal doctrine, and, for that reason, it can only fully be abolished or amended by the Supreme Court or Congress. Nevertheless, some states have acted to limit the application of qualified immunity in state courts. In June 2020, for example, Colorado became the first state to explicitly limit qualified immunity for local law enforcement officers, sheriff's deputies, and Colorado State Patrol officers. The Enhance Law Enforcement Integrity Act (the Act) creates a new "civil action for deprivations of rights" which enables state residents to sue law enforcement officers in state court for alleged violations of the Colorado Constitution. The Act also requires law enforcement agencies to indemnify their officers.

In April 2021, New Mexico enacted the New Mexico Civil Rights Act which bars the defense of qualified immunity for any state or local public official who has caused "the deprivation of any rights, privileges or immunities secured by the Constitution of New Mexico." The New Mexico law also creates a new cause of action under which a plaintiff may sue the government employer for damages for violations of rights under the state Constitution. Whereas Colorado's law applies only to law enforcement officers, New Mexico's applies to all state officials. Neither state law affects federal civil rights claims filed in federal court.

Recent high-profile deaths at the hands of law enforcement have put repeal of the qualified immunity doctrine into the spotlight as a means of preventing excessive use-of-force by law enforcement officers. Many understand qualified immunity to grant too much deference and insulate law enforcement officers from the consequences of misconduct, particularly that aimed at members of minoritized and marginalized communities. In a 2018 dissent, U.S. Supreme Court Justice Sonia Sotomayor wrote that qualified immunity gives license to police to, "shoot first and think later, and it tells the public that palpably unreasonable conduct will go unpunished."[16]

The rationale for abolishing qualified immunity posits that the threat of personal liability will be so great that officers will "think twice" before engaging in misconduct. Indeed, the International Association of Chiefs of Police warns that the "loss of this protection would have a profoundly chilling effect on police officers and limit their ability and willingness to respond to critical incidents without hesitation."[17] There is reason to doubt, however, that repeal of the qualified immunity doctrine would create the intended effect. Research shows that law enforcement officers are almost always indemnified by their employer and governments pay of 99.98 percent of damages recovered for violations of civil rights.[18] Indemnification creates a moral hazard wherein an individual officer does not bear the full costs of his or her behavior, reducing or eliminating the incentive for individual change in behavior. If law enforcement agencies are responsible for their employee's individual actions, however, this may compel departments to implement better policies

to curb officer misconduct to avoid financial repercussions. These hypotheses are unproven, though the recently enacted laws in Colorado and New Mexico may provide the evidence needed in the future to evaluate the effectiveness of repealing qualified immunity, as a means, to curb excessive use-of-force.

In addition, incentivizing behavior change via personal liability assumes that civil rights violations are committed intentionally and that, with the right incentives or disincentives in place, an officer would choose a different course of action. While bad actors exist and intentional brutality does tragically occur, many cases result from officers, in their minds, making the best decision they could at the time. In this way, reforming the principle of qualified immunity does not address systemic failure in policing practices.

Discussion

As a physician organization, the AMA is invested in the betterment of the public health. AMA policy recognizes that policing is a social determinant of health and that inequitable law enforcement practices are a result of structural racism and have a direct, negative impact on health, particularly among historically marginalized and minoritized communities that shoulder the disproportionate burden of police violence. If the inability to hold law enforcement officers individually liable in civil court has a measurable impact on the health of our patients, then police accountability may be ripe for AMA involvement. Literature linking the application of qualified immunity for law enforcement officers to health outcomes, however, is not available and, as noted above, claims that abolishing qualified immunity would result in better policing outcomes are untested. Given that constitutional law doctrines are generally outside the scope of the AMA's work and the lack of evidence that abolishing qualified immunity would indeed reduce police violence, the AMA's contribution to the national conversation about policing might better be focused on a holistic approach to policing. In particular, because of the similarities between medicine and law enforcement—professionals in both fields are frequently placed in high-pressure situations in which they must make split second, life-or-death decisions—it may benefit law enforcement to borrow some of the strategies and practices that the medical profession uses to ensure that its members provide safe and effective care.

First, in medicine, reliance on evidence is a bedrock of clinical decision-making, but the same is not true in policing. The approximately 18,000 law enforcement jurisdictions set policies and procedures independently and generally without the benefit of research to inform those policies. Though efforts are underway to expand evidence-based policing through organizations like the American Society of Evidence-Based Policing, those efforts are nascent. More research is needed to understand and implement those practices and strategies that effectively control crime while maintaining the trust and confidence of the public and ending those that are harmful and result in inequitable, discriminatory treatment of marginalized and minoritized communities.

In addition, law enforcement lacks standardization. Unlike in medicine, where multiple governmental and nongovernmental entities set standards and guidelines for training and clinical practice, law enforcement entities are not required to adhere to external standards, often resulting in fragmented and inconsistent policies.[19] Although accreditation alone will not prevent all negative events, it may be one tool for review and ongoing measurement. Entities like the Commission on Accreditation for Law Enforcement Agencies, Inc. (CALEA) set professional standards for law enforcement through an accreditation program, though accreditation is voluntary, and fewer than 1,000 of the 18,000 law enforcement jurisdictions are currently accredited by CALEA.[20]

Furthermore, application of sentinel event reviews, like those conducted in health care and aviation settings, following a negative event, such as a police shooting, provide a promising upstream approach to reform. A sentinel event review focuses not on assigning blame but bringing together key community stakeholders to conduct a root cause analysis of all factors that led to a negative outcome and reforms that can strengthen the system to prevent recurrence. Like sentinel event reviews in health care, the approach recognizes that failures are often system-wide and not the result of a single individual's actions. The goal, therefore, is to enable systems changes in practice and culture. Sentinel event reviews are an emerging effort, though the U.S. Department of Justice Sentinel Events Initiative has been encouraging and evaluating their adoption since 2014. One of the first jurisdictions to adopt a sentinel event review board (Review Board) was the Tucson Police Department, which convened in summer 2020 following two in-custody deaths of Latino men.[21] The 15 members of the Review Board identified 32 contributing factors and agreed unanimously on 53 recommendations for the Tucson Police Department, the Tucson Fire Department, and the Tucson Public Safety Communications Department to prevent future in-custody deaths. An implementation report produced six months later found that, as a result, of the review, agencies had adopted new policies, procedures, and training to address prior failings.[22]

MILITARIZED EQUIPMENT

The recent controversy over policing methods and excessive or unreasonable force has refocused attention on programs that transfer military equipment to law enforcement agencies across the country. Images during the summer protests of 2020 following the death of George Floyd in police custody that were widely broadcast by news shows and online repeatedly showed police outfitted with tactical gear, including full-body armor and in militarized vehicles, facing off with protestors. Concerns have been raised over whether law enforcement agencies have become too militarized, the use of such equipment, and the impact of the use of such equipment, particularly on communities of color.

Eligible federal, state, and local agencies, under certain circumstances, may obtain certain U.S. Department of Defense (DOD) personal property, including equipment, clothing, vehicles, aircraft, weapons, and ammunition for use in law enforcement, counterdrug, counterterrorism, border security, and/or humanitarian activities.[23] DOD's disposal of excess or surplus military equipment, through sale, transfer, donation, or reutilization, originally dates to the end of World War II. What is now known as the 1033 Program, however, was temporarily authorized by Congress through the National Defense Authorization Act (NDAA) in 1990.[24] It allowed law enforcement agencies to acquire excess military property for a bona fide law enforcement purpose. The original intent was to transfer military equipment in the "War on Drugs" to federal and state agencies to help assist in the fight against drug production and trafficking.[25] Congress officially created the 1033 Program through the Fiscal Year 1997 NDAA.[26] The 1033 Program allowed the transfer or donation of excess DOD property to state, local, and Tribal law enforcement agencies. Agencies that used the property for counterdrug or counterterrorism activities received preference.[27]

The Law Enforcement Support Office (LESO) of the DOD's Defense Logistics Agency (DLA) is responsible for facilitating and managing the 1033 Program and, according to information on LESO's website, more than 8,000 law enforcement agencies to date have enrolled in the 1033 Program.[28] Once accepted into the 1033 Program, a law enforcement agency can review online the available excess DOD inventory that is suitable for law enforcement and make requests for property through the state coordinator. Every request for property must have a justification outlining how the property will be used, and requests must be for bona fide law enforcement purposes. Agencies do not pay for the property but must pay for shipping the items as well as potential storage costs.[29] A caveat of the 1033 Program included a requirement to deploy the

equipment within one year of receipt which may incentivize police to use the equipment for other purposes. Agencies that do not use the equipment within the one-year timeframe are required to return the unused items.[30]

There are two types of property that can be transferred to law enforcement under the program: controlled and uncontrolled. Controlled property consists of military items that are provided via a conditional transfer or "loan" basis; title for the property remains with DLA. Controlled property includes items such as small arms/personal weapons, demilitarized vehicles and aircraft, and night vision equipment. When a law enforcement agency no longer wants the controlled property, it must be returned to LESO. Non-controlled property, on the other hand, consists of common items DLA would sell to the general public, such as office equipment, first aid kits/supplies, hand tools, sleeping bags, computers, and digital cameras. After one-year, general property becomes the property of the law enforcement agency. Most of the equipment transferred is non-controlled property.[31] According to *Politifact.com*, small arms weapons such as rifles and side-arms normally make up about five percent of the total, while less than one percent of property issued is tactical vehicles.[32] In order to request and receive controlled property, participating law enforcement agencies must receive the local governing authority's approval and must certify that, in addition to receiving such approval, they have adopted publicly available protocols for the appropriate use of controlled property, the supervision of such use, and the evaluation of the effectiveness of such use, including auditing and accountability policies.[33] Since the 1033 Program's beginning, more than $7.5 billion worth of property (based on initial acquisition value) has been transferred to law enforcement agencies.[34]

There are certain military items that are not available for transfer to law enforcement agencies through the 1033 Program. This prohibited equipment includes: any aircraft, vessels or vehicles that inherently contain weaponry, (e.g., tanks, Bradley fighting vehicles, armed drones); crew served/large caliber (.50 caliber or greater) weapons and ammunition; military uniforms; body armor; Kevlar helmets; and explosives or pyrotechnics of any kind. Also, aircraft and vehicles available in the program are "demilitarized," meaning that any specific military technology (e.g., communication equipment) are removed prior to transfer to law enforcement agencies.[35]

There are several oversight tools that DLA uses for the program to maintain and ensure compliance with all program requirements and property accountability, including an annual certified inventory by each participating state, biennial federal level program compliance reviews, and annual state coordinator reviews of at least five percent of the law enforcement agencies that have acquired property. In addition, state coordinators and law enforcement agencies may be suspended or terminated from the 1033 Program for non-compliance.[36] In addition, the law was amended by Congress in 2015 to make it clear that each individual agency acquiring controlled equipment has responsibility for training its personnel in the proper use, maintenance, and repair. The law requires each law enforcement agency to certify on an annual basis that it provides annual training to relevant personnel on the maintenance, sustainment, and appropriate use of controlled property.[37] Additional oversight is provided through coordination between LESO and the DOJ to identify law enforcement agencies that are under DOJ investigation or under a consent decree and thus ineligible for the program.

After calls for transparency about the 1033 Program following the Black Lives Matter protests in 2014 in Ferguson, Missouri, in the aftermath of the police shooting of Michael Brown, the DOD released data about the tactical equipment it tracks through the program, and for the first time identified the agencies that received items.[38] Since 2016, there has been more transparency than there was during the first 20 years of the 1033 Program, when record keeping was very spotty.

LESO has a public website page that links to a detailed spreadsheet, that lists all equipment issued to agencies, by state.[39]

While the 1033 Program is perhaps the most publicly well-known program, there are additional DOD programs that allow law enforcement to purchase military-grade equipment. For example, under the 1122 Program, originally authorized in the NDAA for FY1994 (P.L. 103-160, codified at 10 U.S.C §281), the Secretary of Defense is allowed to establish procedures for state and local governments to purchase law enforcement equipment for counterdrug, homeland security, and emergency response activities. Section 885 of the FY2009 NDAA (P.L. 110-417) expanded the program to include homeland security and emergency response operations. The U.S. Army, notably, manages the 1122 Program. Moreover, another program authorizes the Secretary of Defense to sell surplus military equipment to state and local law enforcement, firefighting, homeland security, and emergency management agencies at fair market value. Authorized equipment includes pistols, revolvers, shotguns, rifles of a caliber not exceeding .30, ammunition for such firearms, gas masks, personal protective equipment, and other appropriate equipment. The equipment cannot be transferred or resold by the acquiring agency.[40]

Similar to the 1122 Program, the Department of Homeland Security's (DHS) Urban Areas Strategy Initiative provides grant funds to allow police and sheriffs' departments to purchase crowd-control items such as cuffs, batons, helmets, gas masks, and other such equipment or allow them to use their own money to buy it at discounted federal prices.[41] DHS also has another grant program, the State Homeland Security Program, that provides funding to state, local, and Tribal governments, for terrorism preparedness. Notably, there is less transparency about these other programs, and they do not have the same restrictions as the 1033 Program.

Following the Ferguson protests, numerous concerns were raised about the 1033 Program by members of Congress, the media, and research groups. Congressional hearings were held and in May 2015, following the recommendations of a working group he appointed, then President Barack Obama signed an executive order that prohibited state and local law enforcement from receiving certain types of property, such as grenade launchers and weaponized aircraft, under the 1033 Program.[42] Subsequently, former President Donald Trump rescinded the Obama-era restrictions.

More recently, in the wake of the police killing of George Floyd and the subsequent protests, a provision to place restrictions on the 1033 Program was included in the FY21 NDAA, which was passed over then President Trump's veto. Specifically, Section 1053 bars the transfer to law enforcement agencies of bayonets, lethal grenades, weaponized tracked combat vehicles, and aerial drones equipped with weapons. The provision also requires that personnel in law enforcement agencies that receive DOD equipment under the program undergo training in respect for citizens' constitutional rights and in conflict de-escalation. Finally, legislation was introduced in Congress in 2020 and again this year that includes provisions to demilitarize police departments, i.e., the "George Floyd Justice in Policing Act" (H.R. 1280, 117th Congress), which passed the House of Representatives on March 3, 2021. Section 365 of the bill would place limitations on the 1033 Program, including banning the transfer of controlled equipment (e.g., firearms, ammunition, bayonets, grenade launchers, grenades, explosives, most vehicles, drones, certain aircraft) and require more accountability and reporting from agencies receiving equipment and from DOD to Congress. This provision remains one of the stumbling blocks in negotiations on the bill in the Senate.

Discussion

Supporters of the 1033 Program, including many members of Congress and law enforcement agencies, argue that it provides an efficient way for local police agencies to obtain recycled equipment they otherwise could not afford, and was a good use of tax dollars. Law enforcement notes that there are high risk situations when use of such equipment is necessary and appropriate, such as during mass shooting events. They also point to the numbers, arguing that the 1033 Program does not contribute to militarization given that most of the transferred equipment is of general use, such as first aid kits, blankets, gym equipment, cold weather clothing, and large storage bins, while less than one percent of the equipment are tactical vehicles and only five percent are small arms.[43] Proponents also argue that the 1033 Program helps to increase safety in cities, particularly for law enforcement officers and the public.[44] In an evaluation of the 1033 Program published in 2018 that was conducted by the RAND Corporation and was required by the 2017 NDAA, the authors concluded that the DOD's LESO manages an efficient program that effectively reuses excess property, benefits the law enforcement community, responds diligently to oversight, and is faithful to congressional intent. The study authors acknowledged, however, that, "these efforts are unlikely to resolve perceptions that the program contributes to the militarization of police."[45]

Opponents and critics, however, argue that the 1033 Program has led to an excessive militarization of local police agencies, adversely impacts police culture, erects barriers between police and local communities, and has led to an association with the use of lethal force on suspects.[46] For example, recent research has analyzed factors that increase an agency's likelihood of acquiring specific categories of equipment through the 1033 Program. One study found that agencies with "warrior" tendencies (measured through agencies' body armor policies and special units) and that use asset forfeiture were significantly more likely to acquire a mine-resistant ambush-protected (MRAP) vehicle.[47] Another study assessing the influence of violent crime rates, drug arrest rates, and proportion of minority population on agencies' participation in the 1033 Program, found that high violent crime rates and high proportion of Black population increased an agency's likelihood to obtain any equipment from the 1033 Program.[48] In a 2014 report by the American Civil Liberties Union that examined the use of SWAT teams, the authors stated that, "the use of hyperaggressive tools and tactics results in tragedy for civilians and police officers, escalates the risk of needless violence, destroys property, and undermines individual liberties."[49]

In light of the different ways agencies acquire military equipment, it is difficult to assess the extent to which and whether local police agencies are militarized and how such equipment is actually used. As discussed above, there is no consensus in research studies on the actual impact of the 1033 Program on communities or on police. There is also no clear evidence that regulating or limiting the 1033 Program alone would resolve these issues given the other programs through which law enforcement agencies acquire military equipment, especially since there is less publicly available information on them. Without such evidence, it is difficult to reach conclusions on whether the AMA should support limiting or eliminating the 1033 Program or funding for additional DOD or DHS military equipment programs. And, without such evidence, it would be difficult for the AMA to impactfully advocate on such a position. Therefore, while acknowledging the concerns expressed by Resolution 410, and its sponsors and supporters, the Board determined that the AMA should defer to outside organizations that have the appropriate expertise and resources to fully examine and study these issues and encourage such endeavors.

COMMUNITY-BASED OVERSIGHT BOARDS

Community or civilian oversight boards (COBs) are entities comprised of members of the public who may review, investigate, or discipline law enforcement officer wrongdoings. They vary tremendously in terms of composition, scope, and authority, but generally follow three main models: investigation-focused models that operate separately from law enforcement; review-focused models that review the quality of completed internal affairs investigations; and auditor/monitor models that focus on large-scale systemic reform and, at times, participate in or monitor internal investigations. Currently, there are approximately 200 COBs among the 18,000 law enforcement jurisdictions in the United States, including in 24 of the 50 largest cities.[50,51] Most COBs are created locally by cities, towns, and counties.[52]

The movement toward modern civilian oversight, dates back, to the civil rights era when Black and Latino communities successfully advocated for civilian oversight in their communities. Since that time, many COBs have been created in direct response to high profile events and racially disparate policing. For example, the City of Chicago created its Police Accountability Task Force in response to the 2014 shooting of Laquan McDonald.[53] The findings from the Chicago task force investigation led to the creation of a civilian oversight body.[54] Often, COBs are created in a consent decree between the DOJ and a municipality. For instance, Albuquerque's COB was established via settlement agreement with the DOJ in 2014 following findings of patterns of excessive force by the DOJ.[55]

Proponents of community oversight say that such boards improve public trust, ensure accessible complaint processes, ensure thorough investigations, increase transparency, and deter police misconduct. The push for community oversight also stems from skepticism of self-regulation by police. Proponents argue that internal investigations and disciplinary processes conducted by fellow law enforcement officers are inherently conflicted and biased, and lead to overly permissive supervision that fails to hold officers accountable for wrongdoing. Citizen-led investigatory and disciplinary processes, it is argued, are a necessary external check on police power.

However, despite their growing popularity, evidence of COBs promoting accountability, improving police-community relations, and curbing police misconduct is limited. There is some evidence that external civilian review of internal investigations is associated with a greater likelihood that misconduct complaints will be found to have merit, but, to date, COBs have been found to be largely ineffective due to political opposition, lack of authority to investigate, and lack of power to discipline.[56,57]

Many COBs have limited authority by design. A survey conducted by the National Association for Civilian Oversight of Law Enforcement found that 63 percent of oversight boards have authority to conduct investigations that are independent of the police, but others are limited to audits or reviews of prior internal investigations. Only 40 percent had subpoena power, without which COBs cannot compel witnesses to testify or produce documents.[58] In some instances, because they are staffed by civilians, COBs are not granted access to confidential personnel records or internal investigations documents that might be relevant.[59] Further, COB findings are often advisory and non-binding. For those that can recommend disciplinary action, police chiefs or others may reject their recommendations. Only six percent have authority to discipline officers.[60] One study estimated that when COBs handle civilian misconduct complaints, only seven to nine percent of the complaints result in officer discipline.[61] COBs are sometime limited in scope as well. Some can only investigate serious police violence, which puts systemic failings out of the COBs' reach. Some COBs can only investigate incidents rather than general policing policies, reinforcing the reactive, rather than proactive, approach to police misconduct.[62]

Police unions can sometimes impede COBs. Some object to civilians, who they consider to be unknowledgeable in policing, having the power to judge police actions and argue there are other systems in place to investigate police misconduct, like internal affairs units.[63] Consequently, police or their unions sometimes place restrictions on what information can be released to the COBs or otherwise restrict COBs via collective bargaining agreements.

Discussion

Because of the limitations of existing COBs and limited research demonstrating their effectiveness, it is unclear if expanding civilian authority of police oversight would improve police-community relations and decrease officer misconduct. It may be that authorizing COBs to conduct independent investigations and issue binding disciplinary orders would deter police violence. The necessary attributes of an effective COB, however, remain unclear. Questions about what form COBs ought to take, what powers it ought to be granted, and how to untangle agreements made between police unions and local governments extend beyond the scope of the AMA's expertise.

We also note that medicine has a long tradition of self-regulation that is supported by AMA policy. When a state medical board conducts an investigation or inquiry of a physician's quality of care, we believe that the standard of care must be determined, not only by a physician, but by a physician from the same specialty. Similarly, AMA policy supports peer review processes that are conducted by physicians within the same specialty. We also advocate for strict confidentiality of the proceedings of peer review processes and information reported to licensing boards. If COBs were proposed to oversee physicians' actions, physicians would undoubtedly object.

Again, policy supporting a more holistic approach to policing may be more impactful way for the AMA to advocate. Specifically, there is a movement underway towards more police coordination and engagement with communities on the front-end, which allows communities visibility and input into policing strategies, and elevates them to a meaningful partner in the production of public safety. Community policing has four important features: community-based crime prevention; reorientation of patrol activities to emphasize non-emergency servicing; accountability to the public; and decentralization of command.[64] A community-focused approach has been found to reduce citizen fear and increase citizen satisfaction, which are often linked to a citizen's perception of legitimacy of the police.[65] In a short-term study, brief interactions with the police were shown to improve attitudes towards the police and increase trust of the police.[66]

"Community-oriented" policing is on the rise and quickly becoming the dominant philosophy for policing in America, with over 81 percent of agencies using some community policing approaches.[67] A 2018 report from the Policing Project at NYU School of Law, Police Foundation, and National Urban League, however, found that while most law enforcement agencies are taking steps to build community relations, more can be done. According to this 2018 report, community members desire more input into department policies and practices.[68] More community involvement on the front-end could address some of the upstream, systemic issues that lead to racially disparate policing.

In addition to community-oriented policing, improving, and expanding training on procedurally just policing has been lauded as a strategy for decreasing use-of-force and increasing citizen satisfaction with police. The "procedural justice" model of policing prioritizes transparency, explaining policing actions, and responding to community concerns.[69] In Seattle, for example, a procedural justice training program designed to "slow down" police officers' interaction with community members reduced use-of-force between 15 and 40 percent.[70] Similarly the National Academy of Sciences found that large-scale implementation of procedural justice training in

Chicago led to both reduced complaints against the police by 10 percent and reduced the use of force against civilians by 6.4 percent over two years.[71] Another study found that officers who attended training on procedural justice were more likely to endorse the importance of giving members of the public a voice, granting them dignity and respect, demonstrating neutrality, and trusting them to do the right thing.[72]

We recognize, however, that procedurally just policing and community policing must be accompanied by greater police accountability. Accountability for individual police actions is essential if police are to effectively and equitably protect all citizens, and if police are to have legitimacy in the eyes of community members. As discussed above, there is currently insufficient evidence to support the widescale adoption of police accountability reform proposals that seek to decentralize disciplinary processes away from internal police mechanisms and instead empower independent actors (e.g. community boards and courts) with disciplinary authority. Research does, however, suggest that certain internal accountability mechanisms, such as written policies on use of force, greater supervision of officers by their supervisors, early intervention systems that identify officers with patterns of misconduct, and hiring practices that prevent officers who have been dismissed for misconduct from being unknowingly rehired by other departments, may be effective at changing individual police conduct.[73] While the AMA is not in a position to determine which reforms are preferable over others, we do recognize that greater accountability is necessary to end discriminatory practices and unnecessary or excessive use of police force.

AMA POLICY

AMA policy affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health. Policy further encourages data collections and the study of public health effects of violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities and mandatory reporting of legal intervention deaths and law enforcement officer homicides to public health agencies (Policy H-515-955, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes”).

In November 2020, the AMA adopted new policy recognizing police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color and pledging to work with interested medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers. AMA policy also advocates against the utilization of racial and discriminatory profiling by law enforcement, for appropriate anti-bias training and individual monitoring, and for trauma-informed, community-based safety practices (Policy H-65.954, “Policing Reform”).

AMA policy supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs, and federal funding to encourage increased community and law enforcement participation in crisis intervention training programs. AMA policy also supports evidence-based training programs for corrections officers on effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities (Policy H-345.972, “Mental Health Crisis Interventions”). AMA policy also encourages national standards for school resource officers to include training and certification in child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including

students, teachers, staff and visitors (Policy H-60.902, "School Resource Officer Qualifications and Training").

Several AMA policies directly address law enforcement processes and procedures. AMA policy does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill and advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate (Policy H-430.998, "Use of the Choke and Sleeper Hold in Prisons"). AMA policy recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) and encourages evaluation, management, and post-exposure monitoring and independent research of field deployment of CEDs to better understand the risks and benefits under conditions of actual use (Policy H-145.977, "Use of Conducted Electrical Devices by Law Enforcement Agencies"). AMA policy supports expanded use of body-worn cameras for law enforcement (Policy D-160.919, "Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919). AMA policy advocates for guidelines governing police pursuits and use of advanced technologies to reduce high-speed chases (Policy H-15.964, "Police Chases and Chase-Related Injuries H-15.964"). New AMA policy adopted in 2021 supports prohibiting the use of rubber bullets, chemical irritants, and kinetic impact projectiles to control protests and crowds that do not pose an immediate threat (Policy H-145.969, "Less-Lethal Weapons and Crowd Control "). AMA policy also recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system for the use of kinetic impact projectiles and chemical irritants, as well as greater use of de-escalation techniques and the development of crowd-control techniques which pose a more limited risk of physical harm (Policy H-145.969, "Less-Lethal Weapons and Crowd Control").

AMA policy opposes the use of the terms "excited delirium," expresses concern about law enforcement officer use of force accompanying "excited delirium" that leads to disproportionately high mortality among communities of color, particularly among Black men, and denounces "excited delirium" solely as a justification for the use of force by law enforcement officers (Policy H-130.932, "Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting"). AMA policy opposes the use of sedative/hypnotic and dissociative agents as a pharmacological intervention for agitated individuals in the out-of-hospital setting, when done solely for a law enforcement purpose and recognizes that sedative/hypnotic and dissociative pharmacological interventions for agitated individuals have significant risks (Policy H-130.932, "Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting"). AMA policy also urges training for law enforcement and frontline emergency medical service personnel on de-escalation techniques and the appropriate use of pharmacological intervention for agitated individuals (Policy H-130.932, "Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting"). Finally, AMA policy urges medical and behavioral health specialists, not law enforcement, to serve as first responders and decision makers in medical and mental health emergencies in local communities and that administration of any pharmacological treatments in the out-of-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way (Policy H-130.932, Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting").

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of the Third, Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, and that the remainder of the report be filed.

1. That our AMA advocate for efforts to implement evidence-based policing and the creation of evidence-based standards for law enforcement. (New HOD Policy)

2. That our AMA advocate for sentinel event reviews in the criminal justice system following an adverse event, such as an in-custody death. (New HOD Policy)

3. That our AMA encourage further research by subject matter experts on the issues related to the transfer of military equipment to law enforcement agencies, including the impact on communities, particularly those in minoritized and marginalized communities. (New HOD Policy)

4. That our AMA support greater police accountability, procedurally just policing models, and greater community involvement in policing policies and practices. (New HOD Policy)

5. That Policy H-65.954, "Policing Reform," be reaffirmed. (Reaffirm HOD Policy)

6. That Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," be reaffirmed. (Reaffirm HOD Policy)

7. That Policy H-345.972, "Mental Health Crisis Interventions," be reaffirmed. (Reaffirm HOD Policy)

8. That Policy H-145.969, "Less-Lethal Weapons and Crowd Control," be reaffirmed. (Reaffirm HOD Policy).

Fiscal Note: Less than $5,000.

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Appendix A: AMA Policies Recommended for Reaffirmation

H-65.954 Policing Reform
Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices. (Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21)

H-515.955 Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes
Our AMA:
1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers. (Res. 406, A-16; Modified: BOT Rep. 28, A-18)

H-345.972 Mental Health Crisis Interventions
Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities. (Res. 923, I-15; Appended: Res. 220, I-18; Reaffirmed: CSAPH Rep. 2, A-21)

H-145.969 Less-Lethal Weapons and Crowd Control
Our American Medical Association (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a

safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm. (BOT Rep. 10, A-21)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-N-21

Subject: Improved Access and Coverage to Non-opioid Modalities to Address Pain (Alternate Resolution 218-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted an alternate resolution to Resolutions 218, which is now AMA Policy H-120.922, "Improved Access and Coverage to Non-Opioid Modalities to Address Pain."

The following resolves were referred:

> That although our AMA supports all interventional pain interventions and therapies in general, due to current issues with limitations in coverage and noncoverage, in particular, spine and large joint radiofrequency ablation and other arbitrarily limited non-covered interventional pain management procedures, by private insurance carriers, third party reviewing agencies, Medicare and Medicaid contractors, and Medicare Advantage Plans, the AMA supports coverage of these medically necessary procedures in particular, at this time; and
>
> That our AMA supports coverage of evidence-based spinal cord stimulation trials and implantation, and peripheral nerve stimulation trials and implantation (as both CPT code sets are linked to their respective ICD10 codes as outlined in the AMA CPT Manual) by private insurance carriers, third party reviewing agencies, Medicare and Medicaid contractors, and Medicare Advantage Plans.

Original Resolutions 218 and 235 from the 2019 AMA HOD Annual Meeting contained highly specific information relating to specific medications and medical conditions. Resolution 218 asked that the AMA, "petition the Centers for Medicare and Medicaid Services (CMS) to allow reimbursement for off label use of medications like gabapentin or lidocaine patches at the lowest copayment tier for the indication of pain so that patients can be effectively treated for pain and decrease the number of opioid prescriptions written." Resolution 235 asked that the AMA, "encourage the U.S. Food and Drug Administration (FDA) to consider approving other indications in addition to post-herpetic neuralgia for transdermal lidocaine patches."

During HOD testimony, it became clear that physician delegates had many concerns about a wide range of non-opioid pain care treatment options in addition to the ones listed in the original resolutions. There also was concern raised about ensuring that AMA advocacy to CMS and FDA was focused on actions that CMS and FDA could reasonably be expected to take rather than asking them to take actions beyond their regulatory scope.

As a result of the detailed testimony, the reference committee suggested an alternate "omnibus" resolution to provide for AMA support for a broad range of non-opioid pain care treatment options for coverage and access, as well as placement on a payer's lowest cost-sharing tier. The alternate resolution received support from the Board of Trustees primarily due to the fact that the comprehensive nature of support for patients with pain would augment ongoing AMA advocacy in support of patients with pain and the physicians who provide pain care. After a robust discussion, the HOD adopted the reference committee's "omnibus" recommendation, which is now AMA Policy H-120.922, "Improved Access and Coverage to Non-Opioid Modalities to Address Pain," which states:

> Our AMA will: (1) advocate for increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient's physician; (2) advocate for non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force; and (3) encourage the manufacturers of pharmaceutical pain care options to seek DEA approval for additional indications related to non-opioid pain management therapy.

On their face, the referred resolves involve the same type of highly specific medical procedures and payer responsibilities for those procedures that were at issue in original Resolutions 218 and 235. This report will provide background on the issues presented, discuss relevant AMA policy and provide recommendations.

DISCUSSION

One of the most common elements of the nation's opioid epidemic has been for policymakers and public health officials to largely bypass the fact that improving pain care for America's patients is integral to ending the nation's opioid epidemic. The AMA has long called for the balance needed between policymaking intended to address the opioid epidemic with medical evidence, policy and patient compassion—alongside the reality that there are millions of patients in pain, and that the opioid epidemic has fully shifted to one driven by illicitly manufactured fentanyl, fentanyl analogs, heroin, cocaine and methamphetamine. While policymakers have almost entirely focused on opioid prescribing, physicians and other health care professionals on a national level began to make more judicious opioid prescribing decisions in 2012-13. Part of that decision-making process, however, must not discount the clinical experience that opioid therapy works for many patients. It also must not discount the practical reality faced by physicians and patients daily that if opioid therapy is not the preferred course of treatment, patients must have access to affordable, available non-opioid treatment options supported by medical evidence.

These overarching principles and concerns have guided the AMA in calling for pain-related policies and practices that do more than simply promote, prioritize or pay for minimizing prescription opioid prescribing. Such restrictive policies not only run the risk of undertreating pain, but they may lead to sub-optimal outcomes, increased stigma and ongoing barriers to care.[1] AMA advocacy, therefore, strongly supports efforts focused on health insurance plans, PBMs and other payer policies to be changed and aligned to support comprehensive multimodal, multidisciplinary and restorative pain care. This includes removing administrative and financial barriers (e.g., prior authorization, inappropriate specialty tiering in formularies, prohibitive cost-sharing), as well as supporting payment policies that will promote optimal pain care. Despite recognition among the medical and patient community, these barriers remain pervasive and harm patients.

The U.S. Department of Health and Human Services (HHS) Interagency Pain Care Task Force reported in 2019 that, "multidisciplinary, multimodal approaches to acute and chronic pain are often not supported in time and resources, leaving clinicians with few options to treat often challenging and complex underlying conditions."[2] The report also found that:

> The recent advent of retail pharmacies limiting the duration of prescriptions, making changes to dosage, amounts, or placing restrictive barriers to obtaining properly prescribed pain medications has had the unintended consequence of limiting access to pain care. Without access to sufficient pain care, many patients face unnecessary medical complications, prolonged suffering, and increased risk for psychiatric conditions.

The AMA is deeply concerned that corporate and retail pharmacy and PBM practices are having the unintended consequence of limiting access to pain care—leading to medical complications, heightened stigma and increased pain. These combined payer, pharmacy chain and PBM policies need further investigation and rescission to help ensure patients with pain can receive the type of comprehensive, multidisciplinary, multimodal care that pain experts support, and patients deserve. This applies to a broad range of evidence-based restorative therapies, interventional procedures, behavioral health approaches and complementary and integrative health strategies. More than 90 percent of pain medicine specialists said that they have been required to submit a prior authorization for non-opioid pain care—with them and their staff spending hours per day on these requests.[3]

The AMA Opioid Task Force (Task Force) broadly supports access to the treatments prescribed and recommended by a patient's physician for pain-related care. The Task Force included, among its first recommendations, support for physicians who treat patients with pain. The Task Force recommended support for patients' and physicians' access to comprehensive, affordable, compassionate treatment, including a comprehensive, multidisciplinary, multimodal approach to pain management. The Task Force emphasized that, "[t]his means that payers and employers need to improve access to non-opioid and non-pharmacologic treatment for pain."[4]

The Task Force furthered its 2015 recommendation on comprehensive pain care in 2019, urging additional action by policymakers. The recommendation emphasized the need to, "[r]emove administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care and rehabilitation programs."[5] In part, the 2019 recommendation responded to the fact that physicians had reduced opioid prescribing by 33 percent between 2013-18, but many patients receiving opioid therapy—and part of stable, ongoing care—found themselves subject to payer, chain pharmacy, PBM and state legislative policies that either strongly encouraged or required quantity and/or dosage restrictions on opioid analgesics.

The AMA Pain Care Task Force (PCTF) was formed in 2018 with a goal of identifying a set of priorities for improving pain care that are actionable and that will potentially provide opportunities for collaborative action. The PCTF has prepared a manuscript for publication later this year that describes many of the barriers to effective, high quality and evidence-informed care for patients with pain. Policy and payer issues, workforce and training challenges, legal issues, research challenges, stigma and patient beliefs and expectations all contribute to the barriers physicians and patients experience and are explored in the document. The PCTF also has documented principles for evidence-informed pain management. Additionally, the PCTF continues to be engaged in conversations related to education of physicians along their continuum on issues relevant to the intersection of pain care, opioids, and addiction.

There is no question that the nation's physicians have reduced opioid analgesic supply—both in volume and dose strength—but there has not been a concomitant increase in access to or affordability of evidence-based non-opioid alternatives. This includes medication, including non-opioid pain relievers, anticonvulsants, antidepressants, musculoskeletal agents, anxiolytics, as well as opioid analgesics when appropriate. It includes restorative therapies such as physical therapy, occupational therapy, physiotherapy, therapeutic exercise, osteopathic manipulative therapy (OMT) and other modalities such as massage and therapeutic ultrasound. It also includes interventional procedures, such as neuromodulation, radio frequency ablation, peripheral nerve stimulation, central and peripheral nerve ablation, spine surgery and steroid injections and other emerging interventional therapies as part of the multimodal pain care plan.

The Board notes that these are among the therapies pain specialists use but are routinely subject to prior authorization and other utilization management protocols imposed by payers.[6] In urging the U.S. Centers for Disease Control and Prevention to help reduce payer-imposed barriers to comprehensive pain care, AMA Executive Vice President and CEO, James L. Madara, MD, explained that, "[i]t is challenging for physicians to be directed by the federal government to increase access to nonopioid pain care options when payers and PBMs make that difficult, to impossible, to achieve."[7]

As the above discussion makes clear, the AMA already strongly supports broad access to the types of therapies called for under both the original resolutions and the referred resolves. The Board notes that the policy approved by the HOD at A-19 were a direct response to avoiding having AMA policy focus too narrowly on one type of therapy. The Board is concerned that in focusing too intently on one type of therapy, it potentially raises the risk of excluding other types of non-opioid pain care as part of AMA advocacy. For example, if a payer decided to remove prior authorization and other barriers to the therapies in the referred resolves, they could argue that they have satisfied AMA policy without enhancing access to the much more robust areas of non-opioid pain care used by physicians.

In addition to the overly narrow focus on specific therapies in the referred resolves, the Board also is concerned by the overly vague nature of "coverage," as it is presented in the referred resolves. It is not clear from the testimony or the language of the resolves referred precisely what is meant by "coverage" as that is a term of art used by CMS. Specifically, CMS has processes for the development of National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), both of which require extensive levels of evidence and consideration by CMS.[8] There also is separate CMS policy and processes for trials of a particular service. It is far beyond the scope of this report to delve into whether the procedures named in the referred resolves have the requisite levels of outcomes data, evidence and other criteria needed by CMS as part of the NCD, LCD or other coverage determination. Thus, while the Board supports the underlying intent of the original resolutions and the referred resolves to help ensure patients have access to the therapies recommended by their physician, and the Board would almost certainly support actions by CMS to remove barriers to those therapies, the Board is not aware that CMS has been presented with applications or other information as part of an NCD or LCD. It is challenging, to say the least, to suggest that the AMA should support an NCD or LCD without having access to the data and other information required by CMS. This is not to suggest that the AMA does not support patients receiving those therapies, but it is premature to suggest AMA support for a specific NCD or LCD for a specific therapy at this time.

The Board's recommendation to not adopt the referred resolves does not limit AMA advocacy for increasing access to non-opioid pain care. This is due to the fact that the policies adopted by the HOD in lieu of original resolutions 218 and 235 encompass the underlying intent of the referred

resolves. This is also due to the fact that additional AMA policies outlined below, as well as ongoing AMA advocacy, demonstrate AMA already advocates for a broad range of non-opioid pain care access for patients. The AMA does not and should not favor one evidence-based option over another, which is what the referred resolves are asking the AMA to do. Accordingly, to help ensure AMA advocacy and programmatic efforts continue to support all physicians who treat patients with pain, it is recommended that the resolves referred be not adopted.

AMA POLICY

As discussed thoroughly above, AMA has comprehensive policy in support of ensuring patients have access to the pain care therapies and modalities recommended by their physician. This includes advocating for, "increased access and coverage of non-opioid treatment modalities including pharmaceutical pain care options, interventional pain management procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-based therapies recommended by the patient's physician," as well as, "non-opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients have increased access to evidence-based pain care as recommended by the HHS Interagency Pain Care Task Force. (Policy H-120.922, "Improved Access and Coverage to Non-Opioid Modalities to Address Pain")

Similar AMA policy stresses, "ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living." (Policy H-185.931, "Workforce and Coverage for Pain Management") Notably, AMA policy supports, "health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits." (Policy H-185.931, "Workforce and Coverage for Pain Management")

Interventional chronic pain management means the diagnosis and treatment of pain-related disorders with the application of interventional techniques in managing sub-acute, chronic, persistent and intractable pain. The practice of pain management includes comprehensive assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative treatment options, selection of appropriate treatment options, termination of prescribed treatment options when appropriate, follow-up care, the diagnosis and management of complications and collaboration with other health care providers.

When AMA policy does discuss invasive pain management procedures or techniques—unlike the referred resolves—AMA policy appropriately provides for a wide range, including but not limited to "ablation of targeted nerves; procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics, steroids, and analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging modality; and surgical techniques, such as laser or endoscopic discectomy, or placement of intrathecal infusion pumps, and/or spinal cord stimulators." (Policy H-410.950, "Pain Management")

RECOMMENDATION

The Board recommends that the referred resolves in Alternate Resolution 218-A-19 not be adopted and the remainder of the report be filed.

Fiscal Note: None

REFERENCES

1. The Board notes that the AMA Opioid Task Force has received hundreds of emails and other communication from patients who have been nonconsensually tapered from their current opioid analgesic regimen. The communications also include patients who have not been able to find a physician willing to prescribe opioid analgesics due to fear from investigation or prosecution. In all cases, it is clear to the Board that patients across the country face increased pain and suffering due to misapplication of opioid sparing policies, stigmatization of chronic pain and fear of providing opioid-based pain therapy.
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7. AMA letter to Deborah Dowell, MD, MPH, Senior Medical Advisor/Chief Medical Officer, Division of Unintentional Injury Prevention, U.S. Centers for Disease Control and Prevention. James L. Madara, MD. October 29, 2019. Available at https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-10-29-Letter-to-Dowell-Compton-Giroir.pdf
8. For a good overview, *see* Laxmaiah Manchikanti, MD, et al., "Value-Based Interventional Pain Management: A Review of Medicare National and Local Coverage Determination Policies." Pain Physician 2013; 16:E145-E180. Available at https://www.painphysicianjournal.com/current/pdf?article=MTkwNA%3D%3D&journal=75

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-N-21

Subject: Medical Marijuana License Safety (Resolution 219-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 219-A-19, "Medical Marijuana License Safety," introduced by the Oklahoma delegation, which asked:

> That our American Medical Association draft model state legislation to amend states' prescription drug monitoring programs to include a medical marijuana license registry.

Testimony on Resolution 219 raised numerous issues, including increasing legalization of medical and recreational cannabis; concerns about cannabis use by patients with—or without—a physician's knowledge; how medical marijuana license registries function in select states; and the potential intersection with and appropriate role(s) of a state prescription drug monitoring program (PDMP). This report provides relevant background and discussion, a review of relevant AMA policy and makes policy recommendations.

BACKGROUND

It is likely that any patient who sees a physician will be asked for a current list of any medications, supplements, herbal remedies or other substances being taken. This information is essential to ensure the physician has complete and accurate information that may be relevant to a patient's diagnosis and treatment options for any given ailment or disease.

The U.S. Food and Drug Administration (FDA) is charged with, among other things, reviewing new drug applications, including making recommendations about a drug's scheduling. The U.S. Drug Enforcement Administration (DEA) receives that recommendation and is charged with determining the drug's schedule or changing an existing drug's schedule. Cannabis (also referred to as marijuana or marihuana by DEA), contains the active ingredient delta-9-tetrahydrocannabinol (THC) and is a Schedule I controlled substance.[1] This means that under federal law, there is "no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse." Other Schedule I substances include heroin, LSD, peyote, methamphetamine and Ecstasy.[2]

In testimony to Congress earlier this year, Douglas Throckmorton, MD, Deputy Director, Center for Drug Evaluation and Research, FDA, explained that the FDA has approved four products containing cannabinoids: Epidiolex (standardized, plant derived cannabidiol (CBD)), Marinol (dronabinol, synthetic THC), Syndros (dronabinol), and Cesamet (nabilone, a synthetic THC

derivative). These approved drug products are only available with a prescription from a licensed health care provider. Importantly, FDA has not approved any other cannabis, cannabis-derived or CBD products.

According to the National Conference of State Legislatures, more than 30 states allow for marijuana use by persons with certain medical conditions and an additional 14 states allow for recreational use of marijuana by adults.[3] In the "medical marijuana"[4] states, 29 states provide for the establishment of a patient registry and/or identification card, three states' provisions are pending and Washington does not have such a provision.[5] With respect to patient registries in "medical marijuana" states, it is common for states to require a considerable amount of personally identifiable information and other information, which may be made available to law enforcement and others. For example:

- California established a voluntary, web-based registry to allow law enforcement and the general public to verify the validity of a medical marijuana identification card for a patient. The registry is maintained by the California Department of Public Health.[6]
- Colorado's web-based registry allows patients to apply for an identification card as well as allows so-called "medical marijuana centers" to check whether a card has been revoked. It also has functionality to allow law enforcement to verify a card's validity among other features.[7]
- Ohio patients seeking medical marijuana must first have a certified physician submit information to the registry—after which the patient will receive an email prompting the patient to complete their application and pay a $50 fee.[8]
- North Dakota's patient registry requires patients to apply online, including uploading a photo, in which the state requires eyes to be open and indicates further that applicants should, "[a]void wearing dark, tinted glasses, hats or head coverings when taking the photo."[9]

These examples are not meant to be representative of all patient registries. Most patient registries also include information about whether the patient has a qualifying medical condition, which might include AIDS, amyotrophic lateral sclerosis, Alzheimer's disease, cancer, chronic traumatic encephalopathy, Crohn's disease, epilepsy or another seizure disorder, fibromyalgia, glaucoma, hepatitis C, inflammatory bowel disease, multiple sclerosis, pain that is either chronic and severe or intractable, Parkinson's disease, positive HIV status, post-traumatic stress disorder, sickle cell anemia, spinal cord disease or injury, Tourette's syndrome, traumatic brain injury and/or ulcerative colitis.

Nearly every state has a PDMP[10] that includes information about controlled substances dispensed to patients, as well physicians' and other health care professionals' controlled substances prescribing history. The pharmacist (or other dispenser) is typically required to submit certain information to the PDMP, as well. This typically includes a patient's name, date of birth, address, contact information, physician's DEA registration or National Provider Identifier, dose and quantity of the prescription and potentially a wide variety of information ranging from the site from which the prescription was issued, type of identification and whether the prescription was for a human or animal subject.[11]

Nearly every state has the ability to share PDMP data across state lines.[12] Nearly all PDMPs are administered by the state board of pharmacy. While there is some variation in state law and policy, most state PDMPs contain Schedule II-V information. This information is generally viewed as helpful clinical information for health care professionals. Encouraging physicians to register for

and use state PDMPs when clinically indicated was one of the first recommendations of the AMA Opioid Task Force (the Task Force) in 2015.[13]

DISCUSSION

Most physicians agree that PDMPs have the capability to provide relevant clinical information for physicians and other health care professionals as part of the clinical decision-making process. The Task Force identified many of the useful features of a state-based PDMP in its first recommendations in 2015.[14] The Task Force emphasized the need for PDMPs to be integrated into clinical workflow, including having the PDMP data easily accessible in the electronic health record (EHR) without having to perform multiple clicks, enter multiple passwords, close and open multiple screens and other time-consuming barriers to PDMP use. While this has occurred in some settings, and is improving in others, it is not the norm.

Despite the barriers to PDMP use, registration and use of state-based PDMPs has significantly increased. Registration increased to nearly 2 million physicians and other health care professionals in 2019—almost a 300 percent increase from 2014; and PDMP queries have increased more than 1,100 percent during the same time period to more than 739 million.[15] It is worth noting that while most states now have a legislative mandate to use a PDMP in certain circumstances, voluntary PDMP registration and use began to increase prior to those mandates taking effect.

What is less clear, however, is whether the increased registration and use has led to improved patient outcomes, reduced opioid- and drug-related mortality, an increase in referrals for treatment of a substance use disorder or any other potential benefits of a PDMP.[16] It is also not clear whether any state PDMP already includes information regarding cannabis use. As noted above, with only four exceptions, cannabis, cannabis-derived and cannabinoid products remain Schedule I controlled substances and are not included in any state PDMP law. Resolution 219-A-19 is accurate in the assumption that state laws would need to be changed to allow for a Schedule I controlled substance to be part of the information captured into a state PDMP.

Another possibility is to somehow merge the information that is contained in a medical marijuana patient registry with a state PDMP. The technical aspects of such an endeavor are beyond the scope of the report, but even a cursory review of state PDMPs and medical marijuana patient registries reveals that the underlying software development and database management appear to be different in most states, including the fact that the state pharmacy board is typically not the state agency that administers the medical marijuana patient registry.

In addition, it is not clear if merging PDMPs and medical marijuana patient registries would further allow law enforcement to make inquiries into a state PDMP. Not only does this raise potential conflicts with AMA policy as detailed below, but it is unclear what precisely would be entered into the PDMP. Proponents of including medical marijuana registry information suggest that physicians should have information that a patient has registered for and received authorization to possess, obtain or purchase medical marijuana. On the surface, this sounds like a reasonable position.

Data does not exist, however, on how law enforcement currently uses medical marijuana patient registry information. Data also does not exist on what physicians might do with this information. The AMA Board of Trustees (the Board) is concerned that adding more information to a state PDMP without appropriate safeguards to ensure patient privacy could expose patients' personal health information to law enforcement in ways that could be detrimental. The mere existence of a patient's registration for medical marijuana should not be used as pretext for law enforcement to conduct unfettered searches in a patient's or physician's PDMP record.[17]

In addition to the concerns around increased law enforcement access to a PDMP, the Board notes that the existence of opioid prescriptions in a patient's PDMP report has resulted in myriad complications for patients, including non-consensual tapering, reports of physicians no longer prescribing opioids to such patients and patients subsequently not being able to find a physician willing to provide opioid therapy. Given that use of a legitimate medical prescription has become subject to intense scrutiny, stigma and negative consequences, the Board is concerned that adding information about a patient's authorization to use a Schedule I controlled substance could lead to similar negative consequences.

The other side to this argument is that medical diagnosis, treatment and management of disease are improved when the physician has access to all relevant information about his or her patient. This certainly includes whether a patient is using cannabis for medicinal or recreational use, as well as whether a physician has certified that a patient has one or more of the medical conditions that a state has determined qualify the patient to use cannabis for medicinal purposes. Data is not clear as to whether a patient's primary care physician is the one who is typically certifying the patient. If not, what happens when the primary physician—if reviewing new medical marijuana patient registry data—newly discovers that the patient has been certified for a serious medical condition? What effect(s) would this have on the patient-physician relationship? In addition to the above concerns, the Board notes that there is nothing currently preventing a physician from asking about these issues and that a fully functioning EHR could help resolve incomplete information about the patient's medical history.

While EHRs continue to improve, full integration with PDMPs remains a work-in-progress. In addition, the challenges with data integration would likely be increased significantly given that medical marijuana patient registry data are housed in agencies separate from those administering state PDMPs. It also is not clear what data would be integrated into a state PDMP from the registry. What would law enforcement's access be? Do the potential unintended consequences of listing patient's certification for medicinal cannabis outweigh the potential benefits for the physician and other health care professionals knowing that a patient has been certified? These are among the many questions for which clinical experience, medical evidence and objective data do not exist. Therefore, while the Board supports efforts to ensure physicians have all relevant information about their patients' potential use of cannabis for medicinal use, based on the above discussion and potential unintended consequences, it is premature to recommend developing model legislation.

AMA POLICY

AMA policy on the use of cannabis for medicinal use provides well-established balance for patient safety, autonomy and assurances for free and unfettered communication between the patient and his or her physician (Policy D-95.969, "Cannabis Legalization for Medicinal Use").

With appropriate patient privacy safeguards, the AMA also has strongly advocated in support of PDMPs sharing information on prescriptions for controlled substances among states (Policy H-95.947, "Prescription Drug Monitoring to Prevent Abuse of Controlled Substances"). This includes strong support for having PDMPs administered by, "a state agency whose primary purpose and mission is health care quality and safety rather than a state agency whose primary purpose is law enforcement or prosecutorial," to help ensure the information "is protected from release outside of the health care system" (Policy H-95.946, "Prescription Drug Monitoring Program Confidentiality").

The AMA has advocated for the benefits of PDMPs and "supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate." Recognizing the

workflow challenges, however, AMA policy simultaneously, "encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care" (Policy H-95.939, "Development and Promotion of Single National Prescription Drug Monitoring Program").

RECOMMENDATIONS

The Board recommends that the following be adopted in lieu of Resolution 219-A-19 and the remainder of the report be filed.

1. That our American Medical Association (AMA) support efforts to limit information about medical cannabis in states' prescription drug monitoring programs to only whether a patient has been certified to receive medicinal cannabis consistent with AMA principles safeguarding patient privacy and confidentiality; (New HOD Policy)

2. That our AMA continue its monitoring of state legislation relating to the inclusion of cannabis and related information in state PDMPs. (Directive to Take Action)

Fiscal Note: Less than $500.

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3. State Medical Marijuana Laws. National Conference of State Legislatures. Last updated Oct. 16, 2019. Available at https://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx
4. Disclaimer: While AMA policy makes a clear distinction between cannabis for medicinal use and the recreational use of marijuana, for the purposes of this report, "medical marijuana" will be used throughout as it is how state policy commonly uses the term to refer to cannabis for medicinal use.
5. Id.
6. California Department of Public Health Medical Marijuana Identification Card Program. Available at https://www.cdph.ca.gov/Programs/CHSI/Pages/MMICP.aspx
7. Colorado Department of Health & Environment. Medical Marijuana Registry. Available at https://www.colorado.gov/pacific/cdphe/medicalmarijuana
8. Ohio Medical Marijuana Control Program "How to obtain medical marijuana." https://www.medicalmarijuana.ohio.gov/
9. North Dakota Medical Marijuana Program. Patient Application Instructions. Available at https://mmregistration.health.nd.gov/static/web/InstructionsPatients.pdf
10. While Missouri (at the time of this report was written) does not have a statewide PDMP, St. Louis County operates a PDMP that was "launched in 2017 with 14 participating jurisdictions. Currently, 75 jurisdictions are participating in the program, and these 75 jurisdictions cover 85% of the state's population." Last accessed February 14, 2020. https://pdmp-stlcogis.hub.arcgis.com/
11. *See,* for example, Appendix A of the "Michigan Automated Prescription System Data Submission Guide for Dispensers." Available at https://www.michigan.gov/documents/lara/MI_Data_Submission_Dispenser_Guide_v2.3_656381_7.pdf
12. National Association of Boards of Pharmacy PMP Interconnect®. https://nabp.pharmacy/initiatives/pmp-interconnect/
13. *See* AMA Opioid Task Force fact sheet. "Thinking of prescribing an opioid? Did you check your state prescription drug monitoring program? 2015. Available at https://www.end-opioid-epidemic.org/wp-content/uploads/2017/05/15-0398-opioid-one-physician.pdf
14. AMA Opioid Task Force. "Thinking of prescribing an opioid? Did you check your state prescription drug monitoring program?" 2015. Available at https://www.end-opioid-epidemic.org/wp-content/uploads/2017/05/15-0398-opioid-one-physician.pdf
15. Fact sheet: Physicians' and health care professionals' use of state prescription drug monitoring programs surpass 739 million queries—more than 10 times the queries in 2014. AMA Opioid Task Force. https://end-overdose-epidemic.org/wp-content/uploads/2020/07/AMA-Fact-Sheet-PDMP-use-and-registration-increase-2014-2019-FINAL.pdf
16. It is beyond the scope of this report to detail the research, data and other information concerning effects of PDMPs, but this is an area well-discussed in previous BOT reports, including BoT Report 30-A-19; BoT Report 7-I-18; BoT Report 12-A-18; BoT Report 13-A-17; and BoT Report 3-I-16
17. *See,* for example. CMA tells California Supreme Court it must protect patient data in CURES. November 2, 2015. November 02, 2015. https://www.cmadocs.org/newsroom/news/view/ArticleId/27453/CMA-tells-California-Supreme-Court-it-must-protect-patient-data-in-CURES. The AMA joined CMA in filing an amicus brief emphasizing that patients have a basic right to privacy of their medical information and records. The AMA and CMA argued that access to PDMPs by non-health care individuals should be limited to those instances in which there is probable cause that an unlawful act or a breach of the standard of care may have occurred.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-N-21

Subject: Physician Access to their Medical and Billing Records (Resolution 226-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) considered Resolution 226, "Physician Access to their Medical and Billing Records," introduced by the New York Delegation, which asked:

1. The American Medical Association (AMA) advocate that licensed physicians must always have access to all medical and billing records for their patients from and after date of service including after physician termination.

2. The AMA press for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to the medical and billing records such as treating these records as trade secrets or proprietary.

The HOD heard positive testimony that the AMA has strong policy regarding physician access and management of medical records. Also, testimony was given that the AMA has model state legislation regarding physician employment including a provision that a "physician is entitled to copies of patient charts and any other records relating to the physician's provision of physician services." The Council on Legislation (COL) testified, however, that the COL is currently examining issues surrounding data ownership and stewardship. AMA policy is limited in scope to the physician-patient relationship and a paradigm shift is occurring where patient information is being viewed as a patient-centered concept and information from outside of the physician-patient relationship is growing. Additionally, the COL testified that the first resolve is too broad because a patient may not want a physician to have access to or share all of the patient's medical and billing information for unrelated care that occurs outside of a specific physician-patient relationship. As a result, Resolution 226 was referred.

DISCUSSION

Resolution 226 raises very significant concerns regarding potential physician liability for non-compliance with federal and state laws regarding claims for payment submitted on behalf of the physician. For example, as the Office of the Inspector General of the U.S. Department of Health and Human Services stated, "Physicians should remember that they remain responsible to the Medicare program for bills sent in the physician's name or containing the physician's signature, even if the physician had no actual knowledge of a billing impropriety."[1] Accordingly, AMA policy states that: "Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as

may be necessary to verify that such bills are correct."[2] A physician's inability to access billing records and associated medical records sufficient to monitor compliance with legal and other requirements can potentially expose the physician to severe penalties.

Resolution 226 First Resolve

Given the importance of the issues that Resolution 226 raises, the Board of Trustees (Board) believes that the AMA should engage in advocacy that addresses these issues, with a few qualifications. One qualification concerns the breadth of the advocacy to which the first resolve would commit the AMA. As reference committee testimony noted, the first resolve would require the AMA to advocate that physicians have access to all of a patient's medical and billing records. A patient may not want a physician to have access to or share all of their medical and billing information for unrelated care that occurs outside of a specific physician-patient relationship. The Board agrees with this testimony. Accordingly, the Board recommends that the AMA advocate that physicians have access to their billing records and associated patients' medical records, but not that physicians have access to *all* of those records. The records should also include any billing records submitted under the physician's name, regardless of whether the physician directly provided the item or service.

Although the Board obviously believes that physicians must always have immediate access to the medical records of patients under their care, the Board does not recommend that the AMA advocate that physicians must always have access to their billing records and associated medical records. Instead, the Board recommends that, following Medicare reassignment regulations, the AMA should advocate that physicians have "unrestricted access" to their billing records and related medical records. Medicare reassignment regulations require an entity, e.g., physician practice or hospital, that submits claims on a physician's behalf give the physician unrestricted access to those claims.[3] The Board recommends this approach for two reasons.

First, while the Centers for Medicare and Medicaid Services (CMS) has provided at least some informal guidance concerning what "unrestricted access" means, the first resolve does not define "always." Taken literally, if the HOD adopted the first resolve as written, "always" could be read to require the AMA to advocate that entities, e.g., physician practices, must give employed and contracted physicians immediate access to their billing records and associated medical records at all times. Such an access requirement would likely impose a significant and unnecessary administrative burden on at least some physician practices or other physician-led entities. In contrast, CMS informally interprets "unrestricted access" to mean that an entity may not reasonably refuse or delay access to billing records. CMS has declined to define how quickly an entity must give the physician access to his or her billing records after receiving a request, or when an entity may reasonably refuse to provide access, e.g., when a physician already has the records.[4] Instead, CMS suggests that entities use "common sense."[5] Although CMS' interpretation of "unrestricted access" may not be highly specific, it does appear to provide more direction for AMA advocacy than "always," allows for flexibility and is thus not as likely to impose as great an administrative burden on physician practices or other physician organizations as the undefined term "always" might have.

Second, requiring the AMA to advocate for an access standard other than "unrestricted access" could subject physician practices to an additional administrative burden. Medicare's "unrestricted access" requirement has been in place for independent physician contractors since 2004 and physician employees since 2006.[6] Physician practices and other physician-led organizations may have long-standing policies and procedures in place delineating how their organizations comply with the unrestrictive access requirement. Asking the AMA to advocate for an access different

from the Medicare's regulation could require some practices and physician-led organizations to rewrite long-standing policies and procedures that have worked well for many years.

Finally, the first resolve asks the AMA to advocate that licensed physicians always have access to all medical and billing records for their patients…including after termination. The Board does not believe that the AMA should advocate that entities like physician practices and physician-led organizations incur the administrative burden of an unlimited obligation to provide billing records to physicians after employment or an independent contract has ended, e.g., merely upon request of the physician. Instead, the Board recommends that the AMA adopt policy stating that, after termination of employment or other contractual arrangement, physicians should be given access to their billing records and associated medical records analogous to AMA policy with regard to post-termination access to patient medical records. Policy H-225.950 "AMA Principles for Physician Employment," states in part:

> Where physician possession of all medical records of his or her patients is not already required by state law, the employment agreement should specify that the physician is entitled to copies of patient charts and records upon a specific request in writing from any patient, or when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician.[7]

Absent state law or a patient request, Policy H-225.950 does not state that after termination, the physician should be given access to all of his or her patients' medical records. Instead, the physician should be given patient medical records when necessary for the physician's defense in malpractice actions, administrative investigations or other proceedings against the physician. The Board recommends adopting new policy taking a similar approach, namely, that a physician employer or other entity that bills on behalf of an employed or contracted physician should, post-employment or contract, be obligated to provide the physician with his or her billing records when necessary to defend malpractice actions, administrative investigations or other proceedings against the physician. Taking this approach would reduce the burden that an open-ended obligation might create for physician-owned or led entities and be consistent with existing AMA policy.

Resolution 226 Second Resolve

With regard to the second resolve, the Board agrees that the AMA should advocate that medical records and billing records should not be kept from a physician on the grounds that those records are proprietary or constitute trade secrets. This is particularly true given the physician's need to ensure compliance with fraud and abuse laws, which outweigh any countervailing concerns regarding privilege or secrecy.

Model State Legislation

The Board has adopted state model legislation entitled the "Physician Access to Medical and Billing Records Act" to advocate as outlined in this board report. Any AMA member can access this model bill by e-mailing arc@ama-assn.org.

AMA POLICY

The AMA has several policies addressing issues that Resolution 226 raises. Policy H-190.971, "Physicians' Right to Receive Billing and Remittance Information," states that all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that the AMA develop strategies to assist physicians who are denied such information.

Policy H-225.950, "AMA Principles for Physician Employment," advises that employers should indemnify, defend and save harmless, employed physicians with respect to any violation of law or regulation, or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee. Policy H-385.939, "Hospital Billing on Behalf of Physicians," requires that our AMA: (1) advocate that personnel performing diagnostic and procedural coding of physicians' services provide that information, including itemized billing information, collection rates, procedures, and remittance information, to those physicians providing the coded services; (2) urge physicians to participate in the processes used by entities submitting claims for and receiving payment on behalf of physicians; (3) urge that any entity billing for physicians' services ensure that, when a physician's choice of CPT code has been changed, the physician be so notified and the recoder identified before submission of a bill; (4) encourage physicians to carefully evaluate their billing procedures upon selling their practice or contracting for billing services; (5) encourage physicians to establish billing practice policies and billing compliance programs that include monitoring and reviewing billing accuracy; and (6) encourage physicians who sell their practice or contract out billing services to establish a mechanism for continually reviewing the collection methods and procedures of the billing entity.

RECOMMENDATIONS

In light of these considerations, the Board recommends that the following be adopted in lieu of Resolution 226-A-19 and the remainder of this report be filed:

1. That our AMA advocate that licensed physicians have unrestricted access to all their patients' billing records and associated medical records during employment or while under contract to provide medical or health care items or services. The records should also include any billing records submitted under the physician's name, regardless of whether the physician directly provided the item or service. (Directive to Take Action)

2. That our AMA advocate that, where physician possession of all his or her billing records is not already required by state law, the employment or other contractual arrangement between a physician and entity submitting claims on behalf of the physician should specify that the physician is entitled to copies of his or her billing records subsequent to the termination of employment or contractual arrangement, when such records are necessary for the physician's defense in malpractice actions, administrative investigations, or other proceedings against the physician. (Directive to Take Action)

3. That our AMA advocate for legislation or regulation to eliminate contractual language that bars or limits the treating physician's access to his or her billing records and associated medical records, such as treating these records as trade secrets or proprietary. (Directive to Take Action)

Fiscal Note: Less than $500

REFERENCES

1. Federal Register 65:194 (October 5, 2000) pages 59447- 59452
2. AMA Principles for Physician Employment H-225.950
3. 2 CFR § 424.80(d)(2)
4. Federal Register 71:231 (December 1, 2006) page 69689
5. Id.
6. Federal Register 69:219 (November 15, 2004) pages 66314-66318; Federal Register 71:231 (December 1, 2006) pages 69688-69689
7. AMA Policy H-225.950 AMA Principles for Physician Employment (3)(d)

RELEVANT AMA POLICY

Policy H-190.971, “Physicians' Right to Receive Billing and Remittance Information”
AMA policy is that all physicians are entitled to receive detailed itemized billing and remittance information for medical services they provide, and that the AMA develop strategies to assist physicians who are denied such information.

Policy H-225.950, “AMA Principles for Physician Employment”
1. Addressing Conflicts of Interest
a) A physician's paramount responsibility is to his or her patients. Additionally, given that an employed physician occupies a position of significant trust, he or she owes a duty of loyalty to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.
b) Employed physicians should be free to exercise their personal and professional judgement in voting, speaking and advocating on any manner regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests. Employed physicians also should enjoy academic freedom to pursue clinical research and other academic pursuits within the ethical principles of the medical profession and the guidelines of the organization.
c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.
d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.
(i) No physician should be required or coerced to perform or assist in any non-emergent procedure that would be contrary to his/her religious beliefs or moral convictions; and
(ii) No physician should be discriminated against in employment, promotion, or the extension of staff or other privileges because he/she either performed or assisted in a lawful, non-emergent procedure, or refused to do so on the grounds that it violates his/her religious beliefs or moral convictions.
e) Assuming a title or position that may remove a physician from direct patient-physician relationships--such as medical director, vice president for medical affairs, etc.--does not override professional ethical obligations. Physicians whose actions serve to override the individual patient care decisions of other physicians are themselves engaged in the practice of medicine and are subject to professional ethical obligations and may be legally responsible for such decisions. Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

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

2. Advocacy for Patients and the Profession
a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice, or the methods by which they are compensated.
b) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting
a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.
b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties are urged to obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

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

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

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

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

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

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

6. Payment Agreements
a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.
The AMA will disseminate the AMA Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the American Hospital Association and Medical Group Management Association.

Policy H-385.939 “Hospital Billing on Behalf of Physicians”
The AMA:
(1) advocates that personnel performing diagnostic and procedural coding of physicians' services provide that information, including itemized billing information, collection rates, procedures, and remittance information, to those physicians providing the coded services;
(2) urges physicians to participate in the processes used by entities submitting claims for and receiving payment on behalf of physicians;
(3) urges that any entity billing for physicians' services ensure that, when a physician's choice of CPT code has been changed, the physician be so notified and the recoder identified before submission of a bill;
(4) encourages physicians to carefully evaluate their billing procedures upon selling their practice or contracting for billing services;
(5) encourages physicians to establish billing practice policies and billing compliance programs that include monitoring and reviewing billing accuracy; and
(6) encourages physicians who sell their practice or contract out billing services to establish a mechanism for continually reviewing the collection methods and procedures of the billing entity.

REPORT 12 OF THE BOARD OF TRUSTEES (N-21)
Direct-to-Consumer Genetic Tests
(Resolution 207-A-19)
(Reference Committee B)

EXECUTIVE SUMMARY

Background: This report is in response to Resolution 207-A-19, "Direct-to-Consumer Genetic Tests," which was introduced by the Illinois Delegation. Resolution 207, referred by the House of Delegates, asked the AMA to: 1) regard research using consumer genome data as research on human subjects requiring both informed consent and consumer "opt in"; 2) advocate to prevent genetic testing entities from transferring identifying information to third-parties without consent; 3) support standards that disclose any privacy breaches and prohibit those with ties to testing companies from sharing identifying information without user consent; 4) advocate to extend federal genetic discrimination protections to long-term care, disability, and life insurance.

This report examines: (1) American Medical Association (AMA) policy on direct-to-consumer (DTC) genetic testing and privacy; (2) the DTC genetic testing landscape; (3) genetic databases for clinical research; (4) research using consumer genomic data; (5) third-party and forensic applications; (6) legislation on genetic nondiscrimination, privacy, and human subjects research; and (7) physician guidance and related AMA efforts.

Discussion: The AMA has extensive policy that covers the related topics of human subject research, privacy and consent, genetic discrimination, and genomic testing. Consumer genomic testing has seen explosive growth in participant numbers as well as new use cases. Integration of clinical-grade genetic information into patient care has also been expanding, including via genomic testing partnership models. Research efforts require increasingly large and diverse genetic databases and, in some cases, returning results to participants that may impact clinical care. The use of consumer genetic databases for third party applications and forensics has raised privacy concerns.

Conclusion: Current genetic nondiscrimination protections are limited to the areas of health insurance and employment at the federal level, meaning that consumers in most states today are without protections for additional areas such as life, disability, or long-term care insurance. Users of consumer genetic testing should be advised of the potential risks of their participation including through appropriate informed consent. Notice should be given, and consent provided by users whenever their genetic information is used or shared.

The Board of Trustees recommends that language be adopted to more accurately reflect the intent of the resolution, and that these statements be adopted in lieu of Resolution 207-A-19.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-N-21

Subject: Direct-to-Consumer Genetic Tests (Resolution 207-A-19)

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee B

INTRODUCTION

Resolution 207-A-19, "Direct-to-Consumer Genetic Tests," which was introduced by the Illinois Delegation and referred by the House of Delegates, asked that:

> Our American Medical Association regard research using consumer genome data derived from saliva or cheek swab samples as research on human subjects requiring consents in compliance with the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an "opt in" option to allow more consumer choice in the consent process;
>
> Our AMA amend Policy H-315.983, "Patient Privacy and Confidentiality," by addition to align with current research and privacy infringement findings, as follows:
>
> 1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received, <u>while working with the Department of Health and Human Services (HHS) to stop the transfer of birthdates and state of residence by genetic testing companies and their affiliates, unless there is explicit user approval, to prevent re-identification of the test user by way of surname inference methods.</u>
> 2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required

to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

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

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

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

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

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. Our AMA regards studies using consumer genome data derived from saliva, cheek swab, or other human tissue samples as research on human subjects requiring consents in compliance with the HHS Office for Human Research Protections (OHRP). An “opt in” option is recommended to allow more consumer choice in the consent process.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of 43 identifiers and

the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures.

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. The AMA will work with Congress and HHS to modify the Genetic Information Nondiscrimination Act of 2008 (GINA), which bans genome-based policy and hiring decisions by health insurance companies and employers, by adding Long-Term Care, Life Insurance, and Disability Insurance to the Act to prevent applicant rejection based on their genetic make up.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. a. Our AMA supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identified information with other parties without the consent of the user. An exception would be made when requested by law enforcement authorities or when

keeping the information would seriously threaten their health or that of others. If a data security breach occurs with the Direct-To-Consumer genetic company or its collaborators, then the company has the responsibility to inform all users of the breach and the impact of the unprotected private data on those individuals;

19. Our AMA supports privacy standards that require pharmacies and drug store chains to 50 disclose the source of financial support for drug mailings or phone calls.

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

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

Our AMA work with the Department of Health and Human Services or other relevant parties to modify the rules to prevent genetic testing entities from transferring information about the user's date of birth and state of residence to third parties which may result in the re-identification of the user based on surname inference;

Our AMA work with Congress and the Department of Health and Human Services to extend the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California.

CURRENT AMA POLICY

Existing AMA policy addresses direct-to-consumer (DTC) genetic testing and privacy (see Appendix for full text). AMA Policy D-480.987, "Direct-to-Consumer Marketing and Availability of Genetic Testing," recommends that genetic testing be carried out under the personal supervision of a qualified health professional and that advertisements disclose test limitations. AMA Policy H-480.941, "Direct-to-Consumer Laboratory Testing," advocates for vigilant oversight of DTC laboratory testing and encourages physicians to educate their patients about the risks of DTC tests. AMA Policy H-65.969, "Genetic Discrimination and the Genetic Information Nondiscrimination Act," supports education as well as legislation intended to provide more comprehensive protections. AMA Policies H-460.916, "Protection of Human Subjects in Research," and H-460.980, "Ethical and Societal Considerations in Research," encourage additional education on ethical principles for investigators in human subject research. AMA Policy H-315.983, "Patient Privacy and Confidentiality," affirms that genetic information should be kept confidential and should not be disclosed to third parties without explicit informed consent.

BACKGROUND

DTC genetic testing landscape

Genetic tests have traditionally been ordered by a physician for specific conditions with clear diagnostic and other medical purposes. This report focuses on DTC genetic testing which may not require a physician order. Beginning with saliva or a cheek swab, DTC genetic tests can reveal DNA segments shared with other individuals, offering insights into familial relationships and ancestry. DTC genetic tests can also report specific variants associated with diverse traits and health conditions.

DTC genetic testing has grown exponentially over the past decade. About 30 million consumers, largely from the United States, have already participated in DTC genetic testing. At this rate, an estimated 100 million individuals will undergo DTC genetic testing by 2021.[1]

While the FDA currently does not review all DTC genetic tests before they are offered to the public, those that disclose moderate to high risk health information, such as cancer screening results, are reviewed for evidence that the tests work as advertised.[2] In 2013, 23andMe stopped providing consumers with genetic health risk information after the FDA sent the company a letter. This action led other DTC companies to stop disclosing genetic health risks to consumers. In 2015, 23andMe was cleared by the FDA to market tests that release results for health conditions including increased risk of cancer, and in 2018 was cleared for pharmacogenomic reports.[3,4] To date, 23andMe remains the only company that has received FDA clearance for a DTC genetic test.[2]

Another approach has emerged called a "hybrid" or "DTC 2.0" model of consumer genetic testing that begins with a physician order for screening of healthy individuals.[5–7] Different models include those of AncestryDNA, Color Genomics, and Invitae, which may not be required to seek regulatory clearance from the FDA to return genetic health information, based on the inclusion of a physician order. These tests may also be offered through partnerships with employers and health systems, and include cancer risk and pharmacogenomic results.[8,9] In some cases, College of American Pathologists (CAP) accredited and Clinical Laboratory Improvement Amendments (CLIA) certified laboratories may provide what is considered clinical grade data that may be included in health records and used to support medical decisions.

Genetic databases for clinical research

Genetic databases and biobanks have been designed to support biomedical research by offering various forms of access to participant data. This research has contributed to uncovering the molecular basis for thousands of human diseases and has helped to advance drug discovery.[10] Database sizes are growing which may be necessary to power polygenic risk scores and other findings beyond single gene associations. Such database sizes may be not be feasible to build for a single study, so groups instead may work with common datasets.

Shortcomings of the traditional biobank approach have included a lack of participant diversity, and a need to more frequently return results back to participants.[11,12] When biobanks seek to form external partnerships, particularly with industry, there may be public concern about data security and privacy.[13] Initiatives such as the 100,000 Genomes Project in the United Kingdom have begun leveraging their participant results to help advance clinical care.[14] However, a distinction between research and clinical grade genetic results may mean that some research findings should be considered only initial screening information that should undergo clinical confirmation prior to any changes in patient care.[15]

The All of Us Research Program

The National Institutes of Health (NIH)'s *All of Us* Research Program was launched in 2018 as part of President Obama's Precision Medicine Initiative, as "an ambitious effort to gather data over time from 1 million or more people living in the United States." The program does not focus on any subset of diseases or conditions. Instead, a key focus is recruiting participation from populations traditionally underrepresented in biomedical research, which has long been a challenge for the genetics field. By late-2019, more than 230,000 total participants were enrolled in *All of Us*, with most participants from underrepresented populations.[16]

Genetic data has been highlighted as a key component of the program and in 2018, *All of Us* announced the first awards to three genome centers.[17] In 2019, the program announced a five-year award to Color Genomics to offer genetic counselling services and assist with participant education.[18] Genomic results may be returned to some *All of Us* participants by 2020.[19]

Participant data for the *All of Us* program are stored in a cloud environment where identifying information is removed. This platform will allow computation and interactive testing of hypotheses without access to any individual participant data, thus safeguarding against some potential forms of security breaches. Researchers apply for data access and make their names and descriptions of their projects publicly available. Participants will also have access to their own data including their physical measurements, survey data, and genomic results, and they can choose whether to share results with their physician.[16]

Research using consumer genomic data

Genetic testing companies such as 23andMe also can engage in peer-reviewed genetic research, leveraging their own genetic databases including in many cases partnerships with academics.[20] In addition, genetic testing companies have engaged in their own drug discovery and have partnered with industry via data sharing agreements. In 2018, 23andMe announced a $300 million drug development partnership with GlaxoSmithKline.[21] In 2020, 23andMe sold the rights to license the first drug that the company had internally developed as a potential treatment for inflammation.[22] While users have been informed that they can opt out of having their data used for research at any time, around 80 percent of users have elected to participate.[23] Currently, users are assigned no rights or compensation for the company's research or commercial products.[24]

Other models are being explored to directly compensate participants for their research contributions. A recently launched platform named LunaDNA provides users the capability to sell their genomic and other health data for medical research, where data is exchanged for shares of stock. In 2019, LunaDNA merged with the Genetic Alliance's Platform for Engaging Everyone Responsibly (PEER).[25] One stated aim is to help individuals become partners and active participants in research, in addition to the possibility of receiving a small share of royalties resulting from future drug discoveries.

Third-party and forensic applications

DTC companies such as 23andMe and AncestryDNA allow users to download their own raw genomic data. These raw data files can then be uploaded to various third-party interpretation platforms which provide services such as mining the biomedical literature or genealogy tools. Use of third-party interpretation platforms has been identified as having the potential to increase a user's risks including validity of results and privacy.[26–28]

In terms of privacy, increasingly it has been recognized that genetic data cannot be deidentified. A DNA profile alone may now be adequate to identify most individuals even in the absence of other identifying information, including individuals that have not previously participated in genetic testing.[29] This may increasingly be the case as DNA databases continue to grow with participation from biological relatives that may help uncover identities through DNA matches. It may also be difficult to place safeguards against additional potential uses of genetic data other than those originally intended. For example, an individual's DNA profile designed for a specific purpose such as forensics may be linked to additional genetic data that could reveal health and other sensitive information.[30]

Awareness around forensic applications of DTC genetic data increased in 2018, when a suspect for the Golden State Killer was identified after the upload of crime scene DNA to GEDmatch.[31] This platform offered genealogical services by aggregating user data from other services into a large genetic database. Investigators were able to track down a single individual that fit their profile based on a DNA match to distant family members. Many users left the database when its use by law enforcement in criminal investigations became apparent, and GEDmatch changed its terms of service to require "opt-in" for matching to police-uploaded DNA.[32] In 2019, GEDmatch was acquired by the forensic genomics firm Verogen.

Terms of service from DTC companies have been shown to have tremendous variability around the use and sharing of genetic data.[33] Such terms may also be subject to change with little notice. In 2019, Family Tree DNA surprised many users by announcing that it had been collaborating with the FBI and supporting queries via access to user genetic information, allegedly without informed consent from their users.[34] These revelations led to the Future of Privacy forum, which had released best practices in 2018 that prohibited the sharing of genetic data without consent or as required by law, to remove Family Tree DNA as a supporter.[35]

The U.S. Department of Defense warned in 2019 that use of DTC genetic testing could place military service members at risk, allowing the enemy to target them via "mass surveillance and the ability to track individuals without their authorization or awareness," with unintended security consequences.[36] Accordingly, service members have been advised to refrain from using DTC genetic tests. Information about some genetic variants can also affect a service member's career, which may be particularly problematic when the validity of some DTC genetic tests has been questioned.

DTC genetic testing demand appears to have experienced a decline in 2019.[37] It is unclear whether this may due to privacy or other consumer concerns. This development may signal saturation or a shift to more comprehensive models of genetic testing such as those offered by health systems.

Genetic Nondiscrimination and Privacy Legislation

Federal legislation that covers genetic privacy in the U.S. includes the Health Insurance Portability and Accountability Act (HIPAA) and the Genetic Information Nondiscrimination Act (GINA). The HIPAA Privacy Rule applies to health plans, health care providers, and health information clearinghouses but not to third parties outside of health care.[38] GINA applies to health insurers and employers but not to other contexts such as life, disability, or long-term care insurance.[39]

Various states including California also have additional laws enacted that extend genetic discrimination protections to other areas such as life insurance and educational settings.[39] The California Consumer Privacy Act (CCPA) may also offer additional privacy protections for some consumers. However, extending GINA's protections to other contexts in all states would require an act of Congress.

Human Subjects Research Legislation

Unlike earlier genetic research studies using a traditional model, researchers using DTC genetic data from 23andMe have argued that their work is not human subjects research as defined under the U.S. Department of Health and Human Services, which would require fully informed consent and institutional review board (IRB) approval of the research protocols.[40] Journal editors who published the study agreed that the researchers did not violate the Common Rule because they only

used deidentified data. Extending additional protections, as implemented through IRBs, to data used for research by consumer genetics companies will likely require new legislation.

Physician guidance and related AMA efforts

The American College of Medical Genetics and Genomics has released a position statement on DTC genetic testing.[41] Additional guidance on this topic is available from the Association for Molecular Pathology[42] and the American Society of Human Genetics.[43,44] The *AMA Journal of Ethics* has published an issue on precision health including DTC genetic testing.[45] *JAMA* has also published a number of articles covering topics related to consumer genetic testing.[46]

The AMA has several initiatives to help physicians navigate precision medicine including education, research, and advocacy.[47] The AMA has collaborated with The Jackson Laboratories and Scripps Research Translational Institute on a continuing medical education series called "Precision Medicine For Your Practice," which includes a module called "Genomic Testing for the Healthy Individual."[48] The AMA hosted a "Driving the Future of Precision Medicine Roundtable" in 2019 that examined the current landscape and innovative practices for precision medicine implementation. The AMA is also represented on the National Academies of Sciences, Engineering, and Medicine (NASEM) Roundtable on Genomics and Precision Health and participated in a 2019 workshop on consumer genomics.[49]

Previous Council on Science and Public Health reports have addressed DTC genetic tests and related issues including genetic discrimination, the Precision Medicine Initiative, and payment and coverage for precision medicine.[50–52] In 2019, the AMA sent a letter to the Department of Justice to oppose a proposal for the use of DNA testing for detained immigrants.[53] The AMA has also worked with states, including Delaware, to extend GINA protections.[54]

CONCLUSION

The AMA has extensive policy on human subject research, consent, and genetic discrimination. The current federal GINA protections are limited to health insurance and employment, leaving consumers in most states without protections for areas such as life, disability, or long-term care insurance. It is important that users of consumer genetic testing are aware of the potential risks of their participation, particularly as the numbers of participants and the various use cases continue to grow. Participants in consumer genetic testing should receive notice and provide consent whenever their genetic information is used or shared.

RECOMMENDATIONS

For purposes of clarity, the Board of Trustees recommends that the following statements be adopted in lieu of Resolution 207-A-19, and that the remainder of this report be filed.

1. That our AMA adopt the following new policy:

   "Consumer Genetic Testing and Privacy"
   Our AMA:

   (1) will work with relevant stakeholders to advance laws and regulations that prevent genetic testing entities without explicit, informed, and non-coerced user consent from transferring information about a user such as birthdates and state of residence to third parties which

may result in the re-identification of the user based on surname inference (New HOD Policy).

(2) supports privacy standards that would prohibit pharmaceutical companies, biotechnology companies, universities, and all other entities with financial ties to the genetic testing company from sharing identifiable information, including DNA, with other parties without informed consent of the user. An exception would be made when requested for a duly executed court order or when compelled for public health or safety reasons as outlined in existing AMA policy including H-315.983, "Privacy and Confidentiality," and Medical Code of Ethics 4.1.4, "Forensic Genetics." If a data security or privacy breach occurs with a direct-to-consumer (DTC) genetic company or its collaborators, then the company has the responsibility to inform all users and relevant regulatory bodies of the breach and the impact of the unprotected private data on those individuals (New HOD Policy).

(3) will advocate that research using consumer genomic data derived from saliva or cheek swabs or other human samples should be treated as research on human subjects requiring informed consent consistent with or similar to those required by the Health and Human Services (HHS) Office for Human Research Protection (OHRP), and recommend an "opt in" option to allow more consumer choice in the consent process (New HOD Policy).

(4) will advocate for extending the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the laws of other states, such as California (New HOD Policy).

2. That the following policies be reaffirmed: H-65.969, "Genetic Discrimination and the Genetic Information Nondiscrimination Act," H-185.972, "Genetic Information and Insurance Coverage," D-480.987, "Direct-to-Consumer Marketing and Availability of Genetic Testing," H-480.941, "Direct-to-Consumer Laboratory Testing," H-460.916, "Protection of Human Subjects in Research," H-460.980, "Ethical and Societal Considerations in Research," and H-315.983, "Patient Privacy and Confidentiality" (Reaffirm HOD Policy).

Fiscal Note: Less than $500.

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APPENDIX – Current AMA Policy

D-480.987, "Direct-to-Consumer Marketing and Availability of Genetic Testing"
Our AMA: (1) recommends that genetic testing be carried out under the personal supervision of a qualified health care professional; (2) encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information; (3) will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test; (4) encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information; (5) will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms.

H-480.916, "Direct-to-Consumer Laboratory Testing,"
Our AMA will: (1) advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2) encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.

H-65.969, "Genetic Discrimination and the Genetic Information Nondiscrimination Act"
Our AMA: (1) strongly opposes discrimination based on an individual's genetic information; (2) will pursue and support legislation intended to provide robust and comprehensive protections against genetic discrimination and misuse of genetic information; and (3) supports education for health care providers and patients on the protections against genetic discrimination currently afforded by federal and state laws.

H-185.972, "Genetic Information and Insurance Coverage"
AMA believes: (1) Health insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements. (2) Health insurance providers should be prohibited from establishing differential rates or premium payments based on genetic information or an individual's request for genetic services. (3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information. (4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure would be made.

H-460.916, "Protection of Human Subjects in Research"
Our AMA encourages institutions conducting research with human subjects to implement an ongoing credentialing process to assure that all investigators and relevant staff have been appropriately educated in the ethical principles and relevant government regulations related to human subjects research.

H-460.980, "Ethical and Societal Considerations in Research"
(1) Private organizations and academic institutions should jointly develop a means to continue and enhance broadly based study and discussion of ethical and societal issues in biomedical research. (2) The federal government should provide the resources to support new initiatives within the National Institutes of Health for the funding of research studies in bioethics. Existing federal programs that fund bioethical research studies should be preserved. Private foundations should be encouraged to provide resources to support research studies in bioethics. (3) A uniform set of federal regulations governing research with human subjects, based on the core regulations of the Department of Health and Human Services should be adopted by all federal agencies. Uniformity should not preclude additions to Department regulations that do not conflict with the core regulations or that enhance the protection of research subjects. (4) Associations of regional institutional review boards (IRBs) should be formed to enhance IRB performance through the development of educational site visits and local workshops. (5) Each institution should have a system both for monitoring the conduct of biomedical research and for investigating and reporting allegations of research

misconduct. (6) All investigators involved in research projects should be responsible for the clear articulation and enforcement of standards that ensure the integrity of scientific data and conclusions. Regardless of whether the research project is a result of individual or collaborative efforts, investigators should thoroughly understand the data and conclusions in research publications and studies. (7) As part of their formal training in research investigation, graduate, medical and postdoctoral students should be instructed on the importance of adhering to the ethical and scientific requirements in research conduct and in the reporting of research results. (8) Our AMA encourages study of the inclusion of Socioeconomic Status (SES) data in clinical and public health research identify appropriate minimum standards for the inclusion of such data in research studies.

H-315.983, “Patient Privacy and Confidentiality”
1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received. 2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. 8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. 10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or

prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. 11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. 14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. 16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. 19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. 21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

Code of Medical Ethics 4.1.4, “Forensic Genetics”
With the exception of genetic information (or material) collected under the jurisdiction of a coroner, medical examiner, or other medical legal officer, the release of genetic information from a physician’s records without the patient’s informed consent constitutes a breach of confidentiality. However, under limited circumstances with overriding legal and social considerations, all physicians may disclose such information to the criminal justice system.
Physicians from whom genetic information is sought for purposes of criminal justice: (a) May ethically carry out DNA analysis on stored tissue samples or release genetic information without the consent of a living or deceased patient (or the patient’s authorized surrogate) in response to a warrant or court order. (b) Should release only the minimum information necessary for the specific purpose. (c) Should not be required to provide genetic information when: (i) a suspect whose location is known refuses to provide a tissue sample for genetic analysis; or (ii) a tissue sample for the suspect can be obtained from other sources (such as the body of a deceased suspect). (d) Should decline to participate in the use of information from a genetic database created exclusively for criminal justice for any purpose other than identification.
Issued: 2016

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-N-21

Subject:	Net Neutrality and Public Health (Resolutions 208-I-19 and 211-I-19)
Presented by:	Bobby Mukkamala, MD, Chair
Referred to:	Reference Committee B

INTRODUCTION

At the 2019 Interim Meeting, the House of Delegates (HOD) heard mixed testimony regarding Resolution 208, "Net Neutrality and Public Health," which was introduced by the Medical Student Section and Resolution 211, "Effects of Net Neutrality on Public Health," introduced by the Michigan Delegation.

Resolution 208, "Net Neutrality and Public Health" reads as follows:

> RESOLVED, That our American Medical Association advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network; and be it further
>
> RESOLVED, That our AMA collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds; and be it further
>
> RESOLVED, That our AMA oppose internet data transmission practices that reduce market competition in the health ecosystem.

Resolution 211, "Effects of Net Neutrality on Public Health" reads as follows:

> RESOLVED, That our American Medical Association amend current policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities," by addition and deletion as follows:
>
> Increasing ~~Access to Broadband~~ Internet Access to Reduce Health Disparities
>
> Our AMA: (1) will advocate for net neutrality; and (2) will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the U.S. while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.

During the House of Delegates Interim Meeting the reference committee heard testimony on both Resolution 208 and 211, which were heard together. Testimony was heard that favored maintaining the rules of net neutrality, as repeal could lead companies to place limits on how, where, and when patients and providers are able to access health care data. Other concerns regarding repeal of net

neutrality focused on the potential for companies to pursue policies that could lessen both innovation and competition in health care technology, or increase the cost of health care delivery, thus negatively impacting both physicians and patients. Testimony concerning the use of the term "net neutrality" and its impact on potential AMA advocacy activities was provided as well. Additionally, testimony was given regarding existing AMA policy which already supports the expansion of broadband and wireless connectivity to all rural and underserved areas of the U.S. Finally, testimony was provided that defining essential health data needs to be further evaluated because the transmission of certain health data may need to take precedence over other data. The resolutions were heard during the House of Delegates 2019 Interim Meeting prior to the start of the coronavirus (COVID-19) pandemic.

BACKGROUND

Net neutrality is the principle guiding the strict regulations placed on internet service providers (ISPs) that prohibit or limit content-controlling behavior in order to ensure an equal and open internet for all.[1] In practice, this means that ISPs should not be able to move some data (for example, certain applications or streaming services) into "fast lanes" while blocking, slowing, or limiting in some fashion other data. In other words, ISPs (such as AT&T Internet Services, Cox Communications, Comcast and Verizon) should not be able to block a user from accessing a service such as Skype, Zoom, or slow down Netflix or Roku, in order to encourage the user to keep a cable package or buy a different video-streaming service.

A core issue to net neutrality is how ISPs should be classified under the Communications Act of 1934, if they should be Title I "information services" or Title II "telecommunications or common carrier services." The classification affects the Federal Communications Commission's (FCC) authority over ISPs. As Title II common carriers, the FCC would have significant ability to regulate ISPs, but not if they are classified as Title I. Title I information services are regulated by the Federal Trade Commission (FTC or Commission). In layman's terms, "common carrier services" move data from one place of the customer's choosing to another, and "information services" provide processing or storage services for that data. The debate over Title I vs. Title II classification continues even today.

The FCC regulates interstate and international communications by radio, television, wire, satellite, and cable in all 50 states, the District of Columbia and U.S. territories. An independent U.S. government agency overseen by Congress, the FCC is the federal agency responsible for implementing and enforcing America's communications law and regulations. The makeup of the five-member FCC changes with each U.S. President, and competing interests have ultimately led to the state of net neutrality flipping back and forth over the last several decades. With regard to the FTC, the Commission is headed by five Commissioners, nominated by the President and confirmed by the U.S. Senate, each serving a seven-year term. No more than three Commissioners can be of the same political party. The President chooses one Commissioner to act as Chairman.

DISCUSSION

Federal Regulatory Activity

In the absence of any formal categorization of internet services, the FCC issued several statements regarding broadband regulation.

In 2005, the FCC adopted four principles in order to "encourage broadband deployment and preserve and promote the open and interconnected nature of public Internet."[2] The four principles

are as follows: (1) consumers are entitled to access the lawful Internet content of their choice; (2) consumers are entitled to run applications and services of their choice, subject to the needs of law enforcement; (3) consumers are entitled to connect their choice of legal devices that do not harm the network; and (4) consumers are entitled to competition among network providers, application and service providers, and content providers.[3] At that time, the FCC stated it would consider these principles during "policymaking activities."

In 2010, the Open Internet Order was passed by the FCC. The goal of the Open Internet Order was to "preserve the Internet as an open platform for innovation, investment, job creation, economic growth, competition, and free expression," which ultimately revolved around three basic tenets:[4]

- *Transparency*. Fixed and mobile broadband providers must disclose the network management practices, performance characteristics, and terms and conditions of their broadband services;[5]
- *No blocking*. Fixed broadband providers may not block lawful content, applications, services, or non-harmful devices; mobile broadband providers may not block lawful websites, or block applications that compete with their voice or video telephony services; and
- *No unreasonable discrimination.* Fixed broadband providers may not unreasonably discriminate in transmitting lawful network traffic.

According to the FCC, broadband providers invested $212 billion in the three years following adoption of the rules—from 2011 to 2013—more than in any three-year period since 2002.[6]

Between 2005 and 2012, there were several Congressional attempts to pass legislation containing limitations on net neutrality. These attempts failed, largely due to the argument that the legislation would have benefited industry instead of consumers.

The FCC in its February 26, 2015, open meeting voted 3-2, along party lines, to adopt new open internet rules and released these rules via an Open Internet Report and Order on Remand on March 12, 2015.

One of the most controversial aspects of the rules was the decision to reclassify broadband internet access service (BIAS) as telecommunications service under Title II, thereby subjecting ISPs to a more stringent regulatory framework. The FCC Order reclassifying ISPs as Title II services gave the FCC authority to enforce net neutrality. Specifically, the FCC's 2015 Open Internet Order banned each of the following: Blocking, Throttling, and Paid Prioritization—applying the same rules to both fixed and mobile broadband Internet access service.[7]

- *No Blocking*. The FCC noted at that time that "consumers who subscribe to a retail broadband Internet access service must get what they have paid for—access to all (lawful) destinations on the Internet."[8] Thus, the Order adopted a straightforward ban:
  - A person engaged in the provision of broadband Internet access service, insofar as such person is so engaged, shall not block lawful content, applications, services, or nonharmful devices, subject to reasonable network management.
- *No Throttling*. The FCC noted that "the 2010 rule against blocking contained an ancillary prohibition against the degradation of lawful content, applications, services, and devices, on the ground that such degradation would be tantamount to blocking.[9] The 2015 Order created a separate rule to guard against degradation targeted at specific uses of a customer's broadband connection:
  - A person engaged in the provision of broadband Internet access service, insofar as such person is so engaged, shall not impair or degrade lawful Internet traffic on the basis of

Internet content, application, or service, or use of a non-harmful device, subject to reasonable network management.

- *No Paid Prioritization*. Paid prioritization occurs when a broadband provider accepts payment (monetary or otherwise) to manage its network in a way that benefits particular content, applications, services, or devices.[10] To protect against "fast lanes," the 2015 Order adopted a rule that establishes that:
  - A person engaged in the provision of broadband Internet access service, insofar as such person is so engaged, shall not engage in paid prioritization.

In 2017, with a new Administration at the helm, the FCC proposed reclassifying ISPs as Title I services, effectively repealing the previously established neutrality policies and discarding millions of comments submitted by the public to the FCC. On June 11, 2018, the FCC's Restoring Internet Freedom Order took effect, despite attempts by Congress to stay the Order.[11] The new Order, among other things, reverses the 2015 classification of BIAS as a telecommunications service under Title II of the Communications Act, shifts much of the oversight from the FCC to the FTC and the U.S. Department of Justice, and provides for a less regulated approach.[12] Specifically, the FCC's framework for protecting Internet freedom under this new Order has three key parts: 1) Consumer Protection; 2) Transparency; and 3) Removes Unnecessary Regulations to Promote Broadband Investment.[13]

- *Consumer Protection*. The Federal Trade Commission will police and take action against Internet service providers for anticompetitive acts or unfair and deceptive practices.
- *Transparency*. Internet service providers must publicly disclose information regarding their network management practices, performance, and commercial terms of service. These disclosures must be made via a publicly available, easily accessible company website or through the FCC's website.
- *Removes Unnecessary Regulations to Promote Broadband Investment*. Removes Title II regulations.

The COVID-19 Pandemic and the Dramatic Surge in Internet Usage

According to a Pew Research Center survey conducted in 2019, approximately two-thirds of rural Americans (63 percent) say they have a broadband internet connection at home, up from about a third (35 percent) in 2007.[14] While encouraging, this is far from ideal—particularly as the nation battles the COVID-19 pandemic. Businesses, K-12 schools, colleges and universities, and health providers across the U.S. have been forced to pivot to a new normal built around telework, eLearning, and telehealth. More than 300 million people were under stay-at-home orders when the national public health emergency was declared, resulting in the use of, and need for, a dramatically increased level of internet access through their home connections.[15] The pandemic has pushed regulators and politicians at all levels of government to reevaluate current policies related to bandwidth, traffic and network neutrality.

The massive surge in Internet usage during the COVID-19 crisis will play a major role in the debate over what the appropriate regulatory framework should be for broadband access. For those that have high-speed internet connectivity, the internet has withstood the unimaginable increase of online video-calling, telehealth, teleworking, distance learning and leisure television show and movie bingeing. As people in rural areas and underserved urban areas seek to telework, learn remotely, and access telehealth services, the digital divide in the U.S. becomes even more glaring. Broadband availability has been at the heart of the digital divide long before the pandemic hit, with an estimated 21.3 million people lacking a connection of at least 25 Mbps/3 Mbps (the FCC's

current benchmark) by the end of 2017, according to the FCC. And although this is a decrease from the prior year of 26.1 million people, the U.S. has much work ahead to close the gap.[16]

Current Congressional Activity

In early 2019, federal legislation was introduced that would address the net neutrality debate. However, only one such bill has progressed. The "Save the Internet Act of 2019", H.R. 1644/S. 682 would repeal the Declaratory Ruling, Report and Order, and Order in the matter of restoring internet freedom that was adopted by the Commission on December 14, 2017 (FCC 17–166) and restore the 2015 Order. H.R. 1644 passed (232-190) the House on April 10, 2019 and has been sent to the Senate for consideration.

Republicans in Congress contend that the increased Internet use as a result of shelter-in-place orders is proof positive that the net neutrality rules were unnecessary. Democrats in Congress have turned their focus to the FCC's various Internet connection programs to make sure people at all income levels, in all geographic areas across the U.S. have access to broadband. As a result of the changing Internet landscape due to the pandemic, it is likely that congressional leaders from both parties moving forward will increase their focus on bolstering broadband infrastructure across the country, as this endeavor has bipartisan support, rather than focusing on net neutrality policies specifically.

The Expansion of Telehealth Services as a Result of the COVID-19 Pandemic

Congress appropriated $200 million to the FCC for the Telehealth Program as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, to help health care providers provide connected care services to patients at their homes or mobile locations in response to the novel Coronavirus 2019 disease (COVID-19) pandemic.[17] The COVID-19 Telehealth Program will provide immediate support to eligible health care providers responding to the COVID-19 pandemic by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services until the program's funds have been expended or the COVID-19 pandemic has ended. The COVID-19 Telehealth Program is limited to nonprofit and public eligible health care providers.[18]

As of May 20, 2020, the FCC's COVID-19 Telehealth Program has approved funding for 132 health care providers in 33 states plus Washington, DC for a total of just over $50 million in funding.[19] The FCC is continuing to evaluate COVID-19 Telehealth Program applications and distribute additional funding on a rolling basis.

The FCC's Office of Managing Director and Wireline Competition Bureau (WCB) also is waiving the FCC's red light rule[20] for COVID-19 Telehealth Program applicants to facilitate prompt review and processing of the maximum number of applications to the Program. The "red light" rule normally prevents the FCC from taking action on applications and other requests by entities with delinquent debts with the agency. While the FCC found good cause existed to waive the "red light" rule, the agency was clear that the waiver solely applied to the COVID-19 Telehealth Program and did not affect the agency's ability to take collection action against delinquent debtors.

In addition, on May 22, 2020, U.S. Senators Brian Schatz (D-Hawaii), Lisa Murkowski (R-Alaska), John Boozman (R-Ark.), Angus King (I-Maine), Gary Peters (D-Mich.), Dan Sullivan (R-Alaska), Kevin Cramer (R-N.D.), and Ed Markey (D-Mass.) introduced the Health Care Broadband Expansion During COVID-19 Act. The bipartisan bill would direct $2 billion to help

health care providers increase their broadband capacity and expand telehealth services during the current public health crisis.[21]

AMA POLICY

Existing AMA policy generally promotes increasing patient access to electronic health data, encouraging innovation and competition amongst technology vendors, and removing barriers to internet-based care. In 2020 the AMA developed and published a guidance document containing privacy principles.[22]

Policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities" Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the U.S. while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services.
Citation: Res. 208, I-18;

Policy D-478.979, "Promoting Internet-Based Electronic Health Records and Personal Health Records" Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR.
Citation: (BOT Rep. 11, I-11)

CONCLUSION

The essential nature of broadband communication services that has been highlighted by the COVID-19 pandemic makes it clear that without affordable and high-quality broadband services, workforce participation, commerce, education, and telehealth usage, are drastically curtailed. Additionally, access to broadband is a social determinant of health—both in and of itself and in light of its intersection between education and employment opportunities—and therefore an important component of discussions around health equity.[23] The digital divide was already negatively affecting millions of Americans, but the COVID-19 crisis has placed an increased level of stress on an already fragile system especially in rural and underserved areas. Some argue that the surge in internet usage as a result of stay-at-home orders simply confirms that the FCC's existing policies and programs, combined with low levels of broadband competition, are not meeting the basic needs of Americans. While others contend that the U.S. has fared well during this dramatic surge in internet use as a result of shelter in place orders, much better than some European countries,[24] and regulators and Congress should re-focus their efforts on expanding infrastructure. Given the bolstering of the FCC's COVID-19 Telehealth Program funding and the expansion of telehealth policy through the Centers for Medicare & Medicaid Services[25,26] as a result of the pandemic, our AMA believes that we too should pivot and re-focus our efforts on advocating for the expansion of broadband infrastructure in rural and underserved urban communities across America. Our AMA believes that as these opportunities to expand broadband access and telehealth are adopted and implemented successfully during this health crisis, both Congress and the Administration will be hard pressed to roll these advances back post-pandemic.

RECCOMENDATIONS

The Board of Trustees recommends that Resolution 211-I-19, "Effects of Net Neutrality on Public Health," and Resolution 208-I-19, "Net Neutrality and Public Health," not be adopted and that the remainder of the report be filed.

Fiscal Note: None

REFERENCES

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2. https://apps.fcc.gov/edocs_public/attachmatch/DOC-260435A1.pdf
3. Id.
4. https://docs.fcc.gov/public/attachments/FCC-10-201A1_Rcd.pdf
5. Note: An ISP provides services that enable its customers to connect through the internet. High-speed internet access is commonly referred to as broadband internet. So, if an ISP is capable of providing high-speed internet access, they are considered broadband internet service providers.
6. https://docs.fcc.gov/public/attachments/FCC-15-24A1.pdf
7. https://docs.fcc.gov/public/attachments/FCC-15-24A1.pdf
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10. Id.
11. https://fas.org/sgp/crs/misc/R40616.pdf
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15. https://www.nytimes.com/interactive/2020/us/coronavirus-stay-at-home-order.html
16. https://docs.fcc.gov/public/attachments/FCC-19-44A1.pdf
17. https://www.fcc.gov/covid-19-telehealth-program
18. 42 USC 254(h)(7)(B). "(B)Health care provider --- The term "health care provider" means— (i)post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (ii)community health centers or health centers providing health care to migrants; (iii)local health departments or agencies; (iv)community mental health centers; (v)not-for-profit hospitals; (vi)rural health clinics; (vii)skilled nursing facilities (as defined in section 395i–3(a) of title 42); and (viii)consortia of health care providers consisting of one or more entities described in clauses (i) through (vii)."
19. https://docs.fcc.gov/public/attachments/DOC-364481A1.pdf
20. https://docs.fcc.gov/public/attachments/DA-20-436A1.pdf
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24. https://www.bbc.com/news/technology-51968302
25. https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak
26. https://www.cms.gov/newsroom/press-releases/trump-administration-announces-changes-medicare-advantage-and-part-d-provide-better-coverage-and

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(N-21)

Introduced by: South Carolina, Alabama, Florida, Mississippi, New Jersey, Oklahoma, West Virginia, Arkansas, North Carolina

Subject: Protection of Peer-Review Process

Referred to: Reference Committee B

Whereas, Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice; and

Whereas, It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care; and

Whereas, It is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care; and

Whereas, Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof; and

Whereas, The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself; and

Whereas, A U.S. Senate Oversight Committee in investigating UNOS (United Network for Organ Sharing) has subpoenaed “all relevant materials to include peer-review related materials”; therefore be it

RESOLVED, That our American Medical Association use its full ability and influence to oppose any new attempt(s) to make peer review proceedings, regardless of the venue, discoverable, even if by the U.S. Congress or other U.S. governmental entity. (Directive to Take Action)

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

Received: 06/21/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution should be considered by our AMA House of Delegates as an URGENT resolution because of the on-going attempts by Oversight Committees of the US Congress to obtain peer-reviewed data which would include information by transplant surgeons as well as other physicians involved in the life-saving task of organ transplantation. There can be no guarantee that protected information would not be released in violation of the spirit of peer-reviewed procedures.

RELEVANT AMA POLICY

Legal Protections for Peer Review H-375.962
Definition and Purpose of Peer Review
Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; ie, professional services administered by a physician and the portion of care under a physician's direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes, and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.
Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care. Accountability to patients and their care, to the medical profession and colleagues, and to the institution granting privileges is inherent to the peer review process.
Composition of the Peer Review Committee
Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.
Definitions
Good Faith Peer Review. Peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains, or due to personal vendetta is not considered a good faith peer review.
Medical Peer Review Organizations. Any panel, committee, or organization that is composed of physicians or formed from a medical staff or formed by statute, such as physician wellness peer review boards, which engages in or utilizes peer reviews concerning the care and treatment of patients for the purposes of self-monitoring and maintaining the administration of patient safety and quality of care consistent with optimal standards of practice is a medical peer review organization. The responsibility of a medical peer review organization is to ensure: (1) that all physicians consistently maintain optimal standards of competency to practice medicine; and (2) the quality, safety, and appropriateness of patient care services. The medical peer review committee's obligations include review of allegations of infirmity (e.g., fitness to practice medicine), negligent treatment, and intentional misconduct. Peer review protections and privilege should extend to investigation and subsequent correction of negligent treatment and intentional misconduct.
Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting

of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within his/her knowledge; but such witness cannot be asked about his/her testimony before a peer review organization or about opinions formed by him/her as a result of the peer review organization hearings.

Peer Review Activity. Peer review activity means the procedure by which peer review committees or quality assessment and assurance committees monitor, evaluate, and recommend actions to improve and ensure the delivery and quality of services within the committees' respective facilities, agencies, and professions, including recommendations, consideration of recommendations, actions with regard to recommendations, and implementation of actions.

Peer Review Records. Peer review records mean all complaint files, investigation files, reports, and other investigative information relating to the monitoring, evaluation, and recommendation of actions to improve the delivery and quality of health care services, licensee discipline, or professional competence in the possession of a peer review committee or an employee of a peer review committee.

Privilege. The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

Confidentiality. Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.

Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in good faith peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities.

Citation: BOT Rep. 10, A-09; Reaffirmed: BOT Rep. 13, I-11; Modified: BOT Rep. 05, I-17

Peer Reviewer Immunity D-375.997

Our AMA will: (1) recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process; and (3) continue to work to provide peer review protection under federal law.

Citation: (BOT Rep.8, I-01; Reaffirmation A-05; Modified: CCB/CLRPD Rep. 2, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(N-21)

Introduced by: Medical Student Section

Subject: Poverty-Level Wages and Health

Referred to: Reference Committee B

Whereas, Poverty has been shown to be an independent predictor of both physical and mental health in adults and children, in addition to causing a decreased life expectancy[1–12]; and

Whereas, People living in poverty are more likely to skip medical visits, medication doses, and meals, compounding the health inequities they experience[4,13]; and

Whereas, In 2019, 34 million people in the United States were living in poverty, and the U.S. poverty rate exceeded that of most peer or developed countries[14–16]; and

Whereas, The federal minimum wage was instituted in 1938 to create a minimum standard of living and to protect the health and well-being of employees[17,18]; and

Whereas, The federal U.S. minimum wage has not increased since 2009, while average yearly inflation increased steadily during that time, such that the real value of the minimum wage is now 17% less than it was in 2009 and 31% less than it was in 1968[19–21]; and

Whereas, An American family with two children and two adults working full-time jobs at the federal minimum wage would be roughly at the U.S. poverty level, and furthermore any single parent working a full-time job at the federal minimum wage would be below the federal poverty level[22]; and

Whereas, Due to longstanding systemic and structural discrimination, Black, Indigenous, Latinx, and other people of color, women, LGBTQ+ individuals, and people with disabilities are more likely to be vulnerable to poverty and to be working jobs that make only minimum wage[21,23–29]; and

Whereas, Researchers have documented associations between increased wages and decreases in suicide mortality, decreases in hypertension and heart disease, better birth outcomes, decreased teen birthrates, lower rates of sexually-transmitted infections among women, lower rates of new HIV infection, improvement in self-reported health and fewer days with functional limitations, decreases in smoking prevalence, decreases in youth binge drinking, and increased life expectancy[30–43]; and

Whereas, A low minimum wage results in an increased number of patients relying on Medicaid, resulting in lower overall reimbursements for physicians[44,45]; and

Whereas, The numerous states and localities that have raised their minimum wage above the federal minimum have not incurred adverse impacts on their rates of employment[46–49]; and

Whereas, Multiple bills aimed at raising the federal minimum wage have been proposed and debated in recent years[50]; and

Whereas, Our AMA recognizes the importance and impact of social determinants on health (H-165.822), recognizes health is a basic human right and that the provision of healthcare services is an obligation of an ethical civil society (H-65.960), and encourages screening for social and economic risk factors (H-160.909), but has no policy supporting federal minimum wage regulation for the betterment of individual and public health; therefore be it

RESOLVED, That our American Medical Association support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Poverty's impact upon health has become especially pressing during the COVID-19 pandemic. Poverty and economic stress have been highly correlated with poor health outcomes, as the pandemic reveals the depths of the economic divide that separates the well and well-cared-for from the sick and oft-ignored in America. As we as a nation begin to try to recover from the pandemic, it is imperative that we also try to resolve this long-standing social ill, so that the next national disaster is not so horrifically devastating among society's more vulnerable members and at large. Poverty-level wages, which keep a full-time worker under the poverty line, are massively detrimental to an individual's health. It is unconscionable that a full-time worker in the U.S. may not make enough to keep them alive, much less well, and the effects of this inequity have been made inescapable as the pandemic continues to cause devastation. Further, increasing the minimum wage has been a topic under federal governmental consideration, making this issue highly timely and relevant. Our AMA should act decisively to combat these harms now, to give our pandemic recovery the greatest chance of succeeding for all.

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RELEVANT AMA POLICY

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922
Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes; and (2) study the most efficacious manner by which our AMA can continue to achieve its mission of the betterment of public health by recommending ways in which to strengthen the health and public health system infrastructure.
Res. 407, I-20

Health, In All Its Dimensions, Is a Basic Right H-65.960
Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.
Res. 021, A-19

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.
CMS Rep. 7, I-20

Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909
Our AMA encourages screening for social and economic risk factors in order to improve care plans and direct patients to appropriate resources.
Res. 404, A-13; Reaffirmed: BOT Rep. 39, A-18

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.
Res. 5, I-20

Discriminatory Policies that Create Inequities in Health Care H-65.963
Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
Res. 001, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(N-21)

Introduced by: Medical Student Section

Subject: Supporting Collection of Data on Medical Repatriation

Referred to: Reference Committee B

Whereas, Forced medical repatriation is the involuntary return of civilians in need of medical treatment to their country of origin by healthcare professionals[1]; and

Whereas, Forced medical repatriation results in an involuntary transfer of a patient to a foreign country, provoking an unwarranted intersection between immigration enforcement and the healthcare system[2]; and

Whereas, Of the estimated 10.5 million undocumented immigrants in the United States in 2017, a study found expenditures on immigrants in 2016 accounted for less than 10% of the overall healthcare spending in a population with the highest risk of being uninsured among the non-elderly population[2-4]; and

Whereas, Under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), federally funded health institutions with emergency care capabilities are mandated to treat all patients with emergent medical conditions who present to their facility until deemed stable, regardless of their insurance coverage or financial status[5]; and

Whereas, Once deemed stable, medical centers must consider medical repatriation if no long-term care alternative is available to the patient as a cost-saving mechanism[6]; and

Whereas, Care centers like St. Joseph's Hospital and Medical Center in Phoenix, Arizona, partake in forced medical repatriation for undocumented immigrant patients and a Florida patient experienced involuntary deportation prior to the completion of their appeal or asylum verdict[7-9]; and

Whereas, Forced medical repatriation has led to serious medical consequences for patients, including the exacerbation of existing medical conditions[10,11]; and

Whereas, Patients experienced a lapse and deterioration of care due to the inability of the patient's country of origin to provide adequate treatment and concurrent separation from their community in the U.S. during a time which may require emotional, physical and financial support[6,7,9,12]; and

Whereas, Hospitals fail to inform patients, or their guardians of potential adverse medical consequences related to repatriation[7,13]; and

Whereas, Forced medical repatriation increases health disparities among migrant communities and deters immigrants from seeking necessary medical services[14,15];and

Whereas, Forced medical repatriation often violates the Centers for Medicare and Medicaid Services' Conditions of Participation regulation which commits hospitals to ensure patients have the right to conduct informed decisions regarding their care[16,17]; and

Whereas, Forced medical repatriation violates the patient's constitutional right to due process, especially if the patient is able to claim asylum[18]; and

Whereas, The *AMA Journal of Ethics* encourages health care systems to seek routes of care to avoid forced medical repatriation and the *AMA Code of Ethics* Opinion 1.1.8 states that "physicians should resist any discharge requests that are likely to compromise a patient's safety" and that the "discharge plan should be developed without regard to socioeconomic status, immigration status, or other clinically irrelevant considerations" [2,19,20]; and

Whereas, The AMA is pursuing policy focused on alternative routes for immigrant healthcare through Health Care Payment for Undocumented Persons (D-440.985) and Federal Funding for Safety Net Care for Undocumented Aliens (H-160.956)[21,22]; and

Whereas, Data on repatriation of civilians is not reported through any government agency or otherwise, and there is a lack of documentation[7,23]; therefore be it

RESOLVED, That our American Medical Association ask the Department of Health and Human Services to collect and de-identify any and all instances of medical repatriations from the United States to other countries by medical centers to further identify the harms of this practice (Directive to Take Action); and be it further

RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution denounces the practice of forced medical repatriations. Forced medical repatriations are an important ethical dilemma and public health crisis, impacting vulnerable immigrant communities. Further, this issue has become acutely, highly important during the current pandemic, as we currently have no data on how medical repatriations are decided or enacted and what their outcomes and downstream impacts may be. Without data collection on medical repatriations, we have no way to know whether they are being used in a discriminatory fashion, or what the outcomes are for patients, their healthcare teams, the countries to which the patients are repatriated, the people with whom they travel, and so on. Our AMA currently has no policy on medical repatriation and under the current political climate revolving immigrant health, we feel that this obviously unethical practice urgently needs to be researched and denounced by our AMA. By advocating for data collection and documentation of repatriation cases, this resolution demands transparency on an issue that has been rendered invisible by a lack of data. This resolution represents an urgent and necessary step forward during a time when the health of vulnerable immigrant populations is particularly at risk.

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RELEVANT AMA POLICY

EMTALA -- Major Regulatory and Legislative Developments D-130.982

Our AMA: (1) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject; (2) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services; (3) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the EMTALA regulations; and (4) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply.
BOT Rep. 17, I-02, Reaffirmation: A-07, Modified: BOT Rep. 22, A-17

Access to Emergency Services H-130.970

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average

knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.
(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)
(C) All health plans should be prohibited from requiring prior authorization for emergency services.
(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.
(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.
(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.
(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.
(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.
(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.
2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care.
CMS Rep. A, A-89, Modified: CMS Rep. 6, I-95, Reaffirmation: A-97, Reaffirmed: Sub. Res. 707, A-98, Reaffirmed: Res. 705, A-99, Reaffirmed: CMS Rep. 3, I-99, Reaffirmation: A-00, Reaffirmed: Sub. Res. 706, I-00, Amended: Res. 229, A-01, Reaffirmation and Reaffirmed: Res. 708, A-02, Reaffirmed: CMS Rep. 4, A-12, Reaffirmed: CMS Rep. 07, A-16, Appended: Res. 128, A-17, Reaffirmation: A-18, Reaffirmed in lieu of: Res. 807, I-18

Emergency Medical Treatment and Active Labor Act (EMTALA) H-130.950
Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act ((EMTALA)) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under (EMTALA); (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act ((EMTALA)) rules and regulations; (3) urgently seeks return to the original congressional intent of (EMTALA) to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous (EMTALA) requirements.
Sub. Res. 214, A-97, Reaffirmation: I-98, Reaffirmation: A-99, Appended: Sub. Res. 235 and Reaffirmation A-00, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17)

Emergency Transfer Responsibilities H-130.957
Our AMA supports seeking amendments to Section 1867 of the Social Security Act, pertaining to patient transfer, to:

(1) require that the Office of the Inspector General (IG) request and receive the review of the Quality Improvement Organization (QIO) prior to imposing sanctions;
(2) make the QIO determination in alleged patient transfer violations binding upon the IG;
(3) expand the scope of QIO review to include a determination on whether the medical benefits reasonably expected from the provision of appropriate medical treatment at another facility outweighed the potential risks;
(4) restore the knowing standard of proof for physician violation;
(5) recognize appropriate referral of patients from emergency departments to physician offices;
(6) clarify ambiguous terms such as emergency medical transfer and stabilized transfer;
(7) clarify ambiguous provisions regarding the extent of services which must be provided in examining/treating a patient;
(8) clarify the appropriate role of the on-call specialist, including situations where the on-call specialist may be treating other patients; and
(9) clarify that a discharge from an emergency department is not a transfer within the meaning of the act.
Sub. Res. 78, A-91, Reaffirmation: A-00, Reaffirmed: BOT Rep. 6, A-10; Modified: BOT Rep. 04, A-20

Repeal of COBRA Anti-Physician Provisions H-130.959
It is the policy of the AMA (1) to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of malpractice; and (2) to continue to seek appropriate modifications of Section 1867 of the Social Security Act to preclude liability for discharges from the hospital, including emergency department and outpatient facility.
Sub. Res. 145, I-90, Reaffirmed: Sunset Report, I-00, Reaffirmed: BOT Rep. 6, A-10; Reaffirmed: BOT Rep. 04, A-20

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.
Res. 148, A-02, Reaffirmation: A-07, Reaffirmed: CMS Rep. 1, A-17, Reaffirmation: A-19; Reaffirmation: I-19

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of health care to undocumented residents.
Res. 920, I-06, Reaffirmed and Appended: Res. 140, A-07, Modified: CCB/CLRPD, Rep. 2, A-14

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.
Sub. Res. 207, A-93, Reaffirmed: BOT Rep. 17, I-94, Reaffirmed: Ref Com B, A-96, Reaffirmation: A-02, Reaffirmation: A-07, Reaffirmed: BOT Rep. 22, A-17, Reaffirmation: A-19; Reaffirmation: I-19

Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Our AMA: (1) advocates for and supports legislative efforts to designate healthcare facilities as sensitive locations by law; (2) will work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of healthcare facilities as sensitive locations where U.S. Immigration and Customs Enforcement (ICE) enforcement actions should not occur; (3) encourages healthcare facilities to clearly demonstrate and promote their status as sensitive locations; and (4) opposes the presence of ICE enforcement at healthcare facilities.
Res. 232, I-17)

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Res. 804, I-09, Appended: Res. 409, A-15, Reaffirmation: A-19, Appended: Res. 423, A-19; Reaffirmation: I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(N-21)

Introduced by: Medical Student Section

Subject: Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits

Referred to: Reference Committee B

Whereas, Rape and/or sexual assault is common in the United States, with between 135,755 and 393,980 rapes and/or sexual assaults committed in 2017 alone[1,2]; and

Whereas, 43.6% of women and 24.8% of men have experienced some form of sexual violence, including unwanted sexual contact of any kind, in their lifetimes[3]; and

Whereas, Rape and sexual assault are associated with a wide range of medical and psychological sequelae, including direct physical trauma, PTSD, depression, social phobias, mood regulation deficiencies, impaired sexual function, anxiety, self-harm, suicidal ideation and suicide attempts[4-14]; and

Whereas, Data suggests that a significant proportion of rapes and/or sexual assaults are committed by serial offenders[15-19]; and

Whereas, Identification and incarceration of perpetrators of violent sexual crimes reduces the incidence of future sexual violence committed by these serial offenders[17-23]; and

Whereas, Sexual assault evidence kits (SAEKs), which refer to kits used to collect and store evidence from a victim of sexual assault during a sexual assault forensic examination, are extremely useful in the identification and prosecution of perpetrators of violent sexual crime and are positively associated with successful prosecutions[17,19,22,23-27]; and

Whereas, Even when suspects cannot be immediately identified on the basis of the DNA signature derived from a SAEK, law enforcement officials can upload the DNA profile to the Federal Bureau of Investigation's Combined DNA Index System (CODIS), which can assist in the later identification of the perpetrator[28]; and

Whereas, Despite the obvious utility of testing SAEKs, many remain untested and stored in law enforcement evidence warehouses ("backlogged"), with estimates placing the number of backlogged kits as high as 200,000 nationwide[19,29]; and

Whereas, The cause of backlogged SAEKs have been attributed to lack of standardized policies and procedures, including federal guidelines, inadequate training of law enforcement officers, outdated laboratory policies and lack of resources, such as funding[30]; and

Whereas, The United States Department of Justice's Violence Against Women Act of 1994 (VAWA) and its subsequent reauthorizations provides grants to programs offering medical services to sexual assault survivors contingent on those programs incurring the full cost of forensic medical exams through the offices of State Attorney's General[31-33]; and

Whereas, Standardized insurance billing procedures that include copays and other cost-sharing payments cause victims of sexual assault to be billed for part of the cost of testing forensic evidence, notwithstanding federal mandates like VAWA[34,35]; and

Whereas, The Bureau of Justice Assistance in the US Department of Justice administers the Sexual Assault Kit Initiative (SAKI), a grant program that assists police departments in testing backlogged SAEKs, has resulted in the disbursement of $43 million and the testing of 50,500 kits[40-42]; and

Whereas, Counties that have voluntarily worked to test all backlogged SAEKs in their possession have been extraordinarily successful in solving previously unsolved rapes and sexual assaults[17,19,21,22,36-40]; and

Whereas, Many of these SAEKs, if tested earlier, would have led to the identification and incarceration of serial offenders that would have prevented later assaults[17,19-22,36-38]; and

Whereas, The $9.6 million SAEK testing initiative in Cuyahoga County, Ohio financed new forensic examinations in addition to comprehensive coverage of investigations on backlogged kits with a net estimated savings of $38.7 million, highlighting the cost effectiveness of testing SAEKs[41,42]; and

Whereas, Existing AMA Policy H-80.999 outlines the rights of sexual assault victims but neither explicitly describes the right to have collected medical forensic evidence be tested in a timely manner nor addresses the backlog of untested sexual assault evidence kits; therefore be it

RESOLVED, That our American Medical Association amend Policy H-80.999, "Sexual Assault Survivors," by addition to read as follows:

H-80.999 – SEXUAL ASSAULT SURVIVORS

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitations (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
5. Our AMA will advocate at the state and federal level for (a) the immediate processing of all "backlogged" and new sexual assault examination kits; and (b) additional funding to facilitate the immediate testing of sexual assault evidence kits. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Every year, hundreds of thousands of women are victims of sexual assault, and go on to suffer long-term physical, mental, and financial sequelae as a result. One of the leading tools law enforcement has to identify and track down perpetrators of this horrific act are sexual assault evidence kits (SAEKs), which can provide DNA evidence that links the attacker to DNA signatures in a variety of already-extant government databases. These kits have been shown to be extremely effective in solving sexual assaults. Their collection is very invasive and causes assault victims further stress, but victims frequently choose to undergo this stress, under the impression that the kit will help identify the perpetrator. However, there are almost no laws or regulations that mandate that SAEKs must be tested after collection. Hundreds of thousands of untested SAEKs from hundreds of thousands of sexual assaults languish in the so-called backlog, stored in police warehouses until the statute of limitations has expired. With every passing year, more SAEKs expire, their data becomes inadmissible in court, and more perpetrators of sexual assault are allowed to go free and potentially repeat their crimes. By advocating for mandates that would require all SAEKs, both those in the backlog and those collected in the future, to be fully tested and additional funding for police departments to facilitate those requirements, our AMA can help reduce the prevalence of sexual assault and advance the cause of justice. There is no time to waste.

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RELEVANT AMA POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18

Sexual Assault Survivor Services H-80.998
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17

Addressing Sexual Assault on College Campuses H-515.956
Our AMA: (1) supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting; (2) will work with relevant stakeholders to address the issues of rape, sexual abuse, and physical abuse on college campuses; and (2) will strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses.
Res. 402, A-16; Appended: Res. 424, A-18

HIV, Sexual Assault and Violence H-20.900
Our AMA: (1) believes that HIV testing and Post-Exposure Prophylaxis (PEP) should be offered to all survivors of sexual assault who present within 72 hours of a substantial exposure risk, that these survivors should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained; and (2) supports: (a) education of physicians about the effective use of HIV Post-Exposure Prophylaxis (PEP) and the U.S. PEP Clinical Practice Guidelines, and (b) increased access to, and coverage for, PEP for HIV, as well as enhanced public education on its effective use.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13; Modified: Res. 905, I-18

Access to Emergency Contraception H-75.985
It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter.
CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14

Insurance Discrimination Against Victims of Domestic Violence H-185.976
Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.
Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19

AMA Code of Medical Ethics 8.10 Preventing, Identifying and Treating Violence and Abuse
All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.
To protect patients' well-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in "normal" families, is a private matter best resolved without outside interference, or is caused by victims' own actions.
(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
(i) inform patients about requirements to report;
(ii) obtain the patient's informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 206
(N-21)

Introduced by: Medical Student Section

Subject: Updating Policy on Immigration Laws, Rules, Legislation, and Health Disparities to Better Address National Crises

Referred to: Reference Committee B

Whereas, The 2018 American Community Survey (ACS) reported that about 10.6 million undocumented immigrants were living the United States[1]; and

Whereas, Since the beginning of the COVID-19 pandemic, there have been at least 48 immigration policy changes that have not only affected international travel, student visas, and immigration, and asylum processes, but also caused significant confusion for immigration lawyers[2-4]; and

Whereas, The suspension of the United States Custom and Immigration Services (USCIS) during the COVID-19 pandemic has led to a back-up in the processing of necessary documentation, which has left many unable to access certain benefits necessary for work, receiving healthcare, and accessing public benefits[5]; and

Whereas, The Executive Office for Immigration Review (EOIR) suspended all hearings for non-detained individuals on March 18, 2020, which delayed the processing of asylum seekers enrolled in the Migrant Protection Protocols and left them to remain in Mexico in unsanitary conditions that promotes the spread of the virus[5]; and

Whereas, The federal government used statutes and the Tariff Act of 1930 in order to create rules from the Centers for Disease Control and Prevention (CDC) and CBP that restricted both entry at the northern and southern borders and barred asylum seekers from entering the country due to public health threats, despite evidence suggesting that such restrictions are ineffective and may even divert resources from other interventions[5]; and

Whereas, Immigration courts closed at the beginning of the COVID-19 pandemic and postponed hearings for detained people, prolonging their stay in detention centers[4,5]; and

Whereas, The relief packages that were provided by the government during the pandemic either provided little or no coverage to immigrants and their families, leaving them with few options for testing and treatment[5,7]; and

Whereas, The Families First Coronavirus Response Act (FFCRA) failed to make COVID-19 related services available under emergency Medicaid, which means that immigrants are unable to access these services since they cannot apply for non-emergency Medicaid due to immigration eligibility criteria[1,5,8]; and

Whereas, Undocumented immigrants typically work low-earning jobs and are unable to receive unemployment insurance or government stimulus checks during national crises[5,9]; and

Whereas, The Coronavirus Aid, Relief, and Economic Security (CARES) act limited the ability to receive a stimulus payment to individuals with a social security number, which limits many immigrants who file taxes using Individual Taxpayer Identification Numbers (ITIN)[1,5,8]; and

Whereas, Lapses in work authorization due to slowed processing times and suspension of required processing services may result in immigrants being unemployed or losing benefits offered by their employer[5,8]; and

Whereas, Both the FFCRA and the CARES act expanded Unemployment Insurance (UI) programs, but due to lapses in work authorizations, many immigrants may either not qualify or lose access to this vital benefit[1]; and

Whereas, Previous immigration law changes, such as the February 2020 Public Charge rule, penalized immigrants for using non-cash public assistance like Medicaid, the Supplemental Nutrition Assistance Program (SNAP), the Children's Health Insurance Program (CHIP), several housing programs, and federal poverty level determination by threatening inadmissibility or inability to be granted legal permanent residency in the United States[10,11]; and

Whereas, These changes not only discourage use of publicly funded healthcare and welfare services even among immigrant families to which the rule does not technically apply due to fear and confusion, but also mislead countless immigrant parents to remove their U.S. citizen children from health care insurance, likely leading to unnecessary child morbidity and mortality[10,12-15]; and

Whereas, Decreased participation in public benefit programs would contribute to a greater uninsured population, a decrease in the use of both preventive and curative health services, and negatively affect the health outcomes and financial stability of nearly 22 million noncitizens currently residing in the U.S.[10,16,17]; and

Whereas, On March 27, 2020, the USCIS announced that testing or treatment related to the COVID-19 pandemic would not count as a public charge[18,19]; and

Whereas, Although two filed lawsuits have prevented this ruling from being enacted further, there remains a concern on the potential for future immigration policy to discriminate based on poverty level, housing status, and the need for public benefits[17-19]; and

Whereas, Increased fear of deportation among families, even if only one family member is a non-citizen immigrant, not only causes decreased health care utilization but also causes increased behavioral issues in children[17]; and

Whereas, The 3rd AMA Principle of Medical Ethics states, "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient" [10]; and

Whereas, Our AMA is opposed to any proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP (AMA Policy D-440.927); and

Whereas, Our AMA joined other health care organizations in submission of amicus briefs and comment letters opposing the new public charge regulations, stating “there is no evidence that chilling the use of health and nutrition benefits will result in an increase in income, employment or educational status of immigrants... These sweeping and detrimental changes will ultimately result in far greater costs to the public’s health than any purported benefit offered by DHS” [11]; and

Whereas, Our AMA has set policy precedent to act on behalf of the health of immigrants, refugees, migrant workers, and asylum seekers (AMA Policy H-350.957), and has joined other health care organizations in submitting amicus briefs and comment letters opposing the new public charge regulations, stating “there is no evidence that chilling the use of health and nutrition benefits will result in an increase in income, employment or educational status of immigrants... These sweeping and detrimental changes will ultimately result in far greater costs to the public’s health than any purported benefit offered by DHS”[11]; therefore be it

RESOLVED, That our American Medical Association, in order to prioritize the unique health needs of immigrants, asylees, refugees, and migrant workers during national crises, such as a pandemic:

(1) oppose the slowing or halting of the release of individuals and families that are currently part of the immigration process; and

(2) oppose continual detention when the health of these groups is at risk and supports releasing immigrants on recognizance, community support, bonding, or a formal monitoring program during national crises that impose a health risk; and

(3) support the extension or reauthorization of visas that were valid prior to a national crisis if the crisis causes the halting of immigration processing; and

(4) oppose utilizing public health concerns to deny of significantly hinder eligibility for asylum status to immigrants, refugees, or migrant workers without a viable, medically sound alternative solution (New HOD Policy); and be it further

RESOLVED, That our AMA amend H-350.957, "Addressing Immigrant Health Disparities," by addition as follows:

Addressing Immigrant and Refugee Health Disparities H-350.957

1. Our American Medical Association recognizes the unique health needs of immigrants and refugees and encourages the exploration of issues related to immigrant and refugee health and supports legislation and policies that address the unique health needs of immigrants and refugees.

2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.

3. Our AMA will call for asylum seekers to receive all medically appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.

4. Our AMA opposes any rule, regulation, or policy that would worsen health disparities among refugee or immigrant populations by forcing them to choose between health care or future lawful residency status. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The recent horrific treatment of Haitian refugees at the border, proposal, and implementation of actions like asylum seeker bans, refugee entry suspensions, and postponing of Migration Protection Protocol hearings clearly demonstrate the need for a strong stance on immigrant protections during states of national emergency. Our delegation considers immigrant health and protections to be our strongest priority and ranked this resolution accordingly. To ensure our asks are actionable, the language of our resolution was crafted with the assistance of AMA advocacy staff.

This resolution strengthens AMA policy on legal immigrants' right to health care. It also broadens current policy so the AMA can continue to engage in conversations on immigration policy and their impact on immigrant health. The AAP has released several policy statements on the treatment of immigrant and refugee children, especially as it pertains to the use of detention centers and family separation policies, demonstrating that it is appropriate for our AMA to update existing policies on these issues.

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RELEVANT AMA POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.
Res. 018, A-17

Opposing the Detention of Migrant Children H-60.906
Our AMA: (1) opposes the separation of migrant children from their families and any effort to end or weaken the Flores Settlement that requires the United States Government to release undocumented children "without unnecessary delay" when detention is not required for the protection or safety of that child and that those children that remain in custody must be placed in the "least restrictive setting" possible, such as emergency foster care; (2) supports the humane treatment of all undocumented children, whether with families or not, by advocating for regular, unannounced, auditing of the medical conditions and services provided at all detention facilities by a non-governmental, third party with medical expertise in the care of vulnerable children; and (3) urges continuity of care for migrant children released from detention facilities.
Res. 004, I-18

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
3. Our AMA will call for asylum seekers to receive all medically-appropriate care, including vaccinations in a patient centered, language and culturally appropriate way upon presentation for asylum regardless of country of origin.
Res. 804, I-09 Appended: Res. 409, A-15; Reaffirmation: A-19; Appended: Res. 423, A-19; Reaffirmation: I-19

HIV, Immigration, and Travel Restrictions H-20.901
Our AMA recommends that: (1) decisions on testing and exclusion of immigrants to the United States be made only by the U.S. Public Health Service, based on the best available medical, scientific, and public health information; (2) non- immigrant travel into the United States not be restricted because of HIV status; and (3) confidential medical information, such as HIV status, not be indicated on a passport or visa document without a valid medical purpose.
CSA Rep. 4, A-03; Modified: Res. 2, I-10; Modified: Res. 254, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(N-21)

Introduced by: Medical Student Section

Subject: Authority to Grant Vaccine Exemptions

Referred to: Reference Committee B

Whereas, Vaccination has been a key tool in the public health armory for the past century, eliminating and nearly eliminating the incidence of several previously very burdensome diseases in the United States and worldwide[1-4]; and

Whereas, In regard to infectious pathogens, immunization of a large portion of the population can lead to vaccine-induced "herd immunity", a marked decrease in transmissibility because of the paucity of viable disease hosts, that can eliminate a pathogen from circulation in a population or protect those who are to be immunized for medical reasons, and increasing vaccine uptake enough to achieve herd immunity requires that the vast majority of jurisdictions have imposed vaccination mandates[3,4]; and

Whereas, All jurisdictions offer medical contraindication exemptions to mandates, defined as an exemption due to "a medical condition that prevents them from receiving a vaccine," and some also offer personal belief or religious exemptions to mandates[5,6]; and

Whereas, The process for obtaining a medical vaccine exemption differs from state to state, with some states allowing any healthcare practitioner to provide a medical exemption, and some specifying who qualifies as a healthcare provider, which may include medical doctors, nurse practitioners, or physician assistants[4]; and

Whereas, In light of increasing medical exemptions for vaccines, in 2019 California enacted Senate Bill 276 which called for an electronic, standardized medical exemption form that allows only licensed physicians, surgeons, and registered nurses to prescribe medical exemptions for vaccines, after which the California Department of Public Health would determine whether these medical exemptions are in compliance with the Centers for Disease Control and Prevention guidelines[7]; and

Whereas, Under California law, naturopathic providers (who have also been called naturopathic practitioners, naturopathic doctors, or naturopathic physicians) are not considered "licensed physicians" and are not allowed to grant medical exemptions, while other states, such as Washington, allow naturopathic providers to provide medical vaccine exemptions[8-12]; and

Whereas, Although AMA policy defines physicians as those with MD or DO degrees (H-160.949), in states allowing naturopathic providers to approve medical exemptions, naturopathic providers are allowed to provide vaccine exemptions due to the states' definition of medical authority; and

Whereas, Naturopathic providers do not have a nationally regulated definition of scope of practice or training required, and the definitions, terms used, and requirements vary greatly between states, and recent surveys have found that at most only 20% of naturopathic

practitioners actively recommend vaccination, and as many as 7% of naturopathic practitioners actively recommend against vaccination, raising concerns around allowing their access to writing vaccine exemptions[10,13,14]; and

Whereas, Given that some states have already re-defined "medical authority" to include naturopathic providers, it is possible that there may be further revisions naming other providers as "medical authorities" allowed to give vaccine exemptions, and other complementary or alternative medicine providers, like chiropractors and homeopaths, have documented similar or higher rates of reluctance to recommend vaccination or recommending against vaccination[14]; and

Whereas, This issue has become even more timely and urgent given the ongoing COVID-19 pandemic and the misinformation being spread about available, safe, and effective vaccines that can prevent SARS-CoV-2 infection; therefore be it

RESOLVED, That our American Medical Association oppose medical vaccine exemptions by non-physicians by amending Policy H-440.970, "Nonmedical Exemptions from Immunizations," by addition to read as follows:

Nonmedical Exemptions from Immunizations, H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA: (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to: <u>(a)</u> eliminate non-medical exemptions from mandated pediatric immunizations; <u>and (b) limit medical vaccine exemption authority to only licensed physicians</u>. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Anti-vaccinations stances have been on the rise for the greater part of the 21st century, resulting in outbreaks of diseases once thought almost eradicated such as measles. This issue has become critical as vaccine hesitancy is now prolonging a deadly pandemic, and lack of uptake of the extremely effective COVID-19 vaccines has led to heart wrenching, unnecessary, and entirely preventable losses of life and function. With vaccine mandates becoming more common, some individuals may look to receive unwarranted vaccine exemptions. Some states have a broad definition of "medical authority" which is now allowing alternative practitioners, such as naturopathic providers, to write vaccine exemptions. Naturopathic providers and other alternative medicine providers (like homeopaths and chiropractors) have been shown, through surveys, to be disinclined to recommend vaccines or even to recommend against vaccines. AMA policy does not offer directives or restrictions on who should be allowed to write medical vaccine exemptions, a gap this policy fills. Given the current dire situation of the pandemic and the urgent need to increase vaccination rates, we urge that this policy be considered at the November 2021 meeting, to arm our AMA with another tool in the fight against this ongoing pandemic.

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RELEVANT AMA POLICY

Nonmedical Exemptions from Immunizations H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.

Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop

contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.
2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to eliminate non-medical exemptions from mandated pediatric immunizations.
CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 416, A-19

Practicing Medicine by Non-Physicians H-160.949
Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for “assistant physicians” (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program, or have not completed at least one year of accredited graduate medical education in the U.S).
Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation: A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21

National Immunization Program H-440.992
Our AMA believes the following principles are required components of a national immunization program and should be given high priority by the medical profession and all other segments of society interested and/or involved in the prevention and control of communicable disease: (1) All US children should receive recommended vaccines against diseases in a continuing and ongoing program.

(2) An immunization program should be designed to encourage administration of vaccines as part of a total preventive health care program, so as to provide effective entry into a continuous and comprehensive primary care system.

(3) There should be no financial barrier to immunization of children.

(4) Existing systems of reimbursement for the costs of administering vaccines and follow-up care should be utilized.

(5) Any immunization program should be either (a) part of a continuing physician/patient relationship or (b) the introductory link to a continuing physician/patient relationship wherever possible.

(6) Professionals and allied health personnel who administer vaccines and manufacturers should be held harmless for adverse reactions occurring through no fault of the procedure.

(7) Provision should be made for a sustained, multi-media promotional campaign designed to educate and motivate the medical profession and the public to expect and demand immunizations for children and share responsibility for their completion.

(8) An efficient immunization record-keeping system should be instituted.
Res. 44, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 501, A-09; Reaffirmation: I-10; Reaffirmed: CSAPH Rep. 01, A-20

Distribution and Administration of Vaccines H-440.877
1. It is optimal for patients to receive vaccinations in their medical home to ensure coordination of care. This is particularly true for pediatric patients and for adult patients with chronic disease and co-morbidities. If a vaccine is administered outside the medical home, all pertinent vaccine-related information should be transmitted back to the patient's primary care physician and entered into an immunization registry when one exists to provide a complete vaccination record.
2. All physicians and other qualified health care providers who administer vaccines should have fair and equitable access to all ACIP recommended vaccines. However, when there is a vaccine shortage, those physicians and other health care providers immunizing patients who are prioritized to receive the vaccine based upon medical risks/needs according to ACIP recommendations must be ensured timely access to adequate vaccine supply.
3. Physicians and other qualified health care providers should: (a) incorporate immunization needs into clinical encounters, as appropriate; (b) strongly recommend needed vaccines to their patients in accordance with ACIP recommendations and consistent with professional guidelines; (c) either administer vaccines directly or refer patients to another qualified health care provider who can administer vaccines safely and effectively, in accordance with ACIP recommendations and professional guidelines and consistent with state laws; (d) ensure that vaccination administration is documented in the patient medical record and an immunization registry when one exists; and (e) maintain professional competencies in immunization practices, as appropriate.
4. All vaccines should be administered by a licensed physician, or by a qualified health care provider pursuant to a prescription, order, or protocol agreement from a physician licensed to practice medicine in the state where the vaccine is to be administered or in a manner otherwise consistent with state law.
5. Patients should be provided with documentation of all vaccinations for inclusion in their medical record, particularly when the vaccination is provided by someone other than the patient's primary care physician.
6. Physicians and other qualified health care providers who administer vaccines should seek to use integrated and interoperable systems, including electronic health records and immunization registries, to facilitate access to accurate and complete immunization data and to improve information-sharing among all vaccine providers.
7. Vaccine manufacturers, medical specialty societies, electronic medical record vendors, and immunization information systems should apply uniform bar-coding on vaccines based on standards promulgated by the medical community.

8. Our AMA encourages vaccine manufacturers to make small quantities of vaccines available for purchase by physician practices without financial penalty.
Sub Res. 512, A-06; Reaffirmed: BOT Rep. 26, A-07; BOT Action in response to referred for decision, Res. 902, I-08; Modified: CSAPH Rep. 4, I-14; Appended: Res. 404, A-16; Reaffirmed: CMS Rep. 07, A-17; Reaffirmed: CMS Rep. 6, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(N-21)

Introduced by: Medical Student Section

Subject: Protections for Incarcerated Mothers in the Perinatal Period

Referred to: Reference Committee B

Whereas, Almost 4% of women newly admitted to U.S. prisons are pregnant, and 92% of pregnancy outcomes in prisons resulted in live births[1,2]; and

Whereas, Twenty-five percent of justice juvenile residential facilities house at least one pregnant youth[3]; and

Whereas, Limited data is available regarding health outcomes of incarcerated pregnant people despite the high frequency of pre-existing health conditions in incarcerated populations and the established relationship between incarceration and exacerbation of pre-existing medical conditions[4-7]; and

Whereas, State and federal Maternal Mortality Review Committees and the CDC's surveillance reports on maternal mortality and morbidity already use data from surveillance of perinatal outcomes to improve understanding of disparities among racial groups and inform the development of policies and initiatives aimed at meeting the needs of high-risk populations, but data on incarceration status is not included in this surveillance[6-18]; and

Whereas, Quality improvement research can improve care for vulnerable populations, and data from surveillance of perinatal outcomes and studies regarding the accessibility and quality of healthcare available to pregnant incarcerated people would expand the current knowledge of disparities within this particularly vulnerable group[19-22]; and

Whereas, There are currently no standard methodologies or requirements for collecting data on incarcerated pregnant people and, prior to 2016, had been no organized review of pregnancy outcomes of incarcerated people in the United States[23]; and

Whereas, Incarcerated pregnant people are often deprived of prenatal care, adequate nutrition, access to appropriate accommodations, and timely medical care, all of which are known to contribute to poor health outcomes[5,6,24-29]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) has established guidelines on prenatal and postnatal care for incarcerated women, including assessing pregnancy risk, providing medication-assisted treatment for opioid use disorder in pregnant people, and avoiding the use of restraints on people that are pregnant or within six weeks of postpartum, but data have shown that many incarcerated women do not receive care in accordance with these guidelines[6,23,30]; and

Whereas, Complications during pregnancy and delivery, such as preeclampsia, intrauterine growth restriction, and intrauterine fetal death, are more likely to occur in women that have an opioid addiction and do not receive adequate withdrawal treatment[31]; and

Whereas, Only a small number of states, including Pennsylvania, North Carolina, and Oklahoma, have explicit standards of care for incarcerated pregnant mothers, such as specific lab tests, frequency of prenatal visits with an obstetrician, and screening for high-risk pregnancies[32-34]; and

Whereas, The US Government Accountability Office reported in 2021 that the US Marshals Service and Bureau of Prisons' Detention Standards and Policies either do not align or only partially align with national guidance recommendations on the treatment and care of pregnant people, and the US Bureau of Prisons and most state correctional facilities do not require specific or explicit guidelines for perinatal care or nutrition[35,36]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) recommend exclusive breastfeeding for the first six months of a baby's life[37,38]; and

Whereas, Breast milk has established benefits for the baby, including reduced risks of infection, such as otitis media and pneumonia; other health conditions, such as obesity, type 1 and type 2 diabetes mellitus, asthma, and sudden infant death syndrome (SIDS); as well as established benefits of breastfeeding and breast milk expression for the mother, including reduced risk of breast and ovarian cancer, type 2 diabetes mellitus, and hypertension[37-40]; and

Whereas, Breastfeeding has been associated with improved cognitive and emotional abilities, increased brain development in children, and improved mother-child relationship[41]; and

Whereas, The cost of infant formula is up to $1,500 per year; alternatively, feeding a baby with pasteurized donor human milk costs an average of $4.50 per ounce, and further, the cost of healthcare in a breastfed baby's first year of life is, on average, $331 less than a formula-fed baby[42-46]; and

Whereas, Pumping breast milk can promote a greater maternal-infant bond and improve the health of both the mother and infant[47]; and

Whereas, A woman's right to breastfeed or express breast milk in any private or public location is protected by law in all 50 states of the United States; however, for mothers in prison, there are significant barriers to expressing and storing breast milk, such as requiring presence of a prison guard, time restrictions, and insufficient equipment[48,49]; and

Whereas, Most women who give birth while incarcerated are separated from their child after hospital discharge and usually without sufficient education on breastfeeding[50]; and

Whereas, Restricting mothers from breastfeeding and/or expressing breast milk while incarcerated will decrease their milk supply, hindering their ability to directly breastfeed[51]; and

Whereas, In 2017, the National Commission on Correctional Health Care called on correctional facilities to support programs for incarcerated women to breastfeed their babies directly or pump breast milk and store it for later delivery to the infant[52]; and

Whereas, The protections for incarcerated mothers to express milk may be established on a state-by-state basis, but only California, Connecticut, New Mexico, New York, and Washington have laws offering protections, although still with limitations[48,53-58]; and

Whereas, Our AMA acknowledges the importance of access to healthcare for incarcerated individuals (D-430.997, H-430.986, H-430.997), has supported standards to improve the safety of pregnant incarcerated people (H-420.957), and our AMA has policies in support of breastfeeding (H-245.982) and bonding programs for women prisoners and their newborn children (H-430.990), though these policies do not specify protecting an incarcerated mother's right to express milk; therefore be it

RESOLVED, That our American Medical Association encourage research efforts to characterize the health needs for pregnant inmates, including efforts that utilize data acquisition directly from pregnant inmates (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation requiring all correctional facilities, including those that are privately-owned, to collect and report pregnancy-related healthcare statistics with transparency in the data collection process (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. <u>However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed and/or pump and store breast milk to include incarcerated mothers.</u> The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills <u>and breastfeeding/breast pumping</u> training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

The COVID-19 pandemic has laid bare some of the vast health injustices for people who are incarcerated, making it clear this is a population in urgent need of better protections for their rights, health, and safety. Almost 4% of women are pregnant at the time of prison or jail admission in the U.S. However, there are currently no standard methodologies or requirements for collecting data on incarcerated pregnant people. ACOG has established guidelines on the pre- and postnatal care of incarcerated women, but data have shown that many incarcerated women do not receive care in accordance with these guidelines. Further, although the right to breastfeed in public and the workplace is protected by law in all 50 states, these laws fail to protect those who are incarcerated. There is often a lack of resources or education to support breast pumping and storage practices in jails and prisons, resulting in essentially a lack of adequate access to the important practice of breastfeeding for these women and their babies. We need to fill this AMA policy gap by advocating for the rights and safety of incarcerated persons in the perinatal period and their children. As the voice of America's physicians, it is vital that we take a stand for this vulnerable population whose health is so disproportionately affected in the ongoing pandemic, and this resolution represents a concrete, urgent, and impactful way we can do that.

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RELEVANT AMA POLICY

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:
(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities; (2) encourage all correctional systems to support NCCHC accreditation; (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding; (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and (6) support an incarcerated person’s right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.
Res. 440, A-04; Amended: BOT Action in response to referred for decision; Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep, 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Reaffirmed: Res. 229, A-21

Shackling of Pregnant Women in Labor H-420.957
1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.
If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."
2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.
Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children.
CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Standards of Care for Inmates of Correctional Facilities H-430.997
Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
Res. 60, A-84; Reaffirmed by CLRPD Rep. 3, I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

Support for Breastfeeding H-245.982
1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate Resolution RS-056 (I-20) Page 5 of 6 medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines.
CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12;
Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(N-21)

Introduced by: Medical Student Section

Subject: Increasing Access to Hygiene and Menstrual Products

Referred to: Reference Committee B

Disclaimer: We acknowledge that not all persons who experience menstrual bleeding and need menstrual hygiene products are women, and that the following applies to all individuals who experience menstrual bleeding and require these products.

Whereas, Feminine hygiene products, also known as menstrual care products, are classified as tampons, pads, liners, cups, sponges, or similar products used by individuals with respect to menstruation or other genital-tract secretions[1,2]; and

Whereas, In 2018, the estimated average life-time cost of menstrual products for an individual in the United States was $1,773.33[3]; and

Whereas, Two-thirds of low-income women in the United States of America were unable to afford menstrual products in 2018, and low-income women who are food insecure are more likely to struggle with the choice to either buy food or menstrual hygiene products due to financial strain, and often make the choice for the former[4,5] and

Whereas, The FDA advises that tampons should never be used for more than 8 hours at a time due to risks of bacterial growth that could result in toxic shock syndrome and because unhygienic menstruation practices are a risk factor for secondary infertility[6,7]; and

Whereas, One study showed that one third of low-income women in St. Louis, Missouri used unhygienic menstrual practices such as “strips of cloth, rags, tissues, or toilet paper” due to menstrual hygiene product inaccessibility, and other studies have shown that such practices, including using reusable cloths and insufficient changing of menstrual napkins, increase the likelihood of contracting reproductive and urinary tract infections[5,8,9] and

Whereas, Women who cannot afford menstrual hygiene products are more likely to suffer from moderate/severe depression[10]; and

Whereas, Studies have shown that low-income women are concerned about the high cost of menstrual hygiene products, and are frustrated that their benefits from the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) cannot be used to purchase menstrual hygiene supplies, even though these are necessities for women[5]; and

Whereas, Organizations including the United Nations and Human Rights Watch have classified menstrual hygiene as a human rights issue[11]; and

Whereas, School-aged children in the United States who are unprepared for menarche have increased rates of depression, substance abuse, delinquency, and school dropout[12]; and

Whereas, One in five school-aged girls in the United States have left school early or missed an entire day of school due to lack of access to menstrual products, and roughly three out of four working women have left work early to obtain needed menstrual products[13,14]; and

Whereas, OSHA requires employers to provide all workers with sanitary and immediately-available toilet facilities (restrooms) according to sanitation standards 29 CFR 1910.141, 29 CFR 1926.51 and 29 CFR 1928.110[15]; and

Whereas, Like toilets and toilet paper, menstrual hygiene products are necessary to effectively and sanitarily manage natural and unavoidable bodily functions[16]; and

Whereas, Similar to menstrual product shortages, families may experience diaper need, and families experiencing diaper need may provide fewer diaper changes, increasing the risk for pediatric urinary tract infections and diaper dermatitis, as well as more frequent pediatric care visits, and diaper need is associated with maternal stress and depression[17,18]; and

Whereas, A sufficient supply of diapers costs an average of $936 a year per child, and in a survey of pregnant women, almost 30% reported diaper need[17]; and

Whereas, Currently five states (California, Georgia, Illinois, New York, and New Hampshire) have implemented legislation to provide free menstrual products (i.e., tampons, sanitary napkins) in public school restrooms[19-23]; and

Whereas, Oregon recently introduced State Senate Bill 717 which, if passed, would require an additional $10 per month to SNAP recipients specifically for personal hygiene products, and in 2019, H.R.1882 (Menstrual Equity for All Act of 2019), introduced to the United States House of Representatives, proposed that Medicaid cover the cost of feminine hygiene products[18,19] and HB 4874 has been brought forth to the Illinois House of Representatives and requires the Department of Human Services to permit the coverage of feminine hygiene products under SNAP, WIC, and the Temporary Assistance for Needy Families[24]; and

Whereas, Multiple pieces of legislation have highlighted the movement towards menstrual equity for all by calling for free and accessible menstrual products in public schools, establishing menstrual hygiene products as medical necessities, and allowing purchases for menstrual care products to be eligible for reimbursement through Health Flexible Spending Arrangements and Health Reimbursement Arrangements[25,26]; and

Whereas, Our AMA urges continued adequate funding of WIC (H-245.979, H-245.989), supports feminine hygiene products as a medical necessity (H-525.974), supports legislation to remove all sales tax on feminine hygiene products (H-270.953), and affirms local medical societies establishing relationships with schools to aid in health education, particularly in personal hygiene (H-170.996); therefore be it

RESOLVED, That our American Medical Association recognize the adverse physical and mental health consequences of limited access to menstrual products for school-aged individuals (New HOD Policy); and be it further

RESOLVED, That our AMA support the inclusion of medically necessary hygiene products, including, but not limited to, menstrual hygiene products and diapers, within the benefits covered by appropriate public assistance programs (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for federal legislation and work with state medical societies to increase access to menstrual hygiene products, especially for recipients of public assistance (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage public and private institutions as well as places of work and education to provide free, readily available menstrual care products to workers, patrons, and students (New HOD Policy); and be it further

RESOLVED, That our AMA amend H-525.974, "Considering Feminine Hygiene Products as Medical Necessities," by addition and deletion to read as follows:

> CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES, H-525.974
> Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; ~~and~~ (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs~~.~~; and (3) encourage the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers. (Modify Current HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

"Period poverty" refers to the financial burden on menstruating people who struggle to pay the additional costs of menstrual hygiene products. Low-income women, who often must choose between buying food and buying menstrual hygiene products. Without proper hygiene products, women sustain infections, injuries, or embarrassment. Women who can afford to buy menstrual products still report high rates of having had to miss work since menstrual products are not available publicly, and girls report high rates of having had to miss school for the same reason. This is even more important given how gender inequities deepened in the pandemic, with women disproportionately missing time at work, and all students missing a great deal of time in school, so that women and children now facing pandemic-induced setbacks. Additionally, the pandemic has exacerbated period poverty, leading the US government to classify period products as necessary medical expenses eligible for FSA and HSA reimbursement in the COVID-19 stimulus bill. It is important for the AMA to take a stance on this issue due to the timeliness, considering the amount of legislation on this issue making its way through legislatures. This resolution combats gender inequities and period poverty by making hygiene products available in public spaces, including schools, and incorporating these products in supplemental nutrition programs (WIC/SNAP).

Now is the time for the AMA to take a stance on this issue and provide a voice in the national movement for greater menstrual equity.

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26. 116th Congress of the United States of America. H.R.748: The Coronavirus Aid, Relief, and Economic Security Act. 2020.

RELEVANT AMA POLICY

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize

the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.
3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res. 414, A-10; Reaffirmation: A-12; Reaffirmation: A-13; Appended: CSAPH Rep. 1, I-13; Reaffirmation: A-14; Reaffirmation: I-14; Reaffirmation: A-15; Appended: Res. 407, A-17; Appended: Res. 233, A-18

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979
The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education.
Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14

Adequate Funding of the WIC Program H-245.989
Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children.
Res. 269, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep.1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Considering Feminine Hygiene Products as Medical Necessities H-525.974
Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs.
Res. 218, A-18

Tax Exemptions for Feminine Hygiene Products H-270.953
Our AMA supports legislation to remove all sales tax on feminine hygiene products.
Res. 215, A-16

Establishing Active Liaison with Schools and Colleges H-170.996
Our AMA encourages state and local societies to establish liaison relationships with schools to provide appropriate assistance in health education, particularly personal hygiene, substance misuse, smoking, sexually transmitted disease, quackery, and the role of the physician in maintaining good health.
Res. 72, A-71; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(N-21)

Introduced by: Medical Student Section

Subject: Advocating for the Amendment of Chronic Nuisance Ordinances

Referred to: Reference Committee B

Whereas, Chronic nuisance ordinances (CNOs) are municipal laws that aim to lower the crime rate taking place on rental properties by penalizing property owners if repeated incidents of nuisance activity occur over a set period of time (typically, 12 months)[1]; and

Whereas, CNOs are part of a phenomenon called "third-party policing," through which cities require private citizens – in this case property owners – to address criminal or otherwise undesirable behaviors[1]; and

Whereas, Punishments for violating CNOs may range from warning letters and fines to evictions and building closures, and often involve a "nuisance point system" where a certain number of accumulated points will result in eviction and other actions[1]; and

Whereas, What qualifies as nuisance activity can vary widely between municipalities, though commonly defined as the amount of contact with emergency services, first responders, and police, for criminal behavior that occurs on or near the property, or "alleged nuisance conduct" (assault, harassment, stalking, disorderly conduct, city code violations, noise violations, and others)[2]; and

Whereas, CNOs have been enacted by an estimated 2,000 municipalities across 44 states as of 2014 [3]; and

Whereas, Nuisance ordinances often apply even when a resident was the victim, and not the source, of the nuisance activity[3,17]; and

Whereas, CNOs punish tenants who require police and emergency medical assistance by making eviction a consequence of police responses to their homes[1]; and

Whereas, The reason for calling the police is not taken into account by most CNOs, so people who experience mental health crises may be deemed perpetrators of nuisance activity for seeking emergency medical assistance at a frequency beyond the threshold established in the CNO and may be threatened with eviction by their landlords[1]; and

Whereas, Cities have fined group homes (organizations that provide community-based residences for people with disabilities) after staff sought police or emergency services assistance responding to their residents' medical emergencies[15]; and

Whereas, Health crises that can count as a CNO violation include drug overdoses: public records from a sample of Northeast Ohio cities found that 10-40% of applications of CNOs are related to a person experiencing a drug overdose, many of which explicitly include violations of criminal drug abuse laws as nuisance[15]; and

Whereas, CNO nuisance behavior can include the aesthetic appearance of property, such as litter, an un-mowed lawn, or an "unsightly" yard, which can be applied against residents whose physical, mental, or health-related disabilities prevent them from meeting their municipality's maintenance standards[1]; and

Whereas, In June 2017, an appellate court struck down the Village of Groton's nuisance law as unconstitutional under the First Amendment, the reasoning being that it deterred tenants from seeking police assistance, and discouraged people, including domestic violence victims, from reaching out for help[4]; and

Whereas, Surveys of nuisance ordinance enforcement from across the country suggest that chronic nuisance ordinances disproportionately impact people of color[2]; and

Whereas, Between 2012 and 2018, the city of Rochester, NY issued nearly five times as many nuisance enforcement actions in the quarter of the city with the highest concentration of people of color as it did in the quarter with the lowest concentration of people of color[2]; and

Whereas, A lawsuit filed in August 2017 by a fair housing organization in Peoria, Illinois revealed that properties in predominantly black neighborhoods were more than twice as likely to be cited under the city's nuisance ordinance as white neighborhoods[5]; and

Whereas, A two-year study of Milwaukee, Wisconsin found that properties in predominantly black neighborhoods were over two and a half times as likely to receive a nuisance citation as properties in predominantly white neighborhoods, even when the neighborhoods made similar numbers of calls[6]; and

Whereas, Women with disabilities have a 40% greater chance of experiencing domestic violence than women without disabilities[8]; and

Whereas, There are an estimated 1.3 million women who are the victims of assault by an intimate partner annually, and women have a 25% lifetime risk of intimate partner violence[7]; and

Whereas, Congress acknowledges that "women and families across the country are being discriminated against, denied access to, and even evicted from public and subsidized housing because of their status as victims of domestic violence" [7]; and

Whereas, Domestic violence advocates' efforts in the past decades have been focused on educating law enforcement on how to approach and aid victims in escaping the cycle of domestic violence while maintaining their housing[3]; and

Whereas, This initiative is directly being threatened by CNOs, as calls about domestic disturbances can result in the eviction of everyone in the household[3,10-13]; and

Whereas, Nuisance ordinances frequently fail to make exceptions for police calls made by residents experiencing domestic violence even in cases where exceptions exist, calls placed by survivors of domestic violence are regularly miscategorized and the tenants are punished under the CNO regardless[9]; and

Whereas, Such punishment of domestic violence-related calls for police and medical services discourages victims of domestic violence from seeking help in future assaults[10]; and

Whereas, The use of CNOs may contribute to the “double victimization” of domestic violence victims, who may be evicted because of allegations of disturbing other tenants or property damage caused by their abusers, and thus are more likely to hide the abuse rather than seek help like emergency services[11]; and

Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing nuisance activity is limited[6,9,12]; and

Whereas, Even though Cincinnati reported an overall 22% decrease in nuisance calls from 2006-2010, it is unknown whether this drop is due to underreporting or actual decreases in such behavior[12]; and

Whereas, Housing instability and eviction is associated with a higher risk of depression, anxiety, and even suicide[14,18]; and

Whereas, Individuals who lost legal rights to their housing and whose landlords applied for eviction proceedings were four times more likely to commit suicide (OR = 4.42) compared to individuals who had not experienced eviction[16]; and

Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or victims of domestic violence limit the opportunities for these tenants to find affordable housing in the future, regardless of the circumstances in which they occurred[13]; therefore be it

RESOLVED, That our American Medical Association advocate for amendments to chronic nuisance ordinances that ensure calls made for safety or emergency services are not counted towards nuisance designations (Directive to Take Action); and be it further

RESOLVED, That our AMA support initiatives to: (a) gather data on chronic nuisance ordinance enforcement; and (b) make that data publicly available to enable easier identification of disparities. (New HOD Policy)

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

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

This resolution seeks to advocate for changes in procedure to Chronic Nuisance Ordinances (CNOs) and to support initiatives that increase the data available on CNOs. The COVID-19 pandemic has particularly highlighted the struggles many individuals face in regard to housing. Loss of housing has serious detrimental health effects. Vulnerable populations, like those with mental illness or substance use disorders and victims of domestic violence, are further particularly vulnerable to loss of housing due to eviction for CNOs.

Cities across 44 states in the US have enacted CNOs, which are municipal laws that penalize landowners and tenants when emergency services or law enforcement are called frequently to the premises. Importantly, CNOs in many municipalities do not distinguish between victims and perpetrators of nuisance activities. Numerous health crises can count as a CNO violation including drug overdoses, domestic or partner violence, and even mental health crises. As a consequence, tenants who require frequent police or emergency medical assistance may face threats of eviction and encounter discrimination when applying to housing. Thus, the enforcement of CNOs can penalize callers to the police and emergency services for assistance regardless of the situational context. CNOs are a serious detriment to our mission as physicians to “do no harm”. Our AMA should advocate for the amendment of CNOs to ensure that residents are not reprimanded in situations where they are victims.

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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

Our AMA:
(1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
(2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
(4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
(5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
(6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;
(7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
(8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
(9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
(10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods.
Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(N-21)

Introduced by: Medical Student Section

Subject: Support for Mental Health Courts

Referred to: Reference Committee B

Whereas, "Mental health courts" are correctional diversion and rehabilitation programs used by state and local courts to support individuals with mental illness in the justice system[1-7]; and

Whereas, Mental health courts connect individuals with mental illness to mental health treatment, as an alternative to incarceration or other legal sentences and penalties[1-7]; and

Whereas, Two pieces of federal Congressional legislation, the America's Law Enforcement and Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and resources in the justice system and to establish grants to fund mental health court programs[8-9]; and

Whereas, The continued funding of MIOTCRA programs over the last two decades has been dependent on Congressional appropriations[10]; and

Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA) in the Department of Justice administer grants to fund state and local mental health courts[11,12]; and

Whereas, Research demonstrates that mental health courts appear to be associated with reductions in recidivism, length of incarceration, severity of charges, risk of violence, and rehospitalization among individuals with mental illness in the justice system[3,13-26]; and

Whereas, SAMHSA published a 2015 report noting that because "the vast majority of individuals who come into contact with the criminal justice system appear" before municipal courts and "many of these individuals have mental illness and co-occurring substance use disorders," municipal courts may be an especially effective "and often overlooked" method of diversion of individuals with mental illness from the justice system[26]; and

Whereas, In addition to SAMHSA and BJA, several nonprofit advocacy organizations, including Mental Health America, the National Alliance on Mental Illness, the Treatment Advocacy Center, the National Sheriffs' Association, the Council on State Governments, and the National Center for State Courts, support the use of mental health courts[2,27-32]; and

Whereas, While several hundred mental health courts exist across all 50 states, mental health courts do not exist in all counties and localities, indicating that these programs may not be accessible or available to all individuals who could benefit from them[4]; and

Whereas, Because mental health courts are dependent on participation from national, state, and local governmental agencies, justice systems, and mental health service organizations and on the appropriation of public funds, including federal monies for MIOTCRA programs and grants administered by SAMHSA and BJA[10-12], the AMA can play a role in advocating for the continued support and funding of mental health courts by policymakers; and

Whereas, Courts that connect individuals with mental illness to treatment as an alternative to incarceration exist under many different names, with each focused on different types of mental illness, including "mental health courts" (for mental illness in general), "drug courts" (for substance use disorders), and "sobriety" or "sober courts" (for alcohol use disorder and sometimes certain other substance use disorders)[32-35]; and AMA policy should be inclusive of all these different types; and

Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts, which are similar in function to mental health courts but narrower in scope, "for individuals with addictive disease who are convicted of nonviolent crimes"; and

Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran courts, which are similar in function to mental health courts but narrower in scope, "for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder"; and

Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with previous Policy H-100.955 on drug courts[36-37]; and

Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was extracted in our HOD to remove the restriction on only using veteran courts for nonviolent offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could potentially be used for criminal offenses in general and not only for nonviolent offenses[36]; and

Whereas, To be consistent with our HOD's most recent debate on this matter, Policy H-100.955 on drug courts and any future AMA policy on alternatives to incarceration for individuals with mental illness should not be limited to only nonviolent offenses; therefore be it

RESOLVED, That American Medical Association Policy H-100.955, "Support for Drug Courts," be amended by addition and deletion to read as follows:

Support for Mental Health ~~Drug~~ Courts, H-100.955

Our AMA: (1) supports the establishment and use of mental health ~~drug~~ courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based services and supports ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health ~~drug~~ courts at the state and local level in the United States; and (3) encourages mental health ~~drug~~ courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Date Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

Half of all people incarcerated have mental illness, with 1 in 6 experiencing serious mental illness. Incarceration exacerbates mental illness, and deeply concerning racial inequities are also well documented. These problems are acutely urgent during this pandemic, as incarcerated populations have been at drastically higher risk of SARS-CoV-2 infection and of poor outcomes from COVID-19.

This resolution expands existing AMA policy supporting the use of drug courts to support more generalized mental health courts. This better advocates for patients at risk of incarceration with a range of mental illnesses beyond substance use disorders. These special diversion programs are comprised of physicians, judges, attorneys, and case managers with mental health expertise who offer treatment as an alternative to incarceration and other penalties. Too many of our patients with mental illness unjustly suffer the physical, mental, and social detriments of incarceration and punitive measures, when community-based treatment is often the more humane, effective, and feasible pathway to achieve true rehabilitation. Studies show that recidivism, violence, and hospitalization all decrease when mental health courts are used, improving both health and community outcomes better than incarceration.

Our AMA has been a force in advancing health equity. Mental illness is treatable and manageable, and no one should be incarcerated due to lack of diagnosis, inability to see a psychiatrist, or problems paying for or managing their medication. This resolution ensures that we are pursuing equity and preventing harm, all while increasing access to treatment for our patients and better strengthening and protecting our communities.

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955
Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.
Res. 201, A-12; Appended: BOT Rep. 09, I-19

Support for Veterans Courts H-510.979
Our AMA supports the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.
Res. 202, I-19

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Res. 116, A-12; Reaffirmation A-15

Support for Justice Reinvestment Initiatives, H-95.931
Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for 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.
Res. 205, A-16

Prevention of Impaired Driving H-30.936
Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21.
Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and

poses significant health and safety risks;" (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals.

Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities.

Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life;

Repeat Offenders: Our AMA: (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses; and (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third.

On-board devices: Our AMA: (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members.

CCB/CLRPD Rep. 3, A-14

Court-Initiated Medical Treatment in Criminal Cases, E-9.7.2
Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.
In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:
(a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
(b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician's diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
(c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
(d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.
AMA Principles of Medical Ethics: I,III (Code of Medical Ethics Opinion, Issued: 2016

Decisions for Adult Patients Who Lack Capacity, E-2.1.2
Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. Physicians should engage patients whose capacity is impaired in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.
When a patient lacks decision-making capacity, the physician has an ethical responsibility to:
(a) Identify an appropriate surrogate to make decisions on the patient's behalf:
(i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
(ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
(b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
(c) Provide advice, guidance, and support to the surrogate.
(d) Assist the surrogate to make decisions in keeping with the standard of substituted judgment, basing decisions on:
(i) the patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;
(ii) the patient's views about life and how it should be lived;

(iii) how the patient constructed his or her life story; and
(iv) the patient's attitudes toward sickness, suffering, and certain medical procedures.
(e) Assist the surrogate to make decisions in keeping with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:
(i) the pain and suffering associated with the intervention;
(ii) the degree of and potential for benefit;
(iii) impairments that may result from the intervention;
(iv) quality of life as experienced by the patient.
(f) Consult an ethics committee or other institutional resource when:
(i) no surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;
(ii) ongoing disagreement about a treatment decision cannot be resolved; or
(iii) the physician judges that the surrogate's decision:
a. is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;
b. could not reasonably be judged to be in the patient's best interest; or
c. primarily serves the interests of the surrogate or other third party rather than the patient.
AMA Principles of Medical Ethics: I,III,VIII (Code of Medical Ethics Opinion, Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(N-21)

Introduced by: Association for Clinical Oncology, American College of Rheumatology

Subject: Sequestration

Referred to: Reference Committee B

Whereas, Current relief from application of the sequester to Medicare provided by Congress during the still ongoing COVID-19 pandemic expires at the end of 2021.

Whereas, Additional threats to Medicare, including PAYGO, will create a perfect storm in January 2022 as some practices face a total of 9.75% cuts to their Medicare reimbursement.

Whereas, Practices have not yet recovered from the financial strain of the COVID-19 pandemic.

RESOLVED, That our American Medical Association prioritize strong advocacy in opposition to the application of sequestration to Medicare, including to drugs administered under Medicare Part B. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Expiration of Medicare sequestration relief is fast approaching, with the 2 percent sequester set to take effect on January 1, 2022. With additional cuts, including PAYGO, commencing on the same date, some practices face a total of 9.75% cuts to their Medicare reimbursement. These upcoming cuts place an unreasonable burden on practices and severely impact patient access to care as many practices will struggle to keep their doors open. With the COVID-19 pandemic ongoing and practices still not recovered from the financial strain placed on them during the pandemic, it is essential that our AMA act before the end of the year and prioritize strong advocacy in opposition to the application of sequestration to Medicare, including to drugs administered under Medicare Part B.

RELEVANT AMA POLICY

Exempt Physician-Administered Drugs from Medicare Sequestration H-330.888
Our AMA supports passage of federal legislation 1) exempting payments for biologics and other drugs provided under Medicare Part B from sequestration cuts, and 2) reimbursing providers for reductions in payments for biologics and other drugs furnished under Medicare Part B on or after April 1, 2013.
Citation: (Res. 235, A-13; Reaffirmation A-15)

Sequestration Budget Cuts D-165.941
1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to

medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.

2. Our AMA will take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare payments.

Citation: (Res. 215, I-12; Appended: Res. 222, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(N-21)

Introduced by: Ohio

Subject: Eliminating Unfunded or Unproven Mandates and Regulations

Referred to: Reference Committee B

Whereas, Beginning in 2020, Centers for Medicare and Medicaid Services (CMS) will be demanding that “providers” utilize approved “technology” using practice guidelines when ordering imaging studies; and

Whereas, Such guidelines represent an unfunded mandate for physicians already struggling with massive governmental regulatory burden and underpayment; and

Whereas, These technologies or “Augmented Intelligence,” are limited in their ability to apply clinical context, thus limiting a physician’s ability to order appropriate testing under unique circumstances and stagnating their work-flow, placing patients at risk; and

Whereas, The technology required for this mandatory decision support is extremely expensive, especially for smaller and independent physician practices; therefore be it

RESOLVED, That our American Medical Association advocate for policies that allow for physician judgment and documented medical decision-making to supersede government regulation--including the utilization of Augmented Intelligence--in instances of disputes in patient care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for policies that require “proof of concept,” in the form of independently demonstrated quality improvement, prior to the implementation of any government, insurance company or other third party mandate or regulation on patient care and the physician-patient relationship (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for policies requiring government, insurance company or other third party entities to fully fund any mandates or regulations imposed on patient care and the physician-patient relationship. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

This issue affects many physicians and/or their patients because this affects physicians that order advanced diagnostic imaging services and physicians, practitioners and facilities that furnish advanced diagnostic imaging services.
It is consistent with our mission and strategic plan

It is a time sensitive issue and the call for action is likely to have meaningful impact. The appropriate use criteria Program is set to be fully implemented on January 1, 2022. those ordering advanced diagnostic imaging will be required to consult a qualified Clinical Decision Support Mechanism (CDSM). CDSMs are electronic portals through which appropriate use criteria (AUC) is accessed. Claims that fail to append this information will not be paid.

Such programs must not be unproven or unfunded and that expectation must be clearly made NOW.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(N-21)

Introduced by:	American College of Rheumatology, American Academy of Allergy, Asthma & Immunology, American Academy of Dermatology, American Academy of Ophthalmology, American Society of Dermatopathology, Association for Clinical Oncology, Society for Investigative Dermatology
Subject:	Stakeholder Engagement in Medicare Administrative Contractor Policy Processes
Referred to:	Reference Committee B

Whereas, Contractor Advisory Committees (CACs) and other stakeholders have played an important role in review of policy changes put forth by Medicare Administrative Contractors (MACs); and

Whereas, The Local Coverage Determination (LCD) process historically has considered comment and input from a Contractor Advisory Committee, and, in most cases, LCDs require a 45-day comment period; and

Whereas, Our AMA has strong policy 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; and

Whereas, The 21st Century Cures Act included provisions intended to modernize and strengthen the LCD review process and ensure transparency and stakeholder engagement in MACs' decision making processes, and the Medicare Program Integrity Manual Chapter 13 finalized requirements of the LCD modernization process; and

Whereas, The 21st Century Cures Act and related regulations demonstrate the intent of Congress and CMS to ensure processes for meaningful stakeholder review and input for substantive policy changes; and

Whereas, Some MACs have used Local Coverage Articles (LCAs) to unilaterally issue policy changes that might have the effect of restricting coverage or access, without an attached, supportive LCD, arguing they are only providing billing instructions, when in reality changes could reasonably be expected to have the effect of restricting coverage. In most cases LCAs are coupled with LCDs or a National Coverage Determination (NCD), and the LCA only provides such additional coding/billing or other information as may be needed to implement the coverage policy determined in the LCD or NCD; and

Whereas, MACs issuing changes in coverage policy through LCAs without issuing a proposed LCD are circumventing the notice-and-comment period required of LCDs and other substantive rulemaking, bypassing the stakeholder engagement and transparency in decision making that was intended by Congress; and

Whereas, By issuing LCAs without associated LCDs these MACs are denying stakeholders a meaningful opportunity to review data and decision making criteria, and to provide feedback on proposed changes in coverage policy, and are bypassing consultation with healthcare professional experts and professional societies; and

Whereas, The evidentiary requirements of LCDs are not required in an LCA, and LCAs unilaterally issued without LCDs lack transparency and also do not allow stakeholders to review data or decision criteria, or to submit formal requests for reconsideration of the coverage policy; and

Whereas, These actions by MACs are counter to and not in the spirit of the transparency and increased stakeholder engagement and review intended by Congress in revising the LCD process by way of the 21st Century Cures Act, nor of CMS' improvements to the LCD process following stakeholder feedback to its Request for Information (RFI) in the CY 2018 Physician Fee Schedule; and

Whereas, The significant changes to LCD procedures stemming from the 21st Century Cures Act also allow MACs to change their engagement with traditional CACs, and CACs are no longer being engaged by MACs to function in their roles in reviewing and commenting on proposed policy changes and therefore no longer have a meaningful function; therefore be it

RESOLVED, That our American Medical Association oppose Medicare Administrative Contractors (MACs) issuing Local Coverage Articles (LCAs) that could have the effect of restricting coverage or access without providing data and evidentiary review or without issuing associated Local Coverage Determinations (LCDs) and following required stakeholder processes (New HOD Policy); and be it further

RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid Services (CMS) to ensure no LCAs that could have the effect of restricting coverage or access are issued by MACs without the MAC providing public data, decision criteria, and evidentiary review and allowing comment, or without an associated LCD and the required LCD stakeholder review and input processes, through the modernization requirement of the 21st Century Cures Act (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate to CMS that the agency immediately invalidate any LCAs that it identifies as potentially restricting coverage or access and that were issued without the MACs providing public data, decision criteria, and evidentiary review, or that were issued without an associated LCD and the required stakeholder processes, and that CMS require MACs to restart those processes taking any such proposed changes through LCDs and associated requirements for stakeholder engagement, public data, and evidentiary review (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that Congress consider clarifying legislative language that reinstates a role for local Contractor Advisory Committees in review processes going forward, addressing unintended outcomes of changes in 21st Century Cures Act that allowed local CACs to be left without a voice or purpose. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Recent reforms to Local Coverage Determination (LCD) processes used by Medicare Administrative Contractors (MACs) have increased transparency, clarity, and responsiveness to local clinical and coverage policy concerns. However, MACs are still able to utilize Local Coverage Articles (LCAs) to unilaterally issue policy changes that may have the effect of restricting coverage or access, arguing they are only providing billing instructions when instead the changes could reasonably be expected to have the effect of restricting coverage or access.

Unlike with LCDs, by relying on LCAs the MACs can make significant changes without any requirement that they provide data, scientific justification, or evidentiary review related to the decisions, any notice-and-comment period for stakeholder input, nor any opportunity for reconsideration.

One example is MACs' decisions to reimburse administration of certain highly complex biologics at Medicare's simple therapeutic administration rate, without having to provide stakeholders any scientific explanation of why only the simple therapeutic code is being allowed for those drugs and which decision criteria and data are being used by MACs, and providing no opportunity for reconsideration, despite evidence-based considerations showing how these drugs' high complexity and safety risks meet the definitions for reimbursement under the complex chemotherapy codes. These changes have significant repercussions for practices' ability to provide treatment access to patients.

Decisions like this are happening now without data or evidentiary review being provided and without reconsideration available to physicians. Urgent action is required to further reform these processes in order to protect physician practices and patient access to care.

RELEVANT AMA POLICY

Improving the Local Coverage Determination Process D-330.908

1. Our AMA will advocate through legislative and/or regulatory efforts as follows: A. When Medicare Administrative Contractors (MACs) propose new or revised Local Coverage Determinations (LCDs) said Contractors must: (1) Ensure that Carrier Advisory Committee meeting minutes are recorded and posted to the Contractor's website; and (2) Disclose the rationale for the LCD, including the evidence upon which it is based when releasing an approved LCD; B. That the Centers for Medicare and Medicaid Services adopt a new LCD reconsideration process that allows for an independent review of a MAC's payment policies by a third-party, with appropriate medical and specialty expertise, empowered to make recommendations to the Secretary of Health and Human Services that said policies should be withdrawn or revised; and C. That MACs shall be prohibited from adopting another MAC's LCD without first undertaking a full and independent review of the underlying science and necessity of such LCD in their jurisdiction.

2. Our AMA will work with interested state medical and national specialty societies to develop model legislation or regulations requiring commercial insurance companies, state Medicaid agencies, or third party payers to: A. Publish all edits that are to be used in their claims processing in a manner that is freely accessible and downloadable to physicians; and B. Participate in a transparent process that allows for review, challenge, and deletion of unfair edits.

Res. 807, I-15

Support for Maintaining the Medicare Carrier Advisory Committee and Carrier Medical Director D-330.974
Our AMA will: (1) continue its efforts in urging the Centers for Medicare and Medicaid Services (CMS) management to retain and support local Medicare Carrier Advisory Committees and Medical Directors in their role as policy advisers; and (2) urge the CMS to seek input from the AMA and all interested medical societies before proposing any further changes to the Medicare Carrier Advisory Committee (CAC) framework or to the roles and responsibilities of carrier medical directors.
Res. 121, I-01Reaffirmed: CMS Rep. 5, A-10Reaffirmed: CMS Rep. 01, A-20

Changes to the Medical Profession Resulting from Medicare Administrative Contracting Reforms H-390.851
1. Our AMA will review and monitor the impacts of Medicare Administrative Contracting reforms with periodic reports to the House of Delegates, to include at a minimum: (a) growth, nature and outcomes of actions against physicians by Payment Safeguard Contractors, Zone Program Integrity Contractors, and Recovery Audit Contractors; (b) changes in structure and/or function of Contractor Advisory Committees; and (c) changes in access to Medicare Administrative Contractor Medical Directors and other Medicare Administrative Contractor personnel.
2. All information gathered by our AMA regarding the impact of Medicare administrative contracting reforms will be shared in a timely manner with all state and national medical specialty societies.
Res. 710, I-07Modified: CMS Rep. 01, A-17

Uniformity of Operations of Medicare Administrative Contractors H-390.921
It is the policy of the AMA (1) to use its influence and resources to bring about uniformity of business policies and procedures among the Medicare Administrative Contractors, and (2) to investigate and monitor the differing policies and procedures among the Medicare Administrative Contractors with respect to physician reimbursement.
Res. 154, A-90Reaffirmed: Sunset Report, I-00Modified: CMS Rep. 6, A-10Reaffirmed: CMS Rep. 4, I-15

Medicare Part B Contractor Changes D-335.984
1. Our AMA will: (a) register a formal public complaint to the Centers for Medicare & Medicaid Services (CMS) about the need to accept physician input as part of future contract decisions; (b) ask CMS to require that the local Medicare Administrative Contractor and clearinghouse quickly rectify problems, including having more prompt and effective communication with providers; and (c) advocate for legislation or agency policy changes that provide additional resources to be allocated to the Centers for Medicare and Medicaid Services for the specific purpose of enhancing Part B contractor customer service and accountability in billing and enrollment matters.
2. If CMS and the local Medicare Administrative Contractor and clearinghouse fail to effectively address the problems physicians are facing, our AMA will notify elected officials and the public of these failures and the need for redress.
Res. 218, I-08Reaffirmed: CMS Rep. 01, A-18

Physician Input in MAC Contracting Process D-330.943
1. Our AMA will work with other interested members of the Federation to develop mechanisms with the Centers for Medicare and Medicaid Services that meaningful input from physicians and physician associations may be received and appropriately considered in the Medicare Administrative Contractor contracting processes, both those now underway and those in the future, including input on specific potential contract bidders.

2. Our AMA: (a) encourages the Federation to continue to report problems with Medicare Administrative Contractors (MACs), or other Medicare contractors, to the AMA; (b) will advocate that the Centers for Medicare and Medicaid Services (CMS) ensure that MACs are adequately staffed to handle enrollment, claims review, appeals and other functions in a timely and accurate manner; (c) will advocate that CMS increase training of MAC personnel to ensure they can respond efficiently and effectively to provider inquiries; (d) will advocate that CMS provide sufficient time between announcement and implementation of policy changes to allow contractors to thoroughly understand and adequately prepare to communicate with physicians and other providers about the changes; (e) will urge CMS to publish on its Web site the list of performance standards against which MACs are measured, and a report of each MAC's rating on those performance standards; (f) encourages state medical societies to educate their members regarding MAC performance standards, and to actively petition CMS regarding underperforming MACs; and (g) will advocate that the Centers for Medicare and Medicaid Services impose monetary penalties on MACs that fail to process and pay claims in a timely manner.
Res. 714, I-05Appended: CMS Rep. 5, A-10Reaffirmed: CMS Rep. 01, A-20

Review of Self-Administered Drug List Alterations Under Medicare Part B D-335.983
Our AMA will seek regulatory or legislative changes to require that any alterations to Self-Administered Drug lists made by Medicare Administrative Contractors shall be subject to Carrier Advisory Committee review and advisement.
Res. 811, I-13

Parity of Payment for Administering Biologic Medications H-330.883
Our AMA supports and encourages interested national medical specialty societies and other stakeholders to submit a request to Medicare for a national coverage determination directing Medicare Administrative Contractors to consider all biologics as complex injections or infusions.
CMS Rep. 4, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(N-21)

Introduced by: American College of Rheumatology, Association for Clinical Oncology

Subject: Pharmacy Benefit Manager Reform as a State Legislative Priority

Referred to: Reference Committee B

Whereas, Pharmacy Benefit Managers (PBMs) are third-parties that are contracted by payers to create and manage drug formularies; and

Whereas, PBMs are middle men in the drug supply chain and act in a way that lacks transparency and can create perverse incentives that increase drug prices; and

Whereas, Our AMA has existing policy supporting the regulation of PBMs by state legislatures and insurance commissioners[i]; and

Whereas, Our AMA has not updated its Health Care Reform Objectives or the AMA Vision for Health System Reform to reflect this policy; and

Whereas, Our AMA has not placed PBM reform among its highest state legislative priorities; and

Whereas, The Supreme Court decision in Rutledge v. PCMA has given states greater authority to regulate the activities of PBMs; and

Whereas, It is imperative that states use this broadened authority to regulate abusive PBM practices, therefore be it

RESOLVED, That our American Medical Association make Pharmacy Benefit Manager (PBM) reform a state legislative priority (Directive to Take Action); and be it further

RESOLVED, That our AMA draft model PBM legislation or adopt model legislation from other organizations (Directive to Take Action); and be it further

RESOLVED, That our AMA actively advocate for the passage of PBM reform in state legislatures across the country (Directive to Take Action); and be it further

RESOLVED, That our AMA update its Health Care Reform Objectives and the AMA Vision for Health System Reform to reflect this priority change and the importance of effective PBM regulation. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Abusive pharmacy benefit manager (PBM) practices continue to plague both providers and patients. Over the last few years, we have seen the rate of state-level PBM reform slow. However, in light of the recent Supreme Court decision in Rutledge v. PCMA, states now have greater authority to regulate PBMs. It is imperative that states use this broadened authority to regulate abusive PBM practices.
During the pandemic we have seen more aggressive tactics by PBMs, with exclusionary formularies, mandatory drug switching, copay accumulator policies, and white bagging becoming more common. These policies pose dangers to patients and threaten the integrity of the provider/patient relationship. While PBM transparency will not solve these problems, it will provide policymakers and regulators with more insight into the motivations behind these policies.
Additionally, due to the ongoing COVID-19 pandemic, patients are more vulnerable than ever to the economic pressures associated with higher prescription drug prices. It is imperative that policymakers have the tools to analyze the role that PBMs play in increasing drug prices, particularly the perverse incentives created by the rebate system. It is imperative that our AMA leads on this issue to ensure that the interests of physicians are represented in future state-level PBM legislation.

RELEVANT AMA POLICY

The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
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.
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.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
- 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.
6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.
CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20

[i] American Medical Association Policy Finder: The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(N-21)

Introduced by: Resident and Fellow Section

Subject: Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers

Referred to: Reference Committee B

Whereas, Patients are often not explicitly informed when seeking medical care what the qualifications are of the person treating them[1]; and

Whereas, Physicians are being forced or coerced into "supervising" midlevel providers either directly or indirectly, by using it as a requirement for physician employment[1]; and

Whereas, Physicians are being asked to "supervise," in name only, unreasonably high numbers of midlevel providers opening them up to liability issues[1]; and

Whereas, There have been instances where physicians' licenses have been used, unbeknownst to the physician, to document "supervision" of midlevel providers and also instances where midlevel providers do not even know the identity of their documented "supervising" physician[1]; and

Whereas, Midlevel providers/non-physicians have pushed for changes in legislation requiring "supervision" by physicians be changed to "collaboration" with physicians in effort to equate their training[1]; therefore be it

RESOLVED, That our American Medical Association reaffirm Policies H-160.947 and H-160.950 (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to "supervise" midlevel providers (Directive to Take Action); and be it further

RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a condition for physician employment and in physician employment contracts, especially when physicians are not provided adequate resources and time for this responsibility (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the right of physicians to deny "supervision" to any midlevel provider whom they deem a danger to patient safety and the ability to report unsafe care provided by mid-levels to the appropriate regulatory board with whistleblower protections for physician employment. (Directive to Take Action)

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

Received: 10/21/12

AUTHORS STATEMENT OF PRIORITY

Physicians, as leaders of the health care team, are often called on to supervise other members, including midlevel providers. However, physicians should be notified explicitly when their license is being used to supervise midlevel providers, not be forced to do so as a condition of employment and be able to advocate for the safety of their patients by reporting midlevel providers who are deemed a danger to patients to the appropriate regulatory board.

References:
1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020

RELEVANT AMA POLICY

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.
The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.
Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950

Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each

practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
Citation: (CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(N-21)

Introduced by: Resident and Fellow Section

Subject: Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education

Referred to: Reference Committee B

Whereas, Advanced practice providers and allied health professionals are required under the laws of many states to be supervised to some degree by a physician; and

Whereas, News reports and articles note instances of thoracic surgeons and obstetrician/gynecologists supervising social workers in the provision of group therapy[1] and plastic surgeons supervising physician assistants who advertise themselves as “dermatologists”[2]; and

Whereas, Widely known anecdotal evidence suggests numerous advanced practice providers practicing in various fields while being nominally supervised by physicians not trained in those fields; and

Whereas, Physicians without appropriate training supervising advanced practice providers outside of their expertise defeats the purpose of scope-of-practice laws and endangers patients; therefore be it

RESOLVED, That our American Medical Association conduct a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in field which are not a core part of those physicians’ completed residencies and fellowships. (Directive to Take Action)

Fiscal Note: Estimated cost of $100,000 to implement resolution.

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

As allied health providers have gained temporary independence and increased credit for their work during the pandemic, proactive AMA attention and adequate data regarding supervision is needed to ensure that the supervision we are advocating for is indeed being provided and being done so for the specialty and procedures the physician is qualified to perform and oversee. The results of this study will be able to better inform our advocacy efforts and identify areas where our advocacy is not aligning with the standards we are holding ourselves to and will identify if we need to better regulate ourselves.

References:
1. Ornstein C and ProPublica. Illinois leads Medicare billings for group therapy. Chicago Tribune. 13 Jul 2014. https://www.chicagotribune.com/lifestyles/health/ct-medicare-group-therapy-met-20140713-story.html. Accessed 18 Sep 2019.
2. Al-agba N. The P.A. Problem: Who You See and What You Get. The Healthcare Blog. 24 Nov 2017. https://thehealthcareblog.com/blog/2017/11/24/the-p-a-problem/. Accessed 18 Sep 2019.

RELEVANT AMA POLICY

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987

Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.
Citation: BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13

Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio H-35.969

Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness.
Citation: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 09, A-19

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician. The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.
Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Regulation of Advanced Practice Nurses H-35.964
1. AMA policy is that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts.
2. Our AMA will develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs.
Citation: BOT Action in response to referred for decision Amendment B-3 to Res. 233 A-17

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse

practitioners must work closely enough together to become fully conversant with each other's practice patterns.
Citation: CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Health Workforce H-200.994
The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. Citation: (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03; Reaffirmed: CME Rep. 2, A-13)

Health Care Quality Improvement Act of 1986 Amendments H-275.965
The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists.
Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)The AMA supports modification of the federal Health Care Quality Improvement Act in order to provide immunity from federal antitrust liability to those medical staffs credentialing and conducting good faith peer review for allied health professionals to the same extent that immunity applies to credentialing of physicians and dentists. Citation: (Res. 203, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-05; Reaffirmed: BOT Rep. 10, A-15)

Protecting Physician Led Health Care H-35.966
Our American Medical Association will continue to work with state and specialty medical associations and other organizations to collect, analyze and disseminate data on the expanded use of allied health professionals, and of the impact of this practice on healthcare access (including in poor, underserved, and rural communities), quality, and cost in those states that permit independent practice of allied health professionals as compared to those that do not. This analysis should include consideration of practitioner settings and patient risk-adjustment.
Citation: Res. 238, A-15; Reaffirmed: BOT Rep. 20, A-17

Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital H-35.978
The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. Citation: (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(N-21)

Introduced by: Resident and Fellow Section

Subject: Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care

Referred to: Reference Committee B

Whereas, The book *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in Healthcare* by Niran Al-Agba, MD and Rebekah Bernard, MD published in 2020, seeks to educate patients about the safety of the providers treating them and empower physicians to regain control of the practice of medicine[1]; and

Whereas, The corporatization of medicine, at the expense of quality, safe healthcare, has led to physicians being fired and replaced by midlevel providers, especially in states with legislatively awarded independent practice for midlevel providers[1]; and

Whereas, The corporate practice of medicine has created a situation in which physicians are expected to "train their replacements"; and

Whereas, Post-graduate programs for midlevel providers expand while physician post-graduate training programs stay stagnant or close[1]; therefore be it

RESOLVED, That our American Medical Association study the impact that individual physician scope of practice advocacy has had on physician employment and contract terminations (Directive to Take Action); and be it further

RESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care (Directive to Take Action); and be it further

RESOLVED, That our AMA study the utility of a physician-reported database to track and report institutions that replace physicians with midlevel providers in order to aid patients in seeking physician-led medical care as opposed to care by midlevel providers practicing without physician supervision. (Directive to Take Action)

Fiscal Note: Estimated cost of $250,000 to implement resolution.

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority, but is important to resident and fellow training, especially in assessing the conflicts that may exist between for-profit corporations and providing adequate and appropriate training for trainees.

References:
1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020

RELEVANT AMA POLICY

Practicing Medicine by Non-Physicians H-160.949

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;
(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;
(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;
(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and
(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.
Citation: Res. 317, I-94Modified by Res. 501, A-97Appended: Res. 321, I-98Reaffirmation A-99Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00Reaffirmed: CME Rep. 1, I-00Reaffirmed: CMS Rep. 6, A-10Reaffirmed: Res. 208, I-10Reaffirmed: Res. 224, A-11Reaffirmed: BOT Rep. 9, I-11Reaffirmed: Res. 107, A-14Appended: Res. 324, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(N-21)

Introduced by: Resident and Fellow Section

Subject: The Impact of Midlevel Providers on Medical Education

Referred to: Reference Committee B

Whereas, A survey in 2017 published in Worldviews Evidence Based Nursing revealed that a majority of the 2,300 nurse respondents did not feel competent in evidence-based practice[1]; and

Whereas, Physicians that speak out about the differences in training received by physicians vs. by mid-level providers are being fired, labeled “disrespectful” or labeled “not team players” in the interdisciplinary team treating patients[1]; and

Whereas, More non-physician post-graduate training programs are being formed across the nation; there is still no mandatory requirement for non-physicians to pursue post-graduate training[1]; and

Whereas, Physicians are expected to continue to maintain certification by proving they continue to educate themselves; mid-level providers are not held to the same standard[1]; and

Whereas, Currently mid-levels providers can switch between specialties and subspecialties of medicine and surgery without any formal or regulated training or education[1]; and

Whereas, Physicians are limited in their practice abilities by the post-graduate training they receive[1]; therefore be it

RESOLVED, That our American Medical Association study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated, and standardized education they receive (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for nurse practitioners and physician assistants prior to working within a specialty or subspecialty field (Directive to Take Action); and be it further

RESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for nurse practitioners and physician assistants in order to maintain licensure to practice. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. As leaders of the health care team, physicians work with many different individuals as part of their clinical duties, including midlevel providers (NPs, PAs, etc.). However, these providers do not necessarily require postgraduate training in the specialty area they are working, and do not require any training before changing specialties. Study of this area, as well as the effects this has on medical trainees, is warranted by our AMA.

References:

1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(N-21)

Introduced by: Resident and Fellow Section

Subject: Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

Referred to: Reference Committee B

Whereas, Led by the Society of Pediatric Radiology (SPR), the Image Gently Alliance was formed in late 2006 with the goal of “changing practice by raising awareness of the opportunities to lower radiation dose in the imaging of children” (1); and

Whereas, The SPR recruited other organizations/members of the imaging team into the alliance in 2007 including the American College of Radiology (ACR), American Association of Physicists in Medicine (AAPM), and American Society of Radiologic Technologists (ASRT) (1); and

Whereas, The practice of shielding reproductive organs and in utero fetuses began in the 1950s given concerns about the long-term effects of radiation and the potential for passing on genetic mutations through genetic inheritance (2,3); and

Whereas, In response to these concerns, state and federal laws and regulations have been created requiring the use of gonad shields in medical imaging studies (4,5); and

Whereas, Through technological advances, medical physicists estimate the dose from routine diagnostic imaging to reproductive organs has been reduced by 95% without compromising diagnostic quality (2,3); and

Whereas, Technological advances and optimization have resulted in marginal hereditary risk reduction from gonad shielding ranging from 1x10-6 in women and 5x10-6 in men (6); and

Whereas, Research on radiation dosing has shown that routine diagnostic imaging does not produce harmful levels of radiation to patients and fetuses (2,3); and

Whereas, Modern mechanisms to optimize imaging parameters such as automatic exposure control (AEC) are negatively affected by shielding (7); and

Whereas, The gonad shield results in decreased activity on the detector, triggering AEC to increase radiation output, which results in increased exposure and patient dose along with the degradation of image quality (7); and

Whereas, The gonad shield produces artifacts and can obscure relevant anatomy and diagnostic information (7); and

Whereas, Non-diagnostic or obscured images may need to be repeated increasing patient dose when shields are used (7); and

Whereas, The gonad surface shield is ineffective at reducing internal scatter (7); and

Whereas, Studies have shown that gonad shields are incorrectly placed for females in 91% of radiographs and for males in 66% of radiographs, rendering them ineffective (8,9); and

Whereas, On January 12th, 2021 the National Council on Radiation Protection and Measurements (NCRP) issued a statement that the risks of utilizing gonad shields far outweigh the negligible benefits to reproductive organs and therefore they should not be routinely used (10); and

Whereas, Similar statements opposing routine or mandatory use of gonadal shields were released by the ACR and the AAPM in 2019 and by the ASRT in 2021 (11,12); therefore be it

RESOLVED, That our American Medical Association oppose mandatory use of gonad shields in medical imaging considering the risks far outweigh the benefits (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the code of federal regulations to oppose the routine use of gonad shields in medical imaging (Directive to Take Action); and be it further

RESOLVED, That our AMA, in conjunction with state medical societies, support model state and national legislation to oppose or repeal mandatory use of gonad shields in medical imaging. (New HOD Policy)

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

Received: 10/12/21

AUTHORS STATEMENT OF PRIORITY

This policy is lower priority. It will help the AMA to advocate for evidence-based medicine, and specifically work to decrease harms for our patients while allowing physicians to provide better care.

References

1. https://www.imagegently.org/About-Us/Campaign-Overview
2. https://www.aappublications.org/news/2020/03/31/xrayshields040120
3. https://www.radiologyinfo.org/en/info.cfm?pg=safety-patient-shielding
4. https://www.ecfr.gov/cgi-bin/text-idx?SID=c6fd98dfc8955d41420798f3e5357c66&mc=true&node=se21.8.1000_150&rgn=div8
5. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=1000.50
6. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7005227/
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9. https://pubmed.ncbi.nlm.nih.gov/28437549/
10. https://ncrponline.org/wp-content/themes/ncrp/PDFs/Statement13.pdf
11. https://www.acr.org/Advocacy-and-Economics/Advocacy-News/Advocacy-News-Issues/In-the-June-8-2019-Issue/ACR-Endorses-AAPM-Position-on-Patient-Gonadal-and-Fetal-Shielding
12. https://www.asrt.org/main/news-publications/news/article/2021/01/12/asrt-statement-on-fetal-and-gonadal-shielding

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(N-21)

Introduced by: Texas

Subject: Promoting Sustainability in Medicare Physician Payments

Referred to: Reference Committee B

Whereas, On Jan. 1, 2022, under current law, Medicare participating physicians will receive a 9.75% payment cut because of the expiration of the current reprieve from the 2% sequester stemming from the Budget Control Act of 2011, imposition of a 4% statutory PAYGO sequester resulting from passage of the American Rescue Plan Act of 2021, expiration of the congressionally enacted 3.75% temporary increase in the Medicare Physician Fee Schedule (MPFS) conversion factor, and a continuing statutory freeze in annual MPFS updates under the Medicare Access and CHIP Reauthorization Act (MACRA) that is scheduled to last until 2026; and

Whereas, Adjusted for inflation in practice costs, Medicare physician payment declined 22% from 2001 to 2020, or by 1.3% per year on average; and

Whereas, Medicare physician payments have remained restricted by a budget-neutral financing system in which the Centers for Medicare & Medicaid Services routinely overestimates the utilization and volume of new services, yet budget neutrality adjustments are permanently established in the fee schedule; and

Whereas, Physician and nonphysician practitioner services represent a modest portion of the overall growth in health care costs; and

Whereas, Potential penalties under the Merit-Based Incentive Payment System (MIPS), which apply to MPFS services, will increase to 9% in 2022; and

Whereas, The alternative payment model pathway for physicians under MACRA has yet to be realized, leaving the majority of practices stuck in the MIPS portion of the MACRA program; and

Whereas, Medicare patients suffer as physicians adjust to unpredictable and excessive reductions to payment that inhibit their ability to ensure beneficiaries have access to the care they need; and

Whereas, physician practices are amid the COVID-19 public health emergency, requiring continued infection control protocols that, while necessary, have increased the costs of providing care; therefore be it

RESOLVED, That our American Medical Association continue to advocate for legislation that prevents Medicare cuts from taking place prior to Jan. 1, 2022 (Directive to Take Action); and be it further

RESOLVED, That our AMA seek annual and full Medicare Economic Index updates for Medicare Part B physician payments (Directive to Take Action); and be it further

RESOLVED, That our AMA seek legislation that provides only for positive performance incentives (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for payment policies that allow the Centers for Medicare & Medicaid Services to retroactively adjust overestimates of volume of services by instituting a three-year look-back period to correct Medicare conversion factor estimations. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The 9.75 cut in Medicare physician payments scheduled to occur in 2022 impacts all physician specialties and their patients. The reduced Medicare payments are exacerbated by already low Medicare payment for physician services. Congress must immediately address the forecasted cut before the end of the year. Otherwise, patients may experience a reduced ability to access care as physicians are unable to sustain their practices.
There is an urgent need to address Medicare physician payment stability, and this fits squarely within AMA's mission and strategic plan.
While AMA does have policy on averting Medicare physician payment cuts, this resolution expands upon it by calling for:

- Annual and full MEI updates;
- legislation that provides only for positive performance incentives; and
- CMS to retroactively adjust overestimates of volume of services by instituting a three-year look-back period to correct Medicare conversion factor estimations.

Action by the AMA will have a positive impact on all physician specialties and the AMA is the most appropriate Association to tackle this issue.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(N-21)

Introduced by: Texas

Subject: Opposing Federal Preemption of State Licensing Laws and Scope-of-Practice Expansion Under the Ninth Amendment to Declaration Under the PREP Act

Referred to: Reference Committee B

Whereas, On March 17, 2020, the Secretary of the U.S. Department of Health and Human Services declared a public health emergency caused by COVID-19; and

Whereas, This action triggered the Secretary's authority to issue certain directives relating to public health under the Public Readiness and Emergency Preparedness Act (PREP Act), 42 U.S.C. §247d-6d; and

Whereas, The PREP Act gives broad immunity to certain covered persons from lawsuits and liability under federal and state law in regard to claims for loss caused by, arising out of, relating to, or resulting from the administration to or use by an individual of a covered countermeasure to diseases, threats and conditions, except in the case of willful misconduct; and

Whereas, Effective Sept. 9, 2021, the secretary released the Ninth Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19, (herein after referred to as "the declaration"), expanding liability protection and authority for certain covered persons authorized to prescribe, dispense, and administer COVID-19 therapeutics that are covered countermeasures under section IV of the declaration; and

Whereas, The declaration specifically expands 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 as authorized, approved, or licensed by the U.S. Food and Drug Administration; and

Whereas, The declaration states that it preempts state law that would otherwise prohibit these individuals from independently prescribing, dispensing, or administering COVID-19 therapeutics or other covered countermeasures; and

Whereas, It is a longstanding principle in the U.S. that the practice of medicine is regulated by the state and that states determine and enforce the scope of practice for physicians and health care providers practicing in their respective states; and

Whereas, State scope-of-practice laws serve an important role in protecting public health, including safeguarding patients from improper care provided by individuals acting outside the scope of their practice under state licensure, which is based on education, training, and experience requirements that vary significantly by licensure type as well as by each state for the same type of licensure; and

Whereas, Many states uphold physician-led, team-based care with proper physician delegation and supervision of medical acts performed by nonphysicians to protect patient safety; and

Whereas, The declaration places public health in jeopardy by attempting to override these state guardrails and protocols meant to protect against such variables in physician and health care provider education, training, and experience; and

Whereas, The declaration threatens to erode physician-led, team-based care and interfere with continuity of care in the patient's primary medical home; and

Whereas, For more than 30 years, the American Medical Association's state and federal advocacy has safeguarded the practice of medicine by opposing attempts to inappropriately expand nonphysicians' scope of practice; therefore be it

RESOLVED, That our American Medical Association oppose the U.S. Department of Health and Human Services Secretary's Ninth Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 (the declaration); and be it further

RESOLVED, That our AMA specifically 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 as authorized, approved, or licensed by the U.S. Food and Drug Administration (New HOD Policy); and be it further

RESOLVED, That our AMA also specifically oppose the declaration as it purports to preempt state law that otherwise would prohibit these individuals from independently prescribing, dispensing, or administering COVID-19 therapeutics or other covered countermeasures (New HOD Policy); and be it further

RESOLVED, That our AMA release a statement in opposition to the declaration and ask that it be rescinded (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to advocate for legislation that prevents the federal government from preempting state scope-of-licensure laws for physicians and health care providers. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

The Texas Medical Association (TMA) requests immediate action by the American Medical Association (AMA) to pass this attached proposed resolution opposing the federal government's recent attempt to usurp the states' powers to individually regulate the practice of medicine. This issue affects most of the nation's physicians and their patients, which is why AMA is the most appropriate organization to tackle this urgent concern

Specifically, effective September 9, 2021, the Secretary of the U.S. Department of Health and Human Services issued the Ninth Amendment to the Public Readiness and Emergency Preparedness Act Declaration (the Declaration), which purports, among other things, to unilaterally authorize state-licensed pharmacists to order and administer, and certain pharmacy technicians and pharmacy interns to administer, COVID-19 therapeutics subcutaneously, intramuscularly, or orally as authorized, approved, or licensed by the Federal Drug Administration. This Declaration states that it preempts any state laws to the contrary, thereby attempting to eviscerate state scope-of-practice laws, which are tailored based on variances in education, training, and experience. The federal government's one-size-fits-all approach threatens, not helps, address public health concerns.

TMA's proposed resolution fits squarely within AMA's advocacy efforts on scope expansion and AMA's action on this resolution will positively reflect the voices of physicians nationwide. Accordingly, we ask AMA to swiftly address this pressing scope expansion issue by immediately considering and adopting the proposed resolution submitted by TMA, which calls on AMA to publicly oppose and demand the rescission of the Declaration.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(N-21)

Introduced by: Texas

Subject: Paying Physicians for Services According to the Physician Fee Schedule

Referred to: Reference Committee B

Whereas, The COVID-19 public health emergency has caused a rapid adoption of telehealth; and

Whereas, Patients and physicians continue to find value in the use of telemedicine when the condition is appropriate for this delivery type; and

Whereas, Patients will now expect telemedicine visits when appropriate, since telemedicine is about convenience for the patient, and removing telehealth services from the covered code list will prove disruptive to practices and patients alike; and

Whereas, The Centers for Medicare & Medicaid Services proposes to retain 135 telehealth services added to the Medicare telehealth services list on a Category 3 basis until the end of 2023; and

Whereas, Physicians must have the flexibility to decide whether to see their patients via telehealth or in person without unnecessary and disconnected pricing incentives; and

Whereas, A physician-led and collaborative team-based approach is optimal for patient care delivery and overall health care outcomes, especially when using telehealth; and

Whereas, Physician payment is determined using the resource-based relative value scale, which aligns payments based on the cost and resources used to provide services using physician work, practice expense, and medical liability expense; and

Whereas, Augmenting a physician's practice with telemedicine incurs additional expenses different from those of delivering only in-person care, and offering telemedicine adds expenses such as software, hardware, workflow adjustments, physician and staff training, and patient education; therefore be it

RESOLVED, That our American Medical Association advocate for Congress to require Employee Retirement Income Security Act (ERISA) self-funded employer-sponsored plans, state-regulated plans, Medicare, Medicaid, and TRICARE to pay physicians appropriately for a covered service provided as a telemedicine service to an enrolled patient by a contracted physician at least the same as the contracted rate that would have been paid if the service were provided in an in-person setting (Directive to Take Action); and be it further

RESOLVED, That our AMA support state medical board licensure requirements in the state where the patient is located, but otherwise the geographic and originating site restrictions should be eliminated to allow patients to receive appropriate telehealth services in their homes, residential facilities, and other locations (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that the Centers for Medicare & Medicaid Services retain on a permanent basis the telehealth services added to the Medicare telehealth services list during the public health emergency.(Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Despite the tragedy of the COVID-19 public health emergency, a widely recognized silver lining is the rapid adoption of telehealth which affects nearly all physicians and their patients. As such, it is important for the AMA to act at this meeting to enhance policies so that public and private payers properly pay for physician services associated with telehealth medicine. Addressing physician payment and patient access to physician services via telehealth fits squarely within the AMA mission.

To ensure that telehealth policies continue in a favorable and patient-centered manner at the conclusion of the public health emergency requires the AMA to consider and implement new policy.

While AMA has some existing policy on this topic, current policy does not explicitly call on public and private payers to appropriately pay physicians for a covered service provided as a telemedicine service to an enrolled patient by a contracted physician at least the same as the contracted rate that would have been paid if the service were provided in an in-person setting. Nor does current AMA policy explicitly support state medical board licensure requirements in the state where the patient is located

Given the rapid adoption of and policy evolvement associated with telemedicine, it is an important issue and AMA action will have a positive impact on physicians and their patients. The AMA is the most appropriate entity to tackle this issue.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(N-21)

Introduced by: Florida

Subject: Improve Physician Payments

Referred to: Reference Committee B

Whereas, There are looming Medicare cuts amounting to almost 9.75% on physician practices on January 1, 2022; and

Whereas, The AMA is urging House leaders to extend the 3.75% increase to the Medicare conversion factor that Congress included in the Consolidated Appropriations Act of 2021 which provides for continued stability to the physician and provider community as it works toward broader Medicare payment reform; and

Whereas, Physicians, who have given their time, energy, expertise and in some cases their lives to protect the United States population from the current COVID 19 pandemic deserve to be recognized not by Medicare reductions but by increases; and

Whereas, Our AMA has policy that has not been acted upon in a manner to effect change for American physicians regarding payment cuts; and

Whereas, Our AMA membership of practicing physicians could be improved strengthening our organization; therefore be it

RESOLVED, That our American Medical Association make avoiding the Medicare payment cuts on physician practices a top priority (Directive to Take Action); and be it further

RESOLVED, That our AMA utilize the necessary resources to avoid the pending Medicare physician payment cuts (Directive to Take Action); and be it further

RESOLVED, That our AMA modify policy D-165.941, “Sequestration Budget Cuts,” by addition and deletion to read as follows:

Sequestration Budget Cuts D-165.941

1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.
2. Our AMA will take all necessary legislative and administrative steps to prevent extended ~~or~~ and deeper sequester cuts in Medicare payments to physician practices using the financial means necessary to do so and make this a top priority. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm and take immediate action on policy H-330.932, "Cuts in Medicare and Medicaid Reimbursement," that:

(1) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;(calls for elimination of budget neutrality) (current policy)

(2) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services; (freedom of choice for patients), (current policy)

(3) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; (current policy); and

(4) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases. (current policy) (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reach out to the physicians of the United States via all possible means, to include but not be limited to email, US mail, social media, to encourage physicians to participate in the AMA campaign to improve physician payments (Directive to Take Action); and be it further

RESOLVED, That our AMA have an open and transparent dialogue with Congressional leaders and the Centers for Medicare and Medicaid Services regarding continued devaluation of the American physician and communicate such with America's physicians (both member and non-member). (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is $240,000.

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

This is a top priority resolution as it affects almost all physicians and if not enacted will have serious deleterious impact on practicing physicians and the AMA is the only organization that can tackle this issue. The looming cuts on physician's payments by CMS has a time certain of January 2022 and therefore, this is a top priority right now for all physicians as insurance carriers often follow Medicare changes. The AMA has been working on this for quite some time and there is policy that needs to be acted upon with urgency. This resolution, if made into policy, will strengthen our organization and show both member and non-member physicians that the AMA is focused on helping physicians take care of patients.

RELEVANT AMA POLICY

Sequestration Budget Cuts D-165.941
1. Our AMA will urge Congress to develop a fiscally responsible alternative that would prevent the automatic budget sequestration cuts that would endanger critical programs related to medical research, public health, workforce, food and drug safety, and health care for uniformed service members, as well as trigger cuts in Medicare payments to graduate medical education programs, hospitals, and physicians that will endanger access to care and training of physicians.
2. Our AMA will take all necessary legislative and administrative steps to prevent extended or deeper sequester cuts in Medicare payments.
Citation: (Res. 215, I-12; Appended: Res. 222, A-15)

Cuts in Medicare and Medicaid Reimbursement H-330.932
Our AMA:
(1) continues to oppose payment cuts in the Medicare and Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients;
(2) supports the concept that the Medicare and Medicaid budgets need to expand adequately to adjust for factors such as cost of living, the growing size of the Medicare population, and the cost of new technology;
(3) aggressively encourages CMS to affirm the patient's and the physician's constitutional right to privately contract for medical services;
(4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and
(5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.
Citation: (Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13)

Patient Access Jeopardized By Senate Failure to Correct Medicare Payment Error D-390.988
Our AMA will: (1) aggressively promote expanded grassroots participation in the Medicare Update Campaign through the use of blast fax, e-mails and the toll-free grassroots hotline (1-800-833-6354); (2) continue to work with state and national medical specialty societies, as well as group practices, on physician surveys to measure the effect on patient access to care; (3) immediately disseminate the latest information to physicians regarding Medicare participation, non-participation and private contracting arrangements; and (4) concurrent with all of the above legislative, grassroots and targeted political actions, continue to evaluate aggressive, appropriate legal remedies through court action that could serve to rectify physician concerns about Medicare payment cuts and their impact on patient care.
Citation: (BOT Rep. 24, I-02; Modified: CCB/CLRPD Rep. 4, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(N-21)

Introduced by: Florida

Subject: End Budget Neutrality

Referred to: Reference Committee B

Whereas, Federal law imposes budget neutrality requirements on revisions to RVUs under the Medicare Physician Fee Schedule (MPFS) that result in changes in federal expenditures in excess of $20 million per year[iii]; and

Whereas, Our AMA has calculated that the value of Medicare physician payments declined 22% relative to practice costs between 2001 and 2020[iii] and government officials project that the real value of the MPFS will continue to decline under current federal law[ivv]; and

Whereas, The US has an aging population[vi] which will drive Medicare enrollment growth[vii] and increase Medicare spending[viii]; and

Whereas, The 2021 MPFS Final Rule would have imposed budget neutrality cuts as high as 10% on certain specialists[ix], which made it impossible to implement the rule's appropriate and deserved payment increases for office and outpatient E&M codes without threatening access to care and endangering the economic viability of other physician practices; and

Whereas, Congress provided substantial temporary relief from these cuts[x], including a 3.75-percent across-the-board payment increase under the MPFS, this component of the relief will expire January 1st, 2022 unless further Congressional action is taken; and

Whereas, Existing budget neutrality requirements make implementing appropriate, significant RVU revisions for crucial services under the MPFS difficult or impossible to accomplish while maintaining access to care for beneficiaries who receive treatment from physicians who do not provide these services; and

Whereas, Budget neutrality cuts can create significant, arbitrary distortions in valuations for Medicare physician services and thereby generate looming access crises on a perennial basis; and

Whereas, Our AMA has taken existing stances against budget neutrality (Objects to the use of the relative values as a mechanism to preserve budget neutrality (H-400.959 -Refining and Updating the Physician Work Component of the RBRVS and 400.956-RBRVS development); therefore be it

RESOLVED, That our American Medical Association work towards the elimination of budget neutrality requirements under federal law (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-385.905, "Merit-based Incentive Payment System (MIPS) Update**,"** by addition and deletion to read as follows:

Merit-based Incentive Payment System (MIPS) Update H-385.905
Our AMA will work toward creating and pursuing ~~supports~~ legislation that ensures Medicare physician payments are ~~is~~ sufficient to safeguard beneficiary access to care, ~~replaces or supplements budget~~ eliminate budget neutrality requirements within the MPFS and with respect to ~~in~~ MIPS ~~with~~ incentive payments, ~~or~~ and implements ~~positive~~ annual Medicare physician payment updates that keep pace with rising practice costs. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA reaffirm D-400.989, "Equal Pay for Equal Work," with a special emphasis on the third bullet point and work to create legislation to eliminate budget neutrality:

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

RESOLVED, That our AMA reaffirm and take action on H-400.972, "Physician Payment Reform"

H-400.972, "Physician Payment Reform
It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f)the need for RBRVS conversion factor updates that are not subject to budget neutrality requirements; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
(2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients;
(3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system;
(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;
(5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures;

(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;
(7) seek the elimination of regulations directing patients to points of service;
(8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change;
(9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs;
(10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes;
(11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;
(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;
(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and
(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements. (created in 1992, reaffirmed 10 times) (Reaffirm HOD Policy)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

This is a top priority resolution as it affects all physicians and AMA action will have a positive impact. The AMA has substantial policy to eliminate budget neutrality that has yet to be fully acted upon. Current budget neutrality requirements make implementing appropriate, significant RVU revisions difficult or impossible. Our aging population will drive Medicare enrollment growth and increase spending. Eliminating budget neutrality will help to ensure that Medicare physician payments are sufficient to safeguard beneficiary access to care and payment updates will keep pace with rising practice costs. This resolution, if made into policy, will strengthen our organization and show both member and non-member physicians that the AMA is focused on helping physicians take care of patients.

RELEVANT AMA POLICY

Merit-based Incentive Payment System (MIPS) Update H-385.905
Our AMA supports legislation that ensures Medicare physician payment is sufficient to safeguard beneficiary access to care, replaces or supplements budget neutrality in MIPS with incentive payments, or implements positive annual physician payment updates.
Citation: BOT Rep. 13, I-20

Equal Pay for Equal Work D-400.989
Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update problem because this is the most immediate means of increasing Medicare payments to physicians in rural states and will have the greatest impact; (2) shall seek enactment of legislation directing the General Accounting Office to develop and recommend to Congress policy options for reducing any unjustified geographic disparities in Medicare physician payment rates and improving physician recruitment and retention in underserved rural areas; and (3) shall advocate strongly to the current administration and Congress that additional funds must be put into the Medicare physician payment system and that continued budget neutrality is not an option.
Citation: BOT Rep. 14, A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmation A-08; Reaffirmed: Sub. Res. 810, I-08; Reaffirmation A-09; Reaffirmed: BOT Action in response to referred for decision Res. 212, A-09; Reaffirmed: CMS Rep. 01, A-19

Refining and Updating the Physician Work Component of the RBRVS H-400.959
The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality.
Citation: (BOT Rep. I-93-26; Reaffirmed by BOT Rep. 8 - I-94; Res. 806, I-94; Reaffirmed: Sub. Res. 816, I-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmed: Sub. Res. 104, A-14; Reaffirmation A-15)

RBRVS Development H-400.956
(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review;
(2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies;
(3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work;
(4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and
(5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians.

Citation: (BOT Rep. 16, A-95; BOT Rep. 11, A-96; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmed: Sub. Res. 104, A-14; Reaffirmation A-15)

Physician Payment Reform H-400.972
It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f) the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96);
(2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients;
(3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system;
(4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors;
(5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures;
(6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992;
(7) seek the elimination of regulations directing patients to points of service;
(8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change;
(9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs;
(10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes;
(11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;
(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;

(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and
(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.
Citation: Sub. Res. 109, A-92; Reaffirmed: I-92; Reaffirmed by CMS Rep. 8, A-95 and Sub. Res. 124, A-95; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-02; Reaffirmation A-06; Reaffirmation I-07; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19;

Physician Payment Reform H-390.849
1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:
a) promote improved patient access to high-quality, cost-effective care;
b) be designed with input from the physician community;
c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
d) not require budget neutrality within Medicare Part B;
e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
h) use adequate risk adjustment methodologies;
i) incorporate incentives large enough to merit additional investments by physicians;
j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and
m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.
2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.
3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.
4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.
Citation: CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19

[i] Social Security Act (see: https://www.law.cornell.edu/uscode/text/42/1395w-4 or https://www.ssa.gov/OP_Home/ssact/title18/1848.htm see Section 1848(c)(2)(B)(ii)(II))
[ii] Payment for Physician Services, Social Security Administration (https://www.ssa.gov/OP_Home/ssact/title18/1848.htm see Section 1848(c)(2)(B)(ii)(II))
[iii] AMA: WAKE UP TO FINANCIAL PERIL FACING MEDICARE PAYMENT SYSTEM (SEE HTTPS://WWW.AMA-ASSN.ORG/PRESS-CENTER/PRESS-RELEASES/AMA-WAKE-FINANCIAL-PERIL-FACING-MEDICARE-PAYMENT-SYSTEM)

[iv] 020 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS (https://www.cms.gov/files/document/2020-medicare-trustees-report.pdf see the last paragraph of page 2 of the report)
[v] Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2) https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/2015HR2a.pdf see pages 8 and 9)
[vi] Demographic Turning Points for the United States: Population Projections for 2020 to 2060, United States Census Bureau (see: https://www.census.gov/content/dam/Census/library/publications/2020/demo/p25-1144.pdf)
[vii] Medicare Payment Advisory Commission Data Book, Ju; 2010 (http://www.medpac.gov/docs/default-source/data-book/july2021_medpac_databook_sec.pdf?sfvrsn=0 see chart 2-4)
[viii] Medicare Payment Advisory Commission Data Book, Ju; 2010 (http://www.medpac.gov/docs/default-source/data-book/july2021_medpac_databook_sec.pdf?sfvrsn=0 see chart 1-5)
[ix] CMS, 2021 MPFS Final (see: https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf see: Rule CY 2021 PFS Table 106: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty)
[x] CONGRESS PROVIDES RELIEF ON MEDICARE PAYMENT; PASSES SURPRISE BILLING (HTTPS://WWW.AMA-ASSN.ORG/DELIVERING-CARE/PATIENT-SUPPORT-ADVOCACY/CONGRESS-PROVIDES-RELIEF-MEDICARE-PAYMENT-PASSES-SURPRISE)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(N-21)

Introduced by: Michigan

Subject: Address Adolescent Telehealth Confidentiality Concerns

Referred to: Reference Committee B

Whereas, Adolescents believe that all health care should be confidential and report it as one of the most important aspects of their health care, yet many express concerns regarding privacy and worry that their providers will tell parents about their conversations; and

Whereas, The Academy of Pediatrics recommends providing confidential and private health care to adolescents by allowing sufficient opportunities for adolescents to discuss sensitive issues with physicians without a parent present; and

Whereas, The COVID-19 pandemic has not affected adolescents' needs for confidential services, and the early shift from in-person visits to telehealth visits demonstrated that 85 percent of adolescent primary care visits occurred for sensitive issues including sexual and reproductive health, eating disorders, and substance use; and

Whereas, Recent studies report that only 38 percent of adolescents spent any time alone with a provider within the last year, yet adolescents who experience portions of their visits unaccompanied by a parent are more likely to discuss sensitive topics such as sexual and reproductive health; and

Whereas, Only 27 percent of adolescents reported that they had any alone time with their provider during recent telehealth visits, potentially limiting access to confidential services; and

Whereas, A unique challenge of providing confidential care over telehealth includes finding quiet and private spaces in adolescents' homes that are separate from other household members to discuss sensitive topics without fear of the conversation being overheard; and

Whereas, The American Academy of Pediatrics, Pediatric Health Network, Michigan Medicine, and other organizations have developed frameworks recommending that physicians continue providing confidential and private care to adolescents through telehealth; and

Whereas, The organizations above provide recommendations unique to telehealth to ensure private and confidential visits, including asking the parent to leave for part of the visit and gaining parent buy-in regarding the importance of this privacy; and

Whereas, Additional suggestions to provide confidential care to adolescents through telehealth include asking the adolescent to move to a more private area of the home, providing suggestions on unique areas that patients may go to ensure privacy, the use of headphones and chat features, the use of yes or no answers, asking the adolescent for a 360 degree video view to understand who is in the room, and having the parent and adolescent call from separate devices to easily facilitate the transition to confidential discussions; and

Whereas, AMA Policies H-60.938 and H-60.965 recommend providing confidential care to adolescent patients, but do not address the unique confidentiality concerns of adolescents and their parents accessing telehealth, nor the challenges associated with finding private spaces in an adolescent's home; therefore be it

RESOLVED, That our American Medical Association amend Policy H-60.965, "Confidential Health Services for Adolescents," by addition to read as follows:

Confidential Health Services for Adolescents H-60.965
Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician, parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parent. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care; and
(10) encourages physicians to recognize the unique confidentiality concerns of adolescents and their parents associated with telehealth visits; and
(11) encourages physicians in a telehealth setting to offer a separate examination and counseling apart from others and to ensure that the adolescent is in a private space.
(Modify current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Telehealth utilization has skyrocketed during the COVID-19 pandemic. Along with the opportunities this provides to continue ongoing patient care, come new challenges for health care professionals caring for adolescents especially regarding the ability to provide a private space that preserves the ability to engage in confidential physician-patient communications. As telehealth continues to be a viable and acceptable mode for conducting patient visits, it is critical that health care professionals, patients, and parents have guidance on how best to address confidentiality concerns.

Sources:
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RELEVANT AMA POLICY

Confidential Health Services for Adolescents H-60.965

Our AMA:
(1) reaffirms that confidential care for adolescents is critical to improving their health;
(2) encourages physicians to allow emancipated and mature minors to give informed consent for medical, psychiatric, and surgical care without parental consent and notification, in conformity with state and federal law;
(3) encourages physicians to involve parents in the medical care of the adolescent patient, when it would be in the best interest of the adolescent. When, in the opinion of the physician,

parental involvement would not be beneficial, parental consent or notification should not be a barrier to care;
(4) urges physicians to discuss their policies about confidentiality with parents and the adolescent patient, as well as conditions under which confidentiality would be abrogated. This discussion should include possible arrangements for the adolescent to have independent access to health care (including financial arrangements);
(5) encourages physicians to offer adolescents an opportunity for examination and counseling apart from parents. The same confidentiality will be preserved between the adolescent patient and physician as between the parent (or responsible adult) and the physician;
(6) encourages state and county medical societies to become aware of the nature and effect of laws and regulations regarding confidential health services for adolescents in their respective jurisdictions. State medical societies should provide this information to physicians to clarify services that may be legally provided on a confidential basis;
(7) urges undergraduate and graduate medical education programs and continuing education programs to inform physicians about issues surrounding minors' consent and confidential care, including relevant law and implementation into practice;
(8) encourages health care payers to develop a method of listing of services which preserves confidentiality for adolescents; and
(9) encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws which restrict the availability of confidential care.
Citation: (CSA Rep. A, A-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed by BOT Rep. 9, A-98; Reaffirmed: Res. 825, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, I-14)

E-1.2.12 Ethical Practice in Telemedicine
Innovation in technology, including information technology, is redefining how people perceive time and distance. It is reshaping how individuals interact with and relate to others, including when, where, and how patients and physicians engage with one another.
Telehealth and telemedicine span a continuum of technologies that offer new ways to deliver care. Yet as in any mode of care, patients need to be able to trust that physicians will place patient welfare above other interests, provide competent care, provide the information patients need to make well-considered decisions about care, respect patient privacy and confidentiality, and take steps to ensure continuity of care. Although physiciansfundamental ethical responsibilities do not change, the continuum of possible patient-physician interactions in telehealth/telemedicine give rise to differing levels of accountability for physicians.
All physicians who participate in telehealth/telemedicine have an ethical responsibility to uphold fundamental fiduciary obligations by disclosing any financial or other interests the physician has in the telehealth/telemedicine application or service and taking steps to manage or eliminate conflicts of interests. Whenever they provide health information, including health content for websites or mobile health applications, physicians must ensure that the information they provide or that is attributed to them is objective and accurate.
Similarly, all physicians who participate in telehealth/telemedicine must assure themselves that telemedicine services have appropriate protocols to prevent unauthorized access and to protect the security and integrity of patient information at the patient end of the electronic encounter, during transmission, and among all health care professionals and other personnel who participate in the telehealth/telemedicine service consistent with their individual roles.
Physicians who respond to individual health queries or provide personalized health advice electronically through a telehealth service in addition should:
(a) Inform users about the limitations of the relationship and services provided.
(b) Advise site users about how to arrange for needed care when follow-up care is indicated.
(c) Encourage users who have primary care physicians to inform their primary physicians about the online health consultation, even if in-person care is not immediately needed.

Physicians who provide clinical services through telehealth/telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. In the context of telehealth/telemedicine they further should:
(d) Be proficient in the use of the relevant technologies and comfortable interacting with patients and/or surrogates electronically.
(e) Recognize the limitations of the relevant technologies and take appropriate steps to overcome those limitations. Physicians must ensure that they have the information they need to make well-grounded clinical recommendations when they cannot personally conduct a physical examination, such as by having another health care professional at the patients site conduct the exam or obtaining vital information through remote technologies.
(f) Be prudent in carrying out a diagnostic evaluation or prescribing medication by:
(i) establishing the patient's identity;
(ii) confirming that telehealth/telemedicine services are appropriate for that patients individual situation and medical needs;
(iii) evaluating the indication, appropriateness and safety of any prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and
(iv) documenting the clinical evaluation and prescription.
(g) When the physician would otherwise be expected to obtain informed consent, tailor the informed consent process to provide information patients (or their surrogates) need about the distinctive features of telehealth/telemedicine, in addition to information about medical issues and treatment options. Patients and surrogates should have a basic understanding of how telemedicine technologies will be used in care, the limitations of those technologies, the credentials of health care professionals involved, and what will be expected of patients for using these technologies.
(h) As in any patient-physician interaction, take steps to promote continuity of care, giving consideration to how information can be preserved and accessible for future episodes of care in keeping with patients' preferences (or the decisions of their surrogates) and how follow-up care can be provided when needed. Physicians should assure themselves how information will be conveyed to the patient's primary care physician when the patient has a primary care physician and to other physicians currently caring for the patient.
Collectively, through their professional organizations and health care institutions, physicians should:
(i) Support ongoing refinement of telehealth/telemedicine technologies, and the development and implementation of clinical and technical standards to ensure the safety and quality of care.
(j) Advocate for policies and initiatives to promote access to telehealth/telemedicine services for all patients who could benefit from receiving care electronically.
(k) Routinely monitor the telehealth/telemedicine landscape to:
(i) identify and address adverse consequences as technologies and activities evolve; and
(ii) identify and encourage dissemination of both positive and negative outcomes.

AMA Principles of Medical Ethics: I,IV,VI,IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(N-21)

Introduced by: Michigan

Subject: Medication for Opioid Use Disorder in Physician Health Programs

Referred to: Reference Committee B

Whereas, Physician Health Programs (PHPs) are designed to allow physicians with potentially impairing conditions who either come forward or are referred to be given the opportunity for evaluation, rehabilitation, treatment, and monitoring without disciplinary action in an anonymous, confidential, and respectful manner; and

Whereas, The PHP model is intended to ensure participants receive effective clinical care for mental, physical, and substance abuse disorders and access to a variety of clinical interventions and support; and

Whereas, Currently, physicians referred to PHPs who are diagnosed with opioid use disorder (OUD) involving monitoring or sanctions may be subjected to punitive action by their respective licensing boards; and

Whereas, The stigma associated with illness and impairment, particularly impairment resulting from mental illness, including substance use disorders, can be a powerful obstacle to seeking treatment, especially in the medical community where the presence of this stigma has been described in the literature; and

Whereas, The US Food and Drug Administration recommends approved medications for the treatment of opioid use disorder (MOUD) including methadone, buprenorphine, and naltrexone be available to all patients; and

Whereas, MOUD has been proven to help maintain recovery and prevent death in patients with opioid use disorder (OUD); and

Whereas, It is reported that patients who use MOUD remain in therapy longer than those who do not, and are less likely to use illicit opioids; and

Whereas, A 2019 report from the National Academies of Sciences, Engineering, and Medicine stated that “there is no scientific evidence that justifies withholding medications from OUD patients in any setting” and that such practices amount to “denying appropriate medical treatment,” and that such practices amount to “denying appropriate medical treatment”; and

Whereas, Clinicians should consider a patient’s preferences, past treatment history, current state of illness, and treatment setting when deciding between the use of methadone, buprenorphine, and naltrexone; and

Whereas, Additional considerations apply to health professionals who are actively engaged in, or planning to return to, safety sensitive work; and

Whereas, Treatment programs offering the best possible outcomes are critical to ensuring a pathway to recovery and continuation of clinical practice in a safe and ethical manner with patient protection at the forefront; and

Whereas, The American Society of Addiction *Medicine's Public Policy Statement on Physicians and other Healthcare Professionals with Addiction* includes the recommendation that "Healthcare professionals should be offered the full range of evidence-based treatments, including medication for addiction, in whatever setting they receive treatment. Regulatory agencies (including state licensing boards), professional liability insurers, and credentialing bodies should not discriminate against the type of treatment an individual receives based on unjustified assumptions that certain treatments cause impairment;" therefore be it

RESOLVED, That our American Medical Association work with stakeholders including the Federation of State Medical Boards and the Federation of State Physician Health Programs to develop guidelines supporting the adoption of policies by state-based Physician Health Programs to support individualized decision-making, inclusive of all treatment options including counseling and medication for the treatment of opioid use disorder, and considerations for safety sensitive professionals, to ensure physicians receive effective clinical care to aid in their recovery and safe and ethical return to clinical practice (Directive to Take Action); and be it further

RESOLVED, That our AMA work with stakeholders including the Federation of State Medical Boards and the Federation of State Physician Health Programs to develop model legislation permitting state Boards of Medicine and Osteopathic Medicine to allow for safe-haven or non-reporting of physicians to a licensing board, and/or accept Physician Health Program compliance as an alternative to disciplinary action when public safety is not at risk, and especially for any physicians who voluntarily self-report their physical, mental, and substance use disorders and engage with a Physician Health Program and who successfully complete the terms of participation. (Directive to Take Action)

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

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

Per the December 18, 2020 article, As pandemic rages, physician wellness suffers in silence, Susan R. Bailey, MD, AMA Immediate Past President, states "the need for both physical and mental wellness within our physician community has never been more urgent than it is today." She highlights the impact of COVID-19 in exacerbating the underlying and systemic problems that contribute most directly to physician burnout. Additionally, many experts note the financial, physical, emotional, and mental toll of the pandemic on health care professionals resulting in feelings of anxiety, stress, and isolation that can trigger an unhealthy consumption of mood-altering substances. Physician Health Programs offer a confidential resource for physicians, other licensed health care professionals, or those in training suffering from addictive, psychiatric, medical, behavioral or other potentially impairing conditions. It is imperative that these programs support individualized decision-making, inclusive of all treatment options including counseling and medication for the treatment of opioid use disorder.

RELEVANT AMA POLICY

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968

1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.
2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.
Citation: Res. 222, A-18; Appended: BOT Rep. 02, I-19

Educating Physicians About Physician Health Programs and Advocating for Standards D-405.990

Our AMA will:
(1) work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory;
(2) continue to collaborate with relevant organizations on activities that address physician health and wellness;
(3) in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs;
(4) work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training;
(5) continue to work with and support FSPHP efforts already underway to design and implement the physician health program review process, Performance Enhancement and Effectiveness Review (PEER™), to improve accountability, consistency and excellence among its state member PHPs. The AMA will partner with the FSPHP to help advocate for additional national sponsors for this project; and
(6) continue to work with the FSPHP and other appropriate stakeholders on issues of affordability, cost effectiveness, and diversity of treatment options.
Citation: Res. 402, A-09; Modified: CSAPH Rep. 2, A-11; Reaffirmed in lieu of Res. 412, A-12; Appended: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed: BOT Rep. 15, A-19; Modified: Res. 321, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(N-21)

Introduced by: Michigan

Subject: Resentencing for Individuals Convicted of Marijuana-Based Offenses

Referred to: Reference Committee B

Whereas, Incarceration is a key issue under the domain of Social and Community Context in the Social Determinants of Health topic area of Healthy People 2020 due to numerous disparities in inmate mental and physical health compared to the population, as well as the increased rate of mental health disorders in the children of incarcerated parents; and

Whereas, There is a clear link between incarceration and health, with incarcerated individuals showing higher risk of chronic conditions such as cardiovascular disease, hypertension, and cancer compared to the general population; a study in March 2013 found that each additional year an individual spends in prison corresponds with a decline in life expectancy by two years; and

Whereas, Incarcerated populations are particularly vulnerable to the coronavirus disease 2019 (COVID-19) given the demographics of those experiencing incarceration in addition to the inability to properly "social distance", high population turnover, unsanitary living conditions, poor ventilation systems, inability or inadequacy to properly test and track COVID-19 cases and exposure which have led to an estimated 113,664 COVID-19 cases and 887 related deaths among incarcerated people as of August 2020; and

Whereas, Arrests for marijuana possession, regardless of whether the person was later convicted on these charges, have been shown to negatively impact opportunities such as finding employment, housing, and obtaining student loans, which can lead to widespread and multifactorial individual health consequences; furthermore, criminalization of drug use is associated with increased stigma and discrimination of drug users and that stigma and discrimination is also a causal factor for decreased mental and physical health; and

Whereas, Nationally, African Americans are three times more likely to be arrested for marijuana possession than Whites, a finding that cannot be explained by differences in use; and

Whereas, A 2014 report by the National Research Council found that mandatory minimum sentences for drug offenders “have few, if any, deterrent effects;” and

Whereas, Eighteen states, two territories, and the District of Columbia have legalized the use of recreational and medicinal marijuana, and in the past four years, 23 states have passed laws addressing expungement of certain marijuana convictions, pairing these laws with other policies to its decriminalization or legalization; and

Whereas, In 2018, California became the first state to enact legislation ordering its Department of Justice to conduct a review of criminal records and identify past convictions eligible for sentence dismissal or re-designation in accordance with the Adult Use of Marijuana Act; the outcomes of this legislation showed that reductions in criminal penalties for drug possession

reduce racial and ethnic disparities in the criminal justice system, allowing for improvements in health inequalities linked to social determinants of health; and

Whereas, Illinois passed a bill in May 2019, to expunge convictions for non-violent crimes of possession, manufacturing, and distribution of up to 30 grams and possession up to 500 grams, and Colorado and Massachusetts have approved legislation allowing individuals convicted for possession to petition to seal criminal records of misdemeanor offenses that are no longer considered crimes; and

Whereas, A recent study examining the impact of this type of expungement found that those who do obtain expungement have extremely low subsequent crime rates and experience a significant increase in their wage and employment trajectories and an overall positive impact on the lives of those affected; however, of those legally eligible for expungement, only 6.5 percent obtain it within five years of eligibility, findings that support the development of “automatic” expungement procedures; and

Whereas, Those who have received resentencing for past offenses, including decriminalized marijuana-based charges, have experienced an increase of 22 percent in wages on average within one year of resentencing as well as lower subsequent crime rates that compare favorably to the general population; and

Whereas, Our AMA has policy (H-95.924) supporting public health-based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal us and encouraging research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; and

Whereas, Legislation has been considered at the federal level to, among other provisions, remove marijuana from the list of controlled substances under the Controlled Substances Act and create an opportunity for individuals with marijuana law convictions to petition for expungement and resentencing; therefore be it

RESOLVED, That our American Medical Association adopt policy supporting the expungement, destruction, or sealing of criminal records for marijuana offenses that would now be considered legal (New HOD Policy); and be it further

RESOLVED, That our AMA adopt policy supporting the elimination of violations or other penalties for persons under parole, probation, pre-trial, or other state or local criminal supervision for a marijuana offense that would now be considered legal. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution is timely for two key reasons. First, conversations about legalization of cannabis and concurrent expungement of records are currently happening, as the number of states with cannabis legalization are increasing. It is important that the AMA have a clear stance on the resentencing of persons who are currently serving a sentence for offenses for which the penalty no longer exists and to redesignate or dismiss such offenses from the criminal records of persons who have completed their sentences as set forth in this act. Second, COVID-19 pandemic and incarceration. Incarceration is a key factor due to numerous disparities in inmate mental and physical health compared to the general population. Furthermore, incarcerated populations are particularly vulnerable to COVID-19 given the demographics of those experiencing incarceration. People who are incarcerated are unable to properly "social distance," there are high population turnover, unsanitary living conditions, poor ventilation systems, and systems are unable to properly test and track COVID-19 cases. There were 398,627 cases and 2,715 deaths related to coronavirus reported among prisoners through June 2021. There are thousands of people who are incarcerated and suffering through these conditions solely due to low-level cannabis-based offenses. This resolution seeks to adopt policies that would support legislative changes that have the potential to dramatically improve the health and wellbeing of those affected.

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RELEVANT AMA POLICY

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.
Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(N-21)

Introduced by: New York

Subject: CMS Administrative Requirements

Referred to: Reference Committee B

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

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

RELEVANT AMA POLICY

Administrative Simplification in the Physician Practice D-190.974
1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care, especially for patients in high-deductible health plans.
5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.
6. Our AMA will continue its efforts to ensure that physicians are aware of the value of automating their claims cycle.
Citation: CMS Rep. 8, I-11; Appended: Res. 811, I-12; Reaffirmation A-14; Reaffirmation: A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 805, I-16; Reaffirmation: I-17; Reaffirmation: A-19; Modified: CMS Rep. 09, A-19

Police, Payer and Government Access to Patient Health Information D-315.992
Our AMA will: (1) widely publicize to our patients and others, the risk of uses and disclosures of individually identifiable health information by payers and health plans, without patient consent or authorization, permitted under the final Health Insurance Portability and Accountability Act "privacy" rule; and (2) continue to aggressively advocate to Congress, and the Administration, physician's concerns with the administrative simplification provisions of HIPAA and that the AMA seek changes, including legislative relief if necessary, to reduce the administrative and cost burdens on physicians.
Citation: Res. 246, A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed: BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(N-21)

Introduced by: New York

Subject: Medicare Advantage Plan Mandates

Referred to: Reference Committee B

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

Whereas, Medicare Advantage plans may have restrictive networks; and

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

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

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

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

Received: 10/11/21

AUTHORS STATEMENT OF PRIORITY

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

RELEVANT AMA POLICY

Ending Medicare Advantage Auto-Enrollment H-285.905
Our AMA will work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of "auto-enrollment" of individuals into Medicare Advantage Plans.
Citation: Res. 216, I-16

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930
Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.
Citation: BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19

Elimination of Subsidies to Medicare Advantage Plans D-390.967
1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services.
2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.
Citation: Res. 229, A-07; Modified: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(N-21)

Introduced by: New York

Subject: Prohibit Ghost Guns

Referred to: Reference Committee B

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

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

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

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

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

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

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

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

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

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

Fiscal Note: Minimal - less than $1,000

Received: 10/13/21

AUTHORS STATEMENT OF PRIORITY

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

RELEVANT AMA POLICY

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Firearm Availability H-145.996
1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.
Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16; Appended: Res. 433, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Ban on Handguns and Automatic Repeating Weapons H-145.985
It is the policy of the AMA to:
(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:
(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;
(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;
(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);
(d) the imposition of significant licensing fees for firearms dealers;
(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and
(f) mandatory destruction of any weapons obtained in local buy-back programs.
(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.
(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.
(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.
(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.
Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(N-21)

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

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

Referred to: Reference Committee B

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

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

Whereas, To claim:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY:

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

RELEVANT AMA POLICY

Preventing Anti-Transgender Violence H-65.957
Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an

individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.
Citation: Res. 008, A-19

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with ones gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to ones gender identity.
Citation: Res. 010, A-17

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(N-21)

Introduced by: New York

Subject: Insurers and Vertical Integration

Referred to: Reference Committee B

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

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

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

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

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

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

RESOLVED, That our American Medical Association 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. (Directive to Take Action)

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

Received: 10/13/21

AUTHOR'S STATEMENT OF PRIORITY

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

RELEVANT AMA POLICY

Health Insurance Company Purchase by Pharmacy Chains D-160.920
Our AMA will: (1) continue to analyze and identify the ramifications of the proposed CVS/Aetna or other similar merger in health insurance, pharmacy benefit manager (PBM), and retail pharmacy markets and what effects that these ramifications may have on physician practices and on patient care; (2) continue to convene and activate its AMA-state medical association and national medical specialty society coalition to coordinate CVS/Aetna-related advocacy activity; (3) communicate our AMAs concerns via written statements and testimony (if applicable) to the U.S. Department of Justice (DOJ), state attorneys general and departments of insurance; (4) work to secure state level hearings on the merger; and (5) identify and work with national antitrust and other legal and industry experts and allies.
Citation: BOT Action in response to referred for decision Res. 234, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(N-21)

Introduced by:	Illinois, California, Iowa, Georgia, New Jersey, Pennsylvania, American Academy of Ophthalmology, American Society of Cataract and Refractive Surgery, American Society of Ophthalmic Plastic and Reconstructive Surgery, American Society of Retina Specialists
Subject:	Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients
Referred to:	Reference Committee B

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

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

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

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

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

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

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

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

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

Received: 10/15/21

AUTHORS STATEMENT OF PRIORITY

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

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