

## Reference Committee B

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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

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1 INTRODUCTION

2  
3 At the 2020 November Meeting, the House of Delegates referred the Third, Fourth, and Eighth  
4 Resolve Clauses of Resolution 410-NOV-20, “Policing Reform,” introduced by the Medical  
5 Student Section, which asked:

6  
7 That our AMA advocate for the elimination or reform of qualified immunity, barriers to  
8 civilian oversight, and other measures that shield law enforcement officers from consequences  
9 for misconduct.

10  
11 That our AMA support efforts to demilitarize law enforcement agencies, including elimination  
12 of the controlled category of the United States Department of Defense 1033 Program and  
13 cessation of federal and state funding for civil law enforcement acquisition of military-grade  
14 weapons.

15  
16 That our AMA support the creation of independent, third-party community-based oversight  
17 committees with disciplinary power whose mission will be to oversee and decrease police-on-  
18 public violence.

19  
20 The reference committee heard mixed testimony on these resolves, including significant support for  
21 referral to allow for a more thorough analysis. This Board report, therefore, addresses the Third,  
22 Fourth, and Eighth Resolve Clauses of Resolution 410-NOV-20, specifically, and provides  
23 background, discussion, and recommendations.

24  
25 BACKGROUND

26  
27 Following the well-publicized deaths of Black Americans during police encounters—including  
28 George Floyd, Breonna Taylor, and too many others—as well as the widespread protests in their  
29 aftermath, our nation is engaging in a long-overdue conversation about police violence and excess  
30 force, and how racism and systemic and structural racial injustice manifest in over-policing of  
31 Brown and Black communities. While the AMA recognizes that many who serve in law  
32 enforcement are committed to social justice in their holistic view of justice, AMA policy  
33 acknowledges the need for changes at the federal, state, and local levels to end discriminatory  
34 practices and unnecessary or excessive use of police force. The AMA has been and continues to be  
35 engaged in advocating for such changes. As noted in an AMA Viewpoint by then-Immediate Past  
36 AMA Board Chair Jesse M. Ehrenfeld, MD, MPH, and then-Immediate Past President Patrice  
37 Harris, MD, MA:

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

7  
8 Because of structural racism, historically marginalized and minoritized communities in the United  
9 States shoulder the unfair, unjust, and disproportionate burden of police violence, experiencing  
10 higher levels of mortality, morbidity, inequity, and intergenerational trauma. Police violence is a  
11 leading cause of death for young men in the United States.<sup>2</sup> Over their life course, about one in  
12 every 1,000 Black men can expect to be killed by police. The risk of being killed by police peaks  
13 between the ages of 20 years and 35 years for men and women and for all racial and ethnic groups.  
14 Black women and men and American Indian and Alaska Native women and men, however, are  
15 significantly more likely than white women and men to be killed by police. Latino men are also  
16 more likely to be killed by police than are white men.<sup>3</sup> According to the Mapping Police Violence  
17 database, Black people comprise 28 percent of those killed by police in 2020—despite being only  
18 13 percent of the population.<sup>4</sup> It is important to note that the disproportionate exposure of  
19 communities of color to fatal police violence does not correlate to crime rates.<sup>5</sup> Police-related  
20 deaths have distinct causes, distributions, and consequences for population health from other forms  
21 of violence and currently number in the thousands every year.<sup>6</sup>

22  
23 Beyond the increased rate of fatalities, research also shows that racially marginalized communities  
24 are disproportionately subject to police force, and there is a correlation between policing and  
25 adverse health outcomes. Studies have shown that, “Men, racial/ethnic minorities, young people,  
26 and those living in economically disadvantaged areas are particularly at risk, especially those at the  
27 intersection of these social stratifications.”<sup>7</sup> Standardized policies, such as stop and frisk, normalize  
28 racial profiling and structural racism.<sup>8</sup> An increased prevalence of police encounters is linked to  
29 elevated stress and anxiety levels, along with increased rates of high blood pressure, diabetes, and  
30 asthma—and fatal complications of those comorbid conditions—for both the victim and the  
31 community, including children.<sup>9,10</sup> Racism as a driver of health inequity is also particularly evident  
32 in findings from a 2018 *Lancet* study showing that law enforcement-involved deaths of unarmed  
33 Black individuals were associated with adverse mental health consequences among Black  
34 American adults—regardless of whether the individual affected had a personal relationship with  
35 the victim or the incident was experienced vicariously. The trauma of violence in a person's life  
36 course is associated with chronic stress, higher rates of comorbidities, and lower life expectancy.<sup>11</sup>

### 37 38 QUALIFIED IMMUNITY

39  
40 Qualified immunity is a judicially created legal principle that grants civil immunity to individual  
41 government officials performing discretionary duties within the scope of their employment. Only if  
42 a plaintiff demonstrates that the government official violated, “clearly established statutory or  
43 constitutional rights of which a reasonable person would have known” may a civil suit proceed.<sup>12</sup> It  
44 operates as an affirmative defense for individual government officials, barring damages even if an  
45 unlawful, unconstitutional act was committed. Though qualified immunity is often discussed as it  
46 applies to law enforcement officers, it also applies to most other executive branch officers.  
47 Importantly, qualified immunity is only applied in civil claims and only in suits against government  
48 officials individually. Criminal proceedings and suits against the government itself for damages  
49 caused by officials' actions do not trigger the qualified immunity doctrine.

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

7  
8 The doctrine is often implicated in civil rights lawsuits against state and local police under  
9 42 U.S.C. § 1983 (Section 1983), which creates an avenue to seek damages for civil rights violations  
10 in state or federal court. Over time, the Supreme Court has broadened qualified immunity and  
11 narrowed the path to proceed in a case against a government official, diminishing the protections of  
12 Section 1983. A *Reuters* analysis of appellate court records showed that lower courts have  
13 increasingly granted immunity in cases alleging excessive use of force by law enforcement  
14 officers.<sup>15</sup>

15  
16 Qualified immunity is a federal doctrine, and, for that reason, it can only fully be abolished or  
17 amended by the Supreme Court or Congress. Nevertheless, some states have acted to limit the  
18 application of qualified immunity in state courts. In June 2020, for example, Colorado became the  
19 first state to explicitly limit qualified immunity for local law enforcement officers, sheriff’s  
20 deputies, and Colorado State Patrol officers. The Enhance Law Enforcement Integrity Act (the Act)  
21 creates a new “civil action for deprivations of rights” which enables state residents to sue law  
22 enforcement officers in state court for alleged violations of the Colorado Constitution. The Act also  
23 requires law enforcement agencies to indemnify their officers.

24  
25 In April 2021, New Mexico enacted the New Mexico Civil Rights Act which bars the defense of  
26 qualified immunity for any state or local public official who has caused “the deprivation of any  
27 rights, privileges or immunities secured by the Constitution of New Mexico.” The New Mexico  
28 law also creates a new cause of action under which a plaintiff may sue the government employer  
29 for damages for violations of rights under the state Constitution. Whereas Colorado’s law applies  
30 only to law enforcement officers, New Mexico’s applies to all state officials. Neither state law  
31 affects federal civil rights claims filed in federal court.

32  
33 Recent high-profile deaths at the hands of law enforcement have put repeal of the qualified  
34 immunity doctrine into the spotlight as a means of preventing excessive use-of-force by law  
35 enforcement officers. Many understand qualified immunity to grant too much deference and  
36 insulate law enforcement officers from the consequences of misconduct, particularly that aimed at  
37 members of minoritized and marginalized communities. In a 2018 dissent, U.S. Supreme Court  
38 Justice Sonia Sotomayor wrote that qualified immunity gives license to police to, “shoot first and  
39 think later, and it tells the public that palpably unreasonable conduct will go unpunished.”<sup>16</sup>

40  
41 The rationale for abolishing qualified immunity posits that the threat of personal liability will be so  
42 great that officers will “think twice” before engaging in misconduct. Indeed, the International  
43 Association of Chiefs of Police warns that the “loss of this protection would have a profoundly  
44 chilling effect on police officers and limit their ability and willingness to respond to critical  
45 incidents without hesitation.”<sup>17</sup> There is reason to doubt, however, that repeal of the qualified  
46 immunity doctrine would create the intended effect. Research shows that law enforcement officers  
47 are almost always indemnified by their employer and governments pay of 99.98 percent of  
48 damages recovered for violations of civil rights.<sup>18</sup> Indemnification creates a moral hazard wherein  
49 an individual officer does not bear the full costs of his or her behavior, reducing or eliminating the  
50 incentive for individual change in behavior. If law enforcement agencies are responsible for their  
51 employee’s individual actions, however, this may compel departments to implement better policies

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

5  
6 In addition, incentivizing behavior change via personal liability assumes that civil rights violations  
7 are committed intentionally and that, with the right incentives or disincentives in place, an officer  
8 would choose a different course of action. While bad actors exist and intentional brutality does  
9 tragically occur, many cases result from officers, in their minds, making the best decision they  
10 could at the time. In this way, reforming the principle of qualified immunity does not address  
11 systemic failure in policing practices.

### 12 *Discussion*

13  
14  
15 As a physician organization, the AMA is invested in the betterment of the public health. AMA  
16 policy recognizes that policing is a social determinant of health and that inequitable law  
17 enforcement practices are a result of structural racism and have a direct, negative impact on  
18 health, particularly among historically marginalized and minoritized communities that shoulder  
19 the disproportionate burden of police violence. If the inability to hold law enforcement officers  
20 individually liable in civil court has a measurable impact on the health of our patients, then  
21 police accountability may be ripe for AMA involvement. Literature linking the application of  
22 qualified immunity for law enforcement officers to health outcomes, however, is not available  
23 and, as noted above, claims that abolishing qualified immunity would result in better policing  
24 outcomes are untested. Given that constitutional law doctrines are generally outside the scope of  
25 the AMA's work and the lack of evidence that abolishing qualified immunity would indeed  
26 reduce police violence, the AMA's contribution to the national conversation about policing  
27 might better be focused on a holistic approach to policing. In particular, because of the  
28 similarities between medicine and law enforcement—professionals in both fields are frequently  
29 placed in high-pressure situations in which they must make split second, life-or-death decisions—it  
30 may benefit law enforcement to borrow some of the strategies and practices that the medical  
31 profession uses to ensure that its members provide safe and effective care.

32  
33 First, in medicine, reliance on evidence is a bedrock of clinical decision-making, but the same is  
34 not true in policing. The approximately 18,000 law enforcement jurisdictions set policies and  
35 procedures independently and generally without the benefit of research to inform those policies.  
36 Though efforts are underway to expand evidence-based policing through organizations like the  
37 American Society of Evidence-Based Policing, those efforts are nascent. More research is needed  
38 to understand and implement those practices and strategies that effectively control crime while  
39 maintaining the trust and confidence of the public and ending those that are harmful and result in  
40 inequitable, discriminatory treatment of marginalized and minoritized communities.

41  
42 In addition, law enforcement lacks standardization. Unlike in medicine, where multiple  
43 governmental and nongovernmental entities set standards and guidelines for training and clinical  
44 practice, law enforcement entities are not required to adhere to external standards, often resulting in  
45 fragmented and inconsistent policies.<sup>19</sup> Although accreditation alone will not prevent all negative  
46 events, it may be one tool for review and ongoing measurement. Entities like the Commission on  
47 Accreditation for Law Enforcement Agencies, Inc. (CALEA) set professional standards for law  
48 enforcement through an accreditation program, though accreditation is voluntary, and fewer than  
49 1,000 of the 18,000 law enforcement jurisdictions are currently accredited by CALEA.<sup>20</sup>

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

## 17 18 MILITARIZED EQUIPMENT

19  
20 The recent controversy over policing methods and excessive or unreasonable force has refocused  
21 attention on programs that transfer military equipment to law enforcement agencies across the  
22 country. Images during the summer protests of 2020 following the death of George Floyd in police  
23 custody that were widely broadcast by news shows and online repeatedly showed police outfitted  
24 with tactical gear, including full-body armor and in militarized vehicles, facing off with protestors.  
25 Concerns have been raised over whether law enforcement agencies have become too militarized,  
26 the use of such equipment, and the impact of the use of such equipment, particularly on  
27 communities of color.

28  
29 Eligible federal, state, and local agencies, under certain circumstances, may obtain certain U.S.  
30 Department of Defense (DOD) personal property, including equipment, clothing, vehicles, aircraft,  
31 weapons, and ammunition for use in law enforcement, counterdrug, counterterrorism, border  
32 security, and/or humanitarian activities.<sup>23</sup> DOD's disposal of excess or surplus military equipment,  
33 through sale, transfer, donation, or reutilization, originally dates to the end of World War II. What  
34 is now known as the 1033 Program, however, was temporarily authorized by Congress through the  
35 National Defense Authorization Act (NDAA) in 1990.<sup>24</sup> It allowed law enforcement agencies to  
36 acquire excess military property for a bona fide law enforcement purpose. The original intent was  
37 to transfer military equipment in the "War on Drugs" to federal and state agencies to help assist in  
38 the fight against drug production and trafficking.<sup>25</sup> Congress officially created the 1033 Program  
39 through the Fiscal Year 1997 NDAA.<sup>26</sup> The 1033 Program allowed the transfer or donation of  
40 excess DOD property to state, local, and Tribal law enforcement agencies. Agencies that used the  
41 property for counterdrug or counterterrorism activities received preference.<sup>27</sup>

42  
43 The Law Enforcement Support Office (LESO) of the DOD's Defense Logistics Agency (DLA) is  
44 responsible for facilitating and managing the 1033 Program and, according to information on  
45 LESO's website, more than 8,000 law enforcement agencies to date have enrolled in the  
46 1033 Program.<sup>28</sup> Once accepted into the 1033 Program, a law enforcement agency can review  
47 online the available excess DOD inventory that is suitable for law enforcement and make requests  
48 for property through the state coordinator. Every request for property must have a justification  
49 outlining how the property will be used, and requests must be for bona fide law enforcement  
50 purposes. Agencies do not pay for the property but must pay for shipping the items as well as  
51 potential storage costs.<sup>29</sup> A caveat of the 1033 Program included a requirement to deploy the

1 equipment within one year of receipt which may incentivize police to use the equipment for other  
2 purposes. Agencies that do not use the equipment within the one-year timeframe are required to  
3 return the unused items.<sup>30</sup>

4  
5 There are two types of property that can be transferred to law enforcement under the program:  
6 controlled and uncontrolled. Controlled property consists of military items that are provided via a  
7 conditional transfer or “loan” basis; title for the property remains with DLA. Controlled property  
8 includes items such as small arms/personal weapons, demilitarized vehicles and aircraft, and night  
9 vision equipment. When a law enforcement agency no longer wants the controlled property, it must  
10 be returned to LESO. Non-controlled property, on the other hand, consists of common items DLA  
11 would sell to the general public, such as office equipment, first aid kits/supplies, hand tools,  
12 sleeping bags, computers, and digital cameras. After one-year, general property becomes the  
13 property of the law enforcement agency. Most of the equipment transferred is non-controlled  
14 property.<sup>31</sup> According to *Politifact.com*, small arms weapons such as rifles and side-arms normally  
15 make up about five percent of the total, while less than one percent of property issued is tactical  
16 vehicles.<sup>32</sup> In order to request and receive controlled property, participating law enforcement  
17 agencies must receive the local governing authority’s approval and must certify that, in addition to  
18 receiving such approval, they have adopted publicly available protocols for the appropriate use of  
19 controlled property, the supervision of such use, and the evaluation of the effectiveness of such use,  
20 including auditing and accountability policies.<sup>33</sup> Since the 1033 Program’s beginning, more than  
21 \$7.5 billion worth of property (based on initial acquisition value) has been transferred to law  
22 enforcement agencies.<sup>34</sup>

23  
24 There are certain military items that are not available for transfer to law enforcement agencies  
25 through the 1033 Program. This prohibited equipment includes: any aircraft, vessels or vehicles  
26 that inherently contain weaponry, (e.g., tanks, Bradley fighting vehicles, armed drones); crew  
27 served/large caliber (.50 caliber or greater) weapons and ammunition; military uniforms; body  
28 armor; Kevlar helmets; and explosives or pyrotechnics of any kind. Also, aircraft and vehicles  
29 available in the program are “demilitarized,” meaning that any specific military technology  
30 (e.g., communication equipment) are removed prior to transfer to law enforcement agencies.<sup>35</sup>

31  
32 There are several oversight tools that DLA uses for the program to maintain and ensure compliance  
33 with all program requirements and property accountability, including an annual certified inventory  
34 by each participating state, biennial federal level program compliance reviews, and annual state  
35 coordinator reviews of at least five percent of the law enforcement agencies that have acquired  
36 property. In addition, state coordinators and law enforcement agencies may be suspended or  
37 terminated from the 1033 Program for non-compliance.<sup>36</sup> In addition, the law was amended by  
38 Congress in 2015 to make it clear that each individual agency acquiring controlled equipment has  
39 responsibility for training its personnel in the proper use, maintenance, and repair. The law requires  
40 each law enforcement agency to certify on an annual basis that it provides annual training to  
41 relevant personnel on the maintenance, sustainment, and appropriate use of controlled property.<sup>37</sup>  
42 Additional oversight is provided through coordination between LESO and the DOJ to identify law  
43 enforcement agencies that are under DOJ investigation or under a consent decree and thus  
44 ineligible for the program.

45  
46 After calls for transparency about the 1033 Program following the Black Lives Matter protests in  
47 2014 in Ferguson, Missouri, in the aftermath of the police shooting of Michael Brown, the DOD  
48 released data about the tactical equipment it tracks through the program, and for the first time  
49 identified the agencies that received items.<sup>38</sup> Since 2016, there has been more transparency than  
50 there was during the first 20 years of the 1033 Program, when record keeping was very spotty.

1 LESO has a public website page that links to a detailed spreadsheet, that lists all equipment issued  
2 to agencies, by state.<sup>39</sup>

3  
4 While the 1033 Program is perhaps the most publicly well-known program, there are additional  
5 DOD programs that allow law enforcement to purchase military-grade equipment. For example,  
6 under the 1122 Program, originally authorized in the NDAA for FY1994 (P.L. 103-160, codified at  
7 10 U.S.C §281), the Secretary of Defense is allowed to establish procedures for state and local  
8 governments to purchase law enforcement equipment for counterdrug, homeland security, and  
9 emergency response activities. Section 885 of the FY2009 NDAA (P.L. 110-417) expanded the  
10 program to include homeland security and emergency response operations. The U.S. Army,  
11 notably, manages the 1122 Program. Moreover, another program authorizes the Secretary of  
12 Defense to sell surplus military equipment to state and local law enforcement, firefighting,  
13 homeland security, and emergency management agencies at fair market value. Authorized  
14 equipment includes pistols, revolvers, shotguns, rifles of a caliber not exceeding .30, ammunition  
15 for such firearms, gas masks, personal protective equipment, and other appropriate equipment. The  
16 equipment cannot be transferred or resold by the acquiring agency.<sup>40</sup>

17  
18 Similar to the 1122 Program, the Department of Homeland Security's (DHS) Urban Areas Strategy  
19 Initiative provides grant funds to allow police and sheriffs' departments to purchase crowd-control  
20 items such as cuffs, batons, helmets, gas masks, and other such equipment or allow them to use  
21 their own money to buy it at discounted federal prices.<sup>41</sup> DHS also has another grant program, the  
22 State Homeland Security Program, that provides funding to state, local, and Tribal governments,  
23 for terrorism preparedness. Notably, there is less transparency about these other programs, and they  
24 do not have the same restrictions as the 1033 Program.

25  
26 Following the Ferguson protests, numerous concerns were raised about the 1033 Program by  
27 members of Congress, the media, and research groups. Congressional hearings were held and in  
28 May 2015, following the recommendations of a working group he appointed, then President Barack  
29 Obama signed an executive order that prohibited state and local law enforcement from receiving  
30 certain types of property, such as grenade launchers and weaponized aircraft, under the  
31 1033 Program.<sup>42</sup> Subsequently, former President Donald Trump rescinded the Obama-era  
32 restrictions.

33  
34 More recently, in the wake of the police killing of George Floyd and the subsequent protests, a  
35 provision to place restrictions on the 1033 Program was included in the FY21 NDAA, which was  
36 passed over then President Trump's veto. Specifically, Section 1053 bars the transfer to law  
37 enforcement agencies of bayonets, lethal grenades, weaponized tracked combat vehicles, and aerial  
38 drones equipped with weapons. The provision also requires that personnel in law enforcement  
39 agencies that receive DOD equipment under the program undergo training in respect for citizens'  
40 constitutional rights and in conflict de-escalation. Finally, legislation was introduced in Congress in  
41 2020 and again this year that includes provisions to demilitarize police departments, i.e., the  
42 "George Floyd Justice in Policing Act" (H.R. 1280, 117<sup>th</sup> Congress), which passed the House of  
43 Representatives on March 3, 2021. Section 365 of the bill would place limitations on the  
44 1033 Program, including banning the transfer of controlled equipment (e.g., firearms, ammunition,  
45 bayonets, grenade launchers, grenades, explosives, most vehicles, drones, certain aircraft) and  
46 require more accountability and reporting from agencies receiving equipment and from DOD to  
47 Congress. This provision remains one of the stumbling blocks in negotiations on the bill in the  
48 Senate.

1 *Discussion*

2  
3 Supporters of the 1033 Program, including many members of Congress and law enforcement  
4 agencies, argue that it provides an efficient way for local police agencies to obtain recycled  
5 equipment they otherwise could not afford, and was a good use of tax dollars. Law enforcement  
6 notes that there are high risk situations when use of such equipment is necessary and appropriate,  
7 such as during mass shooting events. They also point to the numbers, arguing that the  
8 1033 Program does not contribute to militarization given that most of the transferred equipment is  
9 of general use, such as first aid kits, blankets, gym equipment, cold weather clothing, and large  
10 storage bins, while less than one percent of the equipment are tactical vehicles and only five  
11 percent are small arms.<sup>43</sup> Proponents also argue that the 1033 Program helps to increase safety in  
12 cities, particularly for law enforcement officers and the public.<sup>44</sup> In an evaluation of the 1033  
13 Program published in 2018 that was conducted by the RAND Corporation and was required by the  
14 2017 NDAA, the authors concluded that the DOD's LESO manages an efficient program that  
15 effectively reuses excess property, benefits the law enforcement community, responds diligently to  
16 oversight, and is faithful to congressional intent. The study authors acknowledged, however, that,  
17 "these efforts are unlikely to resolve perceptions that the program contributes to the militarization  
18 of police."<sup>45</sup>

19  
20 Opponents and critics, however, argue that the 1033 Program has led to an excessive militarization  
21 of local police agencies, adversely impacts police culture, erects barriers between police and local  
22 communities, and has led to an association with the use of lethal force on suspects.<sup>46</sup> For example,  
23 recent research has analyzed factors that increase an agency's likelihood of acquiring specific  
24 categories of equipment through the 1033 Program. One study found that agencies with "warrior"  
25 tendencies (measured through agencies' body armor policies and special units) and that use asset  
26 forfeiture were significantly more likely to acquire a mine-resistant ambush-protected (MRAP)  
27 vehicle.<sup>47</sup> Another study assessing the influence of violent crime rates, drug arrest rates, and  
28 proportion of minority population on agencies' participation in the 1033 Program, found that high  
29 violent crime rates and high proportion of Black population increased an agency's likelihood to  
30 obtain any equipment from the 1033 Program.<sup>48</sup> In a 2014 report by the American Civil Liberties  
31 Union that examined the use of SWAT teams, the authors stated that, "the use of hyperaggressive  
32 tools and tactics results in tragedy for civilians and police officers, escalates the risk of needless  
33 violence, destroys property, and undermines individual liberties."<sup>49</sup>

34  
35 In light of the different ways agencies acquire military equipment, it is difficult to assess the extent  
36 to which and whether local police agencies are militarized and how such equipment is actually  
37 used. As discussed above, there is no consensus in research studies on the actual impact of the  
38 1033 Program on communities or on police. There is also no clear evidence that regulating or  
39 limiting the 1033 Program alone would resolve these issues given the other programs through  
40 which law enforcement agencies acquire military equipment, especially since there is less publicly  
41 available information on them. Without such evidence, it is difficult to reach conclusions on  
42 whether the AMA should support limiting or eliminating the 1033 Program or funding for  
43 additional DOD or DHS military equipment programs. And, without such evidence, it would be  
44 difficult for the AMA to impactfully advocate on such a position. Therefore, while acknowledging  
45 the concerns expressed by Resolution 410, and its sponsors and supporters, the Board determined  
46 that the AMA should defer to outside organizations that have the appropriate expertise and  
47 resources to fully examine and study these issues and encourage such endeavors.

## 1 COMMUNITY-BASED OVERSIGHT BOARDS

2  
3 Community or civilian oversight boards (COBs) are entities comprised of members of the public  
4 who may review, investigate, or discipline law enforcement officer wrongdoings. They vary  
5 tremendously in terms of composition, scope, and authority, but generally follow three main  
6 models: investigation-focused models that operate separately from law enforcement; review-  
7 focused models that review the quality of completed internal affairs investigations; and  
8 auditor/monitor models that focus on large-scale systemic reform and, at times, participate in or  
9 monitor internal investigations. Currently, there are approximately 200 COBs among the 18,000  
10 law enforcement jurisdictions in the United States, including in 24 of the 50 largest cities.<sup>50,51</sup> Most  
11 COBs are created locally by cities, towns, and counties.<sup>52</sup>  
12

13 The movement toward modern civilian oversight, dates back, to the civil rights era when Black and  
14 Latino communities successfully advocated for civilian oversight in their communities. Since that  
15 time, many COBs have been created in direct response to high profile events and racially disparate  
16 policing. For example, the City of Chicago created its Police Accountability Task Force in  
17 response to the 2014 shooting of Laquan McDonald.<sup>53</sup> The findings from the Chicago task force  
18 investigation led to the creation of a civilian oversight body.<sup>54</sup> Often, COBs are created in a consent  
19 decree between the DOJ and a municipality. For instance, Albuquerque's COB was established via  
20 settlement agreement with the DOJ in 2014 following findings of patterns of excessive force by the  
21 DOJ.<sup>55</sup>  
22

23 Proponents of community oversight say that such boards improve public trust, ensure accessible  
24 complaint processes, ensure thorough investigations, increase transparency, and deter police  
25 misconduct. The push for community oversight also stems from skepticism of self-regulation by  
26 police. Proponents argue that internal investigations and disciplinary processes conducted by  
27 fellow law enforcement officers are inherently conflicted and biased, and lead to overly permissive  
28 supervision that fails to hold officers accountable for wrongdoing. Citizen-led investigatory and  
29 disciplinary processes, it is argued, are a necessary external check on police power.  
30

31 However, despite their growing popularity, evidence of COBs promoting accountability, improving  
32 police-community relations, and curbing police misconduct is limited. There is some evidence that  
33 external civilian review of internal investigations is associated with a greater likelihood that  
34 misconduct complaints will be found to have merit, but, to date, COBs have been found to be  
35 largely ineffective due to political opposition, lack of authority to investigate, and lack of power to  
36 discipline.<sup>56,57</sup>  
37

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

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

### 6 7 *Discussion*

8  
9 Because of the limitations of existing COBs and limited research demonstrating their effectiveness,  
10 it is unclear if expanding civilian authority of police oversight would improve police-community  
11 relations and decrease officer misconduct. It may be that authorizing COBs to conduct independent  
12 investigations and issue binding disciplinary orders would deter police violence. The necessary  
13 attributes of an effective COB, however, remain unclear. Questions about what form COBs ought  
14 to take, what powers it ought to be granted, and how to untangle agreements made between police  
15 unions and local governments extend beyond the scope of the AMA's expertise.

16  
17 We also note that medicine has a long tradition of self-regulation that is supported by AMA policy.  
18 When a state medical board conducts an investigation or inquiry of a physician's quality of care, we  
19 believe that the standard of care must be determined, not only by a physician, but by a physician  
20 from the same specialty. Similarly, AMA policy supports peer review processes that are conducted  
21 by physicians within the same specialty. We also advocate for strict confidentiality of the  
22 proceedings of peer review processes and information reported to licensing boards. If COBs were  
23 proposed to oversee physicians' actions, physicians would undoubtedly object.

24  
25 Again, policy supporting a more holistic approach to policing may be more impactful way for the  
26 AMA to advocate. Specifically, there is a movement underway towards more police coordination  
27 and engagement with communities on the front-end, which allows communities visibility and input  
28 into policing strategies, and elevates them to a meaningful partner in the production of public  
29 safety. Community policing has four important features: community-based crime prevention;  
30 reorientation of patrol activities to emphasize non-emergency servicing; accountability to the  
31 public; and decentralization of command.<sup>64</sup> A community-focused approach has been found to  
32 reduce citizen fear and increase citizen satisfaction, which are often linked to a citizen's perception  
33 of legitimacy of the police.<sup>65</sup> In a short-term study, brief interactions with the police were shown to  
34 improve attitudes towards the police and increase trust of the police.<sup>66</sup>

35  
36 "Community-oriented" policing is on the rise and quickly becoming the dominant philosophy for  
37 policing in America, with over 81 percent of agencies using some community policing  
38 approaches.<sup>67</sup> A 2018 report from the Policing Project at NYU School of Law, Police Foundation,  
39 and National Urban League, however, found that while most law enforcement agencies are taking  
40 steps to build community relations, more can be done. According to this 2018 report, community  
41 members desire more input into department policies and practices.<sup>68</sup> More community involvement  
42 on the front-end could address some of the upstream, systemic issues that lead to racially disparate  
43 policing.

44  
45 In addition to community-oriented policing, improving, and expanding training on procedurally  
46 just policing has been lauded as a strategy for decreasing use-of-force and increasing citizen  
47 satisfaction with police. The "procedural justice" model of policing prioritizes transparency,  
48 explaining policing actions, and responding to community concerns.<sup>69</sup> In Seattle, for example, a  
49 procedural justice training program designed to "slow down" police officers' interaction with  
50 community members reduced use-of-force between 15 and 40 percent.<sup>70</sup> Similarly the National  
51 Academy of Sciences found that large-scale implementation of procedural justice training in

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

6  
7 We recognize, however, that procedurally just policing and community policing must be  
8 accompanied by greater police accountability. Accountability for individual police actions is  
9 essential if police are to effectively and equitably protect all citizens, and if police are to have  
10 legitimacy in the eyes of community members. As discussed above, there is currently insufficient  
11 evidence to support the widescale adoption of police accountability reform proposals that seek to  
12 decentralize disciplinary processes away from internal police mechanisms and instead empower  
13 independent actors (e.g. community boards and courts) with disciplinary authority. Research does,  
14 however, suggest that certain internal accountability mechanisms, such as written policies on use of  
15 force, greater supervision of officers by their supervisors, early intervention systems that identify  
16 officers with patterns of misconduct, and hiring practices that prevent officers who have been  
17 dismissed for misconduct from being unknowingly rehired by other departments, may be effective  
18 at changing individual police conduct.<sup>73</sup> While the AMA is not in a position to determine which  
19 reforms are preferable over others, we do recognize that greater accountability is necessary to end  
20 discriminatory practices and unnecessary or excessive use of police force.

## 21 22 AMA POLICY

23  
24 AMA policy affirms that physical and verbal violence between law enforcement officers and public  
25 citizens, particularly within racial and ethnic minority populations, is a social determinant of  
26 health. Policy further encourages data collections and the study of public health effects of violence  
27 between law enforcement officers and public citizens, particularly within ethnic and racial minority  
28 communities and mandatory reporting of legal intervention deaths and law enforcement officer  
29 homicides to public health agencies (Policy H-515-955, “Research the Effects of Physical or  
30 Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health  
31 Outcomes”).

32  
33 In November 2020, the AMA adopted new policy recognizing police brutality as a manifestation of  
34 structural racism which disproportionately impacts Black, Indigenous, and other people of color  
35 and pledging to work with interested medical societies in a public health effort to support the  
36 elimination of excessive use of force by law enforcement officers. AMA policy also advocates  
37 against the utilization of racial and discriminatory profiling by law enforcement, for appropriate  
38 anti-bias training and individual monitoring, and for trauma-informed, community-based safety  
39 practices (Policy H-65.954, “Policing Reform”).

40  
41 AMA policy supports implementation of law enforcement-based crisis intervention training  
42 programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team  
43 model programs, and federal funding to encourage increased community and law enforcement  
44 participation in crisis intervention training programs. AMA policy also supports evidence-based  
45 training programs for corrections officers on effectively interacting with people with mental health  
46 and other behavioral issues in all detention and correction facilities (Policy H-345.972, “Mental  
47 Health Crisis Interventions”). AMA policy also encourages national standards for school resource  
48 officers to include training and certification in child psychology and development, restorative  
49 justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural  
50 humility, and individual and institutional safety and the development of policies that foster the best  
51 environment for learning through protecting the health and safety of those in school, including

1 students, teachers, staff and visitors (Policy H-60.902, “School Resource Officer Qualifications and  
2 Training”).

3  
4 Several AMA policies directly address law enforcement processes and procedures. AMA policy  
5 does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers,  
6 but as the use of deadly force with the potential to kill and advocates that with all incidents  
7 involving the application of choke and sleeper holds there should be timely medical surveillance of  
8 the inmate (Policy H-430.998, “Use of the Choke and Sleeper Hold in Prisons”). AMA policy  
9 recommends that law enforcement departments and agencies should have in place specific  
10 guidelines, rigorous training, and an accountability system for the use of conducted electrical  
11 devices (CEDs) and encourages evaluation, management, and post-exposure monitoring and  
12 independent research of field deployment of CEDs to better understand the risks and benefits under  
13 conditions of actual use (Policy H-145.977, “Use of Conducted Electrical Devices by Law  
14 Enforcement Agencies”). AMA policy supports expanded use of body-worn cameras for law  
15 enforcement (Policy D-160.919, “Increased Use of Body-Worn Cameras by Law Enforcement  
16 Officers D-160.919). AMA policy advocates for guidelines governing police pursuits and use of  
17 advanced technologies to reduce high-speed chases (Policy H-15.964, “Police Chases and Chase-  
18 Related Injuries H-15.964”). New AMA policy adopted in 2021 supports prohibiting the use of  
19 rubber bullets, chemical irritants, and kinetic impact projectiles to control protests and crowds that  
20 do not pose an immediate threat (Policy H-145.969, “Less-Lethal Weapons and Crowd Control “).  
21 AMA policy also recommends that law enforcement agencies have in place specific guidelines,  
22 rigorous training, and an accountability system for the use of kinetic impact projectiles and  
23 chemical irritants, as well as greater use of de-escalation techniques and the development of crowd-  
24 control techniques which pose a more limited risk of physical harm (Policy H-145.969, “Less-  
25 Lethal Weapons and Crowd Control”).

26  
27 AMA policy opposes the use of the terms “excited delirium,” expresses concern about law  
28 enforcement officer use of force accompanying “excited delirium” that leads to disproportionately  
29 high mortality among communities of color, particularly among Black men, and denounces  
30 “excited delirium” solely as a justification for the use of force by law enforcement officers  
31 (Policy H-130.932, “Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital  
32 Setting”). AMA policy opposes the use of sedative/hypnotic and dissociative agents as a  
33 pharmacological intervention for agitated individuals in the out-of-hospital setting, when done  
34 solely for a law enforcement purpose and recognizes that sedative/hypnotic and dissociative  
35 pharmacological interventions for agitated individuals have significant risks (Policy H-130.932,  
36 “Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital Setting”). AMA  
37 policy also urges training for law enforcement and frontline emergency medical service personnel  
38 on de-escalation techniques and the appropriate use of pharmacological intervention for agitated  
39 individuals (Policy H-130.932, “Pharmacological Intervention for Agitated Individuals in the Out-  
40 of-Hospital Setting”). Finally, AMA policy urges medical and behavioral health specialists, not law  
41 enforcement, to serve as first responders and decision makers in medical and mental health  
42 emergencies in local communities and that administration of any pharmacological treatments in the  
43 out-of-hospital setting be done equitably, in an evidence-based, anti-racist, and stigma-free way  
44 (Policy H-130.932, Pharmacological Intervention for Agitated Individuals in the Out-of-Hospital  
45 Setting”).

#### 46 47 RECOMMENDATIONS

48  
49 The Board recommends that the following be adopted in lieu of the Third, Fourth, and Eighth  
50 Resolve Clauses of Resolution 410-NOV-20, and that the remainder of the report be filed.

- 1 1. That our AMA advocate for efforts to implement evidence-based policing and the creation of  
2 evidence-based standards for law enforcement. (New HOD Policy)  
3
- 4 2. That our AMA advocate for sentinel event reviews in the criminal justice system following an  
5 adverse event, such as an in-custody death. (New HOD Policy)  
6
- 7 3. That our AMA encourage further research by subject matter experts on the issues related to the  
8 transfer of military equipment to law enforcement agencies, including the impact on  
9 communities, particularly those in minoritized and marginalized communities. (New HOD  
10 Policy)  
11
- 12 4. That our AMA support greater police accountability, procedurally just policing models, and  
13 greater community involvement in policing policies and practices. (New HOD Policy)  
14
- 15 5. That Policy H-65.954, "Policing Reform," be reaffirmed. (Reaffirm HOD Policy)  
16
- 17 6. That Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law  
18 Enforcement Officers and Public Citizens on Public Health Outcomes," be reaffirmed.  
19 (Reaffirm HOD Policy)  
20
- 21 7. That Policy H-345.972, "Mental Health Crisis Interventions," be reaffirmed. (Reaffirm HOD  
22 Policy)  
23
- 24 8. That Policy H-145.969, "Less-Lethal Weapons and Crowd Control," be reaffirmed. (Reaffirm  
25 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

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1 INTRODUCTION

2

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

6

7 The following resolves were referred:

8

9 That although our AMA supports all interventional pain interventions and therapies in general,  
10 due to current issues with limitations in coverage and noncoverage, in particular, spine and  
11 large joint radiofrequency ablation and other arbitrarily limited non-covered interventional pain  
12 management procedures, by private insurance carriers, third party reviewing agencies,  
13 Medicare and Medicaid contractors, and Medicare Advantage Plans, the AMA supports  
14 coverage of these medically necessary procedures in particular, at this time; and

15

16 That our AMA supports coverage of evidence-based spinal cord stimulation trials and  
17 implantation, and peripheral nerve stimulation trials and implantation (as both CPT code sets  
18 are linked to their respective ICD10 codes as outlined in the AMA CPT Manual) by private  
19 insurance carriers, third party reviewing agencies, Medicare and Medicaid contractors, and  
20 Medicare Advantage Plans.

21

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

30

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

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

10  
11 Our AMA will: (1) advocate for increased access and coverage of non-opioid treatment  
12 modalities including pharmaceutical pain care options, interventional pain management  
13 procedures, restorative therapies, behavioral therapies, physical and occupational therapy, and  
14 other evidence-based therapies recommended by the patient’s physician; (2) advocate for non-  
15 opioid treatment modalities being placed on the lowest cost-sharing tier for the indication of  
16 pain so that patients have increased access to evidence-based pain care as recommended by the  
17 HHS Interagency Pain Care Task Force; and (3) encourage the manufacturers of  
18 pharmaceutical pain care options to seek DEA approval for additional indications related to  
19 non-opioid pain management therapy.  
20

21 On their face, the referred resolves involve the same type of highly specific medical procedures and  
22 payer responsibilities for those procedures that were at issue in original Resolutions 218 and 235.  
23 This report will provide background on the issues presented, discuss relevant AMA policy and  
24 provide recommendations.  
25

## 26 DISCUSSION

27  
28 One of the most common elements of the nation’s opioid epidemic has been for policymakers and  
29 public health officials to largely bypass the fact that improving pain care for America’s patients is  
30 integral to ending the nation’s opioid epidemic. The AMA has long called for the balance needed  
31 between policymaking intended to address the opioid epidemic with medical evidence, policy and  
32 patient compassion—alongside the reality that there are millions of patients in pain, and that the  
33 opioid epidemic has fully shifted to one driven by illicitly manufactured fentanyl, fentanyl analogs,  
34 heroin, cocaine and methamphetamine. While policymakers have almost entirely focused on opioid  
35 prescribing, physicians and other health care professionals on a national level began to make more  
36 judicious opioid prescribing decisions in 2012-13. Part of that decision-making process, however,  
37 must not discount the clinical experience that opioid therapy works for many patients. It also must  
38 not discount the practical reality faced by physicians and patients daily that if opioid therapy is not  
39 the preferred course of treatment, patients must have access to affordable, available non-opioid  
40 treatment options supported by medical evidence.  
41

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

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

5  
6 The recent advent of retail pharmacies limiting the duration of prescriptions, making changes  
7 to dosage, amounts, or placing restrictive barriers to obtaining properly prescribed pain  
8 medications has had the unintended consequence of limiting access to pain care. Without  
9 access to sufficient pain care, many patients face unnecessary medical complications,  
10 prolonged suffering, and increased risk for psychiatric conditions.  
11

12 The AMA is deeply concerned that corporate and retail pharmacy and PBM practices are having  
13 the unintended consequence of limiting access to pain care—leading to medical complications,  
14 heightened stigma and increased pain. These combined payer, pharmacy chain and PBM policies  
15 need further investigation and rescission to help ensure patients with pain can receive the type of  
16 comprehensive, multidisciplinary, multimodal care that pain experts support, and patients deserve.  
17 This applies to a broad range of evidence-based restorative therapies, interventional procedures,  
18 behavioral health approaches and complementary and integrative health strategies. More than 90  
19 percent of pain medicine specialists said that they have been required to submit a prior  
20 authorization for non-opioid pain care—with them and their staff spending hours per day on these  
21 requests.<sup>3</sup>  
22

23 The AMA Opioid Task Force (Task Force) broadly supports access to the treatments prescribed  
24 and recommended by a patient’s physician for pain-related care. The Task Force included, among  
25 its first recommendations, support for physicians who treat patients with pain. The Task Force  
26 recommended support for patients’ and physicians’ access to comprehensive, affordable,  
27 compassionate treatment, including a comprehensive, multidisciplinary, multimodal approach to  
28 pain management. The Task Force emphasized that, “[t]his means that payers and employers need  
29 to improve access to non-opioid and non-pharmacologic treatment for pain.”<sup>4</sup>  
30

31 The Task Force furthered its 2015 recommendation on comprehensive pain care in 2019, urging  
32 additional action by policymakers. The recommendation emphasized the need to, “[r]emove  
33 administrative and other barriers to comprehensive, multimodal, multidisciplinary pain care and  
34 rehabilitation programs.”<sup>5</sup> In part, the 2019 recommendation responded to the fact that physicians  
35 had reduced opioid prescribing by 33 percent between 2013-18, but many patients receiving opioid  
36 therapy—and part of stable, ongoing care—found themselves subject to payer, chain pharmacy,  
37 PBM and state legislative policies that either strongly encouraged or required quantity and/or  
38 dosage restrictions on opioid analgesics.  
39

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

1 There is no question that the nation’s physicians have reduced opioid analgesic supply—both in  
2 volume and dose strength—but there has not been a concomitant increase in access to or  
3 affordability of evidence-based non-opioid alternatives. This includes medication, including non-  
4 opioid pain relievers, anticonvulsants, antidepressants, musculoskeletal agents, anxiolytics, as well  
5 as opioid analgesics when appropriate. It includes restorative therapies such as physical therapy,  
6 occupational therapy, physiotherapy, therapeutic exercise, osteopathic manipulative therapy (OMT)  
7 and other modalities such as massage and therapeutic ultrasound. It also includes interventional  
8 procedures, such as neuromodulation, radio frequency ablation, peripheral nerve stimulation,  
9 central and peripheral nerve ablation, spine surgery and steroid injections and other emerging  
10 interventional therapies as part of the multimodal pain care plan.  
11

12 The Board notes that these are among the therapies pain specialists use but are routinely subject to  
13 prior authorization and other utilization management protocols imposed by payers.<sup>6</sup> In urging the  
14 U.S. Centers for Disease Control and Prevention to help reduce payer-imposed barriers to  
15 comprehensive pain care, AMA Executive Vice President and CEO, James L. Madara, MD,  
16 explained that, “[i]t is challenging for physicians to be directed by the federal government to  
17 increase access to nonopioid pain care options when payers and PBMs make that difficult, to  
18 impossible, to achieve.”<sup>7</sup>  
19

20 As the above discussion makes clear, the AMA already strongly supports broad access to the types  
21 of therapies called for under both the original resolutions and the referred resolves. The Board  
22 notes that the policy approved by the HOD at A-19 were a direct response to avoiding having  
23 AMA policy focus too narrowly on one type of therapy. The Board is concerned that in focusing  
24 too intently on one type of therapy, it potentially raises the risk of excluding other types of non-  
25 opioid pain care as part of AMA advocacy. For example, if a payer decided to remove prior  
26 authorization and other barriers to the therapies in the referred resolves, they could argue that they  
27 have satisfied AMA policy without enhancing access to the much more robust areas of non-opioid  
28 pain care used by physicians.  
29

30 In addition to the overly narrow focus on specific therapies in the referred resolves, the Board also  
31 is concerned by the overly vague nature of “coverage,” as it is presented in the referred resolves. It  
32 is not clear from the testimony or the language of the resolves referred precisely what is meant by  
33 “coverage” as that is a term of art used by CMS. Specifically, CMS has processes for the  
34 development of National Coverage Determinations (NCD) and Local Coverage Determinations  
35 (LCD), both of which require extensive levels of evidence and consideration by CMS.<sup>8</sup> There also  
36 is separate CMS policy and processes for trials of a particular service. It is far beyond the scope of  
37 this report to delve into whether the procedures named in the referred resolves have the requisite  
38 levels of outcomes data, evidence and other criteria needed by CMS as part of the NCD, LCD or  
39 other coverage determination. Thus, while the Board supports the underlying intent of the original  
40 resolutions and the referred resolves to help ensure patients have access to the therapies  
41 recommended by their physician, and the Board would almost certainly support actions by CMS to  
42 remove barriers to those therapies, the Board is not aware that CMS has been presented with  
43 applications or other information as part of an NCD or LCD. It is challenging, to say the least, to  
44 suggest that the AMA should support an NCD or LCD without having access to the data and other  
45 information required by CMS. This is not to suggest that the AMA does not support patients  
46 receiving those therapies, but it is premature to suggest AMA support for a specific NCD or LCD  
47 for a specific therapy at this time.  
48

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

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

7  
8 **AMA POLICY**

9  
10 As discussed thoroughly above, AMA has comprehensive policy in support of ensuring patients  
11 have access to the pain care therapies and modalities recommended by their physician. This  
12 includes advocating for, “increased access and coverage of non-opioid treatment modalities  
13 including pharmaceutical pain care options, interventional pain management procedures,  
14 restorative therapies, behavioral therapies, physical and occupational therapy, and other evidence-  
15 based therapies recommended by the patient’s physician,” as well as, “non-opioid treatment  
16 modalities being placed on the lowest cost-sharing tier for the indication of pain so that patients  
17 have increased access to evidence-based pain care as recommended by the HHS Interagency Pain  
18 Care Task Force. (Policy H-120.922, “Improved Access and Coverage to Non-Opioid Modalities to  
19 Address Pain”)

20  
21 Similar AMA policy stresses, “ensuring access to multiple analgesic strategies, including non-  
22 opioid options and interventional approaches when appropriate, with a focus on achieving  
23 improvement in function and activities of daily living.” (Policy H-185.931, “Workforce and  
24 Coverage for Pain Management”) Notably, AMA policy supports, “health insurance coverage that  
25 gives patients access to the full range of evidence-based chronic pain management modalities, and  
26 that coverage for these services be equivalent to coverage provided for medical or surgical  
27 benefits.” (Policy H-185.931, “Workforce and Coverage for Pain Management”)

28  
29 Interventional chronic pain management means the diagnosis and treatment of pain-related  
30 disorders with the application of interventional techniques in managing sub-acute, chronic,  
31 persistent and intractable pain. The practice of pain management includes comprehensive  
32 assessment of the patient, diagnosis of the cause of the patient's pain, evaluation of alternative  
33 treatment options, selection of appropriate treatment options, termination of prescribed treatment  
34 options when appropriate, follow-up care, the diagnosis and management of complications and  
35 collaboration with other health care providers.

36  
37 When AMA policy does discuss invasive pain management procedures or techniques—unlike the  
38 referred resolves—AMA policy appropriately provides for a wide range, including but not limited  
39 to “ablation of targeted nerves; procedures involving any portion of the spine, spinal cord,  
40 sympathetic nerves or block of major peripheral nerves, including percutaneous precision needle  
41 placement within the spinal column with placement of drugs such as local anesthetics, steroids, and  
42 analgesics, in the spinal column under fluoroscopic guidance or any other radiographic or imaging  
43 modality; and surgical techniques, such as laser or endoscopic discectomy, or placement of  
44 intrathecal infusion pumps, and/or spinal cord stimulators.” (Policy H-410.950, “Pain  
45 Management”)

46  
47 **RECOMMENDATION**

48  
49 The Board recommends that the referred resolves in Alternate Resolution 218-A-19 not be adopted  
50 and the remainder of the report be filed.

Fiscal Note: None

## REFERENCES

- <sup>1</sup>. 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.
- <sup>2</sup>. U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website: <https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html>
- <sup>3</sup>. Second Annual Survey of Pain Medicine Specialists Highlights Continued Plight of Patients with Pain and Barriers to Providing Non-Opioid Care. American Board of Pain Medicine (ABPM). November 11, 2019. Available at <http://abpm.org/uploads/files/abpm%20survey%202019-v3.pdf>
- <sup>4</sup>. AMA Opioid Task Force 2015 recommendations. Available at <https://www.end-opioid-epidemic.org/wp-content/uploads/2019/05/AMA-Task-Force-to-Reduce-Opioid-Abuse-Overview-updated-June-2019-one-pager.pdf>
- <sup>5</sup>. AMA Opioid Task Force 2019 recommendations. Available at <https://www.end-opioid-epidemic.org/wp-content/uploads/2019/05/2019-AMA-Opioid-Task-Force-Recommendations-FINAL.pdf>
- <sup>6</sup>. See ABPM survey, note 3.
- <sup>7</sup>. 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>
- <sup>8</sup>. 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

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## 1 INTRODUCTION

2  
3 At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates  
4 (HOD) referred Resolution 219-A-19, “Medical Marijuana License Safety,” introduced by the  
5 Oklahoma delegation, which asked:

6  
7 That our American Medical Association draft model state legislation to amend states’  
8 prescription drug monitoring programs to include a medical marijuana license registry.  
9

10 Testimony on Resolution 219 raised numerous issues, including increasing legalization of medical  
11 and recreational cannabis; concerns about cannabis use by patients with—or without—a  
12 physician’s knowledge; how medical marijuana license registries function in select states; and the  
13 potential intersection with and appropriate role(s) of a state prescription drug monitoring program  
14 (PDMP). This report provides relevant background and discussion, a review of relevant AMA  
15 policy and makes policy recommendations.  
16

## 17 BACKGROUND

18  
19 It is likely that any patient who sees a physician will be asked for a current list of any medications,  
20 supplements, herbal remedies or other substances being taken. This information is essential to  
21 ensure the physician has complete and accurate information that may be relevant to a patient’s  
22 diagnosis and treatment options for any given ailment or disease.  
23

24 The U.S. Food and Drug Administration (FDA) is charged with, among other things, reviewing  
25 new drug applications, including making recommendations about a drug’s scheduling. The U.S.  
26 Drug Enforcement Administration (DEA) receives that recommendation and is charged with  
27 determining the drug’s schedule or changing an existing drug’s schedule. Cannabis (also referred to  
28 as marijuana or marihuana by DEA), contains the active ingredient delta-9-tetrahydrocannabinol  
29 (THC) and is a Schedule I controlled substance.<sup>1</sup> This means that under federal law, there is “no  
30 currently accepted medical use in the United States, a lack of accepted safety for use under medical  
31 supervision, and a high potential for abuse.” Other Schedule I substances include heroin, LSD,  
32 peyote, methamphetamine and Ecstasy.<sup>2</sup>  
33

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

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

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

- 13  
14 • California established a voluntary, web-based registry to allow law enforcement and  
15 the general public to verify the validity of a medical marijuana identification card for  
16 a patient. The registry is maintained by the California Department of Public Health.<sup>6</sup>  
17 • Colorado’s web-based registry allows patients to apply for an identification card as  
18 well as allows so-called “medical marijuana centers” to check whether a card has  
19 been revoked. It also has functionality to allow law enforcement to verify a card’s  
20 validity among other features.<sup>7</sup>  
21 • Ohio patients seeking medical marijuana must first have a certified physician submit  
22 information to the registry—after which the patient will receive an email prompting  
23 the patient to complete their application and pay a \$50 fee.<sup>8</sup>  
24 • North Dakota’s patient registry requires patients to apply online, including uploading  
25 a photo, in which the state requires eyes to be open and indicates further that  
26 applicants should, “[a]void wearing dark, tinted glasses, hats or head coverings when  
27 taking the photo.”<sup>9</sup>

28  
29 These examples are not meant to be representative of all patient registries. Most patient registries  
30 also include information about whether the patient has a qualifying medical condition, which might  
31 include AIDS, amyotrophic lateral sclerosis, Alzheimer’s disease, cancer, chronic traumatic  
32 encephalopathy, Crohn’s disease, epilepsy or another seizure disorder, fibromyalgia, glaucoma,  
33 hepatitis C, inflammatory bowel disease, multiple sclerosis, pain that is either chronic and severe or  
34 intractable, Parkinson’s disease, positive HIV status, post-traumatic stress disorder, sickle cell  
35 anemia, spinal cord disease or injury, Tourette’s syndrome, traumatic brain injury and/or ulcerative  
36 colitis.

37  
38 Nearly every state has a PDMP<sup>10</sup> that includes information about controlled substances dispensed  
39 to patients, as well physicians’ and other health care professionals’ controlled substances  
40 prescribing history. The pharmacist (or other dispenser) is typically required to submit certain  
41 information to the PDMP, as well. This typically includes a patient’s name, date of birth, address,  
42 contact information, physician’s DEA registration or National Provider Identifier, dose and  
43 quantity of the prescription and potentially a wide variety of information ranging from the site from  
44 which the prescription was issued, type of identification and whether the prescription was for a  
45 human or animal subject.<sup>11</sup>

46  
47 Nearly every state has the ability to share PDMP data across state lines.<sup>12</sup> Nearly all PDMPs are  
48 administered by the state board of pharmacy. While there is some variation in state law and policy,  
49 most state PDMPs contain Schedule II-V information. This information is generally viewed as  
50 helpful clinical information for health care professionals. Encouraging physicians to register for

1 and use state PDMPs when clinically indicated was one of the first recommendations of the AMA  
2 Opioid Task Force (the Task Force) in 2015.<sup>13</sup>

3  
4 DISCUSSION

5  
6 Most physicians agree that PDMPs have the capability to provide relevant clinical information for  
7 physicians and other health care professionals as part of the clinical decision-making process. The  
8 Task Force identified many of the useful features of a state-based PDMP in its first  
9 recommendations in 2015.<sup>14</sup> The Task Force emphasized the need for PDMPs to be integrated into  
10 clinical workflow, including having the PDMP data easily accessible in the electronic health record  
11 (EHR) without having to perform multiple clicks, enter multiple passwords, close and open  
12 multiple screens and other time-consuming barriers to PDMP use. While this has occurred in some  
13 settings, and is improving in others, it is not the norm.

14  
15 Despite the barriers to PDMP use, registration and use of state-based PDMPs has significantly  
16 increased. Registration increased to nearly 2 million physicians and other health care professionals  
17 in 2019—almost a 300 percent increase from 2014; and PDMP queries have increased more than  
18 1,100 percent during the same time period to more than 739 million.<sup>15</sup> It is worth noting that while  
19 most states now have a legislative mandate to use a PDMP in certain circumstances, voluntary  
20 PDMP registration and use began to increase prior to those mandates taking effect.

21  
22 What is less clear, however, is whether the increased registration and use has led to improved  
23 patient outcomes, reduced opioid- and drug-related mortality, an increase in referrals for treatment  
24 of a substance use disorder or any other potential benefits of a PDMP.<sup>16</sup> It is also not clear whether  
25 any state PDMP already includes information regarding cannabis use. As noted above, with only  
26 four exceptions, cannabis, cannabis-derived and cannabinoid products remain Schedule I controlled  
27 substances and are not included in any state PDMP law. Resolution 219-A-19 is accurate in the  
28 assumption that state laws would need to be changed to allow for a Schedule I controlled substance  
29 to be part of the information captured into a state PDMP.

30  
31 Another possibility is to somehow merge the information that is contained in a medical marijuana  
32 patient registry with a state PDMP. The technical aspects of such an endeavor are beyond the scope  
33 of the report, but even a cursory review of state PDMPs and medical marijuana patient registries  
34 reveals that the underlying software development and database management appear to be different  
35 in most states, including the fact that the state pharmacy board is typically not the state agency that  
36 administers the medical marijuana patient registry.

37  
38 In addition, it is not clear if merging PDMPs and medical marijuana patient registries would further  
39 allow law enforcement to make inquiries into a state PDMP. Not only does this raise potential  
40 conflicts with AMA policy as detailed below, but it is unclear what precisely would be entered into  
41 the PDMP. Proponents of including medical marijuana registry information suggest that physicians  
42 should have information that a patient has registered for and received authorization to possess,  
43 obtain or purchase medical marijuana. On the surface, this sounds like a reasonable position.

44  
45 Data does not exist, however, on how law enforcement currently uses medical marijuana patient  
46 registry information. Data also does not exist on what physicians might do with this information.  
47 The AMA Board of Trustees (the Board) is concerned that adding more information to a state  
48 PDMP without appropriate safeguards to ensure patient privacy could expose patients' personal  
49 health information to law enforcement in ways that could be detrimental. The mere existence of a  
50 patient's registration for medical marijuana should not be used as pretext for law enforcement to  
51 conduct unfettered searches in a patient's or physician's PDMP record.<sup>17</sup>

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

9  
10 The other side to this argument is that medical diagnosis, treatment and management of disease are  
11 improved when the physician has access to all relevant information about his or her patient. This  
12 certainly includes whether a patient is using cannabis for medicinal or recreational use, as well as  
13 whether a physician has certified that a patient has one or more of the medical conditions that a  
14 state has determined qualify the patient to use cannabis for medicinal purposes. Data is not clear as  
15 to whether a patient’s primary care physician is the one who is typically certifying the patient. If  
16 not, what happens when the primary physician—if reviewing new medical marijuana patient  
17 registry data—newly discovers that the patient has been certified for a serious medical condition?  
18 What effect(s) would this have on the patient-physician relationship? In addition to the above  
19 concerns, the Board notes that there is nothing currently preventing a physician from asking about  
20 these issues and that a fully functioning EHR could help resolve incomplete information about the  
21 patient’s medical history.

22  
23 While EHRs continue to improve, full integration with PDMPs remains a work-in-progress. In  
24 addition, the challenges with data integration would likely be increased significantly given that  
25 medical marijuana patient registry data are housed in agencies separate from those administering  
26 state PDMPs. It also is not clear what data would be integrated into a state PDMP from the registry.  
27 What would law enforcement’s access be? Do the potential unintended consequences of listing  
28 patient’s certification for medicinal cannabis outweigh the potential benefits for the physician and  
29 other health care professionals knowing that a patient has been certified? These are among the  
30 many questions for which clinical experience, medical evidence and objective data do not exist.  
31 Therefore, while the Board supports efforts to ensure physicians have all relevant information  
32 about their patients’ potential use of cannabis for medicinal use, based on the above discussion and  
33 potential unintended consequences, it is premature to recommend developing model legislation.

#### 34 35 AMA POLICY

36  
37 AMA policy on the use of cannabis for medicinal use provides well-established balance for patient  
38 safety, autonomy and assurances for free and unfettered communication between the patient and  
39 his or her physician (Policy D-95.969, “Cannabis Legalization for Medicinal Use”).

40  
41 With appropriate patient privacy safeguards, the AMA also has strongly advocated in support of  
42 PDMPs sharing information on prescriptions for controlled substances among states (Policy  
43 H-95.947, “Prescription Drug Monitoring to Prevent Abuse of Controlled Substances”). This  
44 includes strong support for having PDMPs administered by, “a state agency whose primary  
45 purpose and mission is health care quality and safety rather than a state agency whose primary  
46 purpose is law enforcement or prosecutorial,” to help ensure the information “is protected from  
47 release outside of the health care system” (Policy H-95.946, “Prescription Drug Monitoring  
48 Program Confidentiality”).

49  
50 The AMA has advocated for the benefits of PDMPs and “supports the voluntary use of state-based  
51 prescription drug monitoring programs (PDMP) when clinically appropriate.” Recognizing the

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

5

6 RECOMMENDATIONS

7

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

10

- 11 1. That our American Medical Association (AMA) support efforts to limit information about  
12 medical cannabis in states’ prescription drug monitoring programs to only whether a patient  
13 has been certified to receive medicinal cannabis consistent with AMA principles safeguarding  
14 patient privacy and confidentiality; (New HOD Policy)
- 15
- 16 2. That our AMA continue its monitoring of state legislation relating to the inclusion of cannabis  
17 and related information in state PDMPs. (Directive to Take Action)

Fiscal Note: Less than \$500.

## REFERENCES

1. U.S. Drug Enforcement Administration. Controlled Substances by CSA Schedule. Available at [https://www.deadiversion.usdoj.gov/schedules/orangebook/e\\_cs\\_sched.pdf](https://www.deadiversion.usdoj.gov/schedules/orangebook/e_cs_sched.pdf)
2. U.S. Drug Enforcement Administration. Schedule I Controlled Substances. Available at <https://www.deadiversion.usdoj.gov/schedules/>
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](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.cmadoes.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

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1 INTRODUCTION

2  
3 At the 2019 Annual Meeting, the American Medical Association (AMA) House of Delegates  
4 (HOD) considered Resolution 226, “Physician Access to their Medical and Billing Records,”  
5 introduced by the New York Delegation, which asked:

- 6  
7 1. The American Medical Association (AMA) advocate that licensed physicians  
8 must always have access to all medical and billing records for their patients from  
9 and after date of service including after physician termination.  
10  
11 2. The AMA press for legislation or regulation to eliminate contractual language  
12 that bars or limits the treating physician’s access to the medical and billing  
13 records such as treating these records as trade secrets or proprietary.  
14

15 The HOD heard positive testimony that the AMA has strong policy regarding physician access and  
16 management of medical records. Also, testimony was given that the AMA has model state  
17 legislation regarding physician employment including a provision that a “physician is entitled to  
18 copies of patient charts and any other records relating to the physician’s provision of physician  
19 services.” The Council on Legislation (COL) testified, however, that the COL is currently  
20 examining issues surrounding data ownership and stewardship. AMA policy is limited in scope to  
21 the physician-patient relationship and a paradigm shift is occurring where patient information is  
22 being viewed as a patient-centered concept and information from outside of the physician-patient  
23 relationship is growing. Additionally, the COL testified that the first resolve is too broad because a  
24 patient may not want a physician to have access to or share all of the patient’s medical and billing  
25 information for unrelated care that occurs outside of a specific physician-patient relationship. As a  
26 result, Resolution 226 was referred.  
27

28 DISCUSSION

29  
30 Resolution 226 raises very significant concerns regarding potential physician liability for non-  
31 compliance with federal and state laws regarding claims for payment submitted on behalf of the  
32 physician. For example, as the Office of the Inspector General of the U.S. Department of Health  
33 and Human Services stated, “Physicians should remember that they remain responsible to the  
34 Medicare program for bills sent in the physician’s name or containing the physician’s signature,  
35 even if the physician had no actual knowledge of a billing impropriety.”<sup>1</sup> Accordingly, AMA  
36 policy states that: “Employed physicians have a responsibility to assure that bills issued for  
37 services they provide are accurate and should therefore retain the right to review billing claims as

1 may be necessary to verify that such bills are correct.”<sup>2</sup> A physician’s inability to access billing  
2 records and associated medical records sufficient to monitor compliance with legal and other  
3 requirements can potentially expose the physician to severe penalties.

4  
5 *Resolution 226 First Resolve*

6  
7 Given the importance of the issues that Resolution 226 raises, the Board of Trustees (Board)  
8 believes that the AMA should engage in advocacy that addresses these issues, with a few  
9 qualifications. One qualification concerns the breadth of the advocacy to which the first resolve  
10 would commit the AMA. As reference committee testimony noted, the first resolve would require  
11 the AMA to advocate that physicians have access to all of a patient’s medical and billing records.  
12 A patient may not want a physician to have access to or share all of their medical and billing  
13 information for unrelated care that occurs outside of a specific physician-patient relationship. The  
14 Board agrees with this testimony. Accordingly, the Board recommends that the AMA advocate that  
15 physicians have access to their billing records and associated patients’ medical records, but not that  
16 physicians have access to *all* of those records. The records should also include any billing records  
17 submitted under the physician’s name, regardless of whether the physician directly provided the  
18 item or service.

19  
20 Although the Board obviously believes that physicians must always have immediate access to the  
21 medical records of patients under their care, the Board does not recommend that the AMA  
22 advocate that physicians must always have access to their billing records and associated medical  
23 records. Instead, the Board recommends that, following Medicare reassignment regulations, the  
24 AMA should advocate that physicians have “unrestricted access” to their billing records and related  
25 medical records. Medicare reassignment regulations require an entity, e.g., physician practice or  
26 hospital, that submits claims on a physician’s behalf give the physician unrestricted access to those  
27 claims.<sup>3</sup> The Board recommends this approach for two reasons.

28  
29 First, while the Centers for Medicare and Medicaid Services (CMS) has provided at least some  
30 informal guidance concerning what “unrestricted access” means, the first resolve does not define  
31 “always.” Taken literally, if the HOD adopted the first resolve as written, “always” could be read to  
32 require the AMA to advocate that entities, e.g., physician practices, must give employed and  
33 contracted physicians immediate access to their billing records and associated medical records at  
34 all times. Such an access requirement would likely impose a significant and unnecessary  
35 administrative burden on at least some physician practices or other physician-led entities. In  
36 contrast, CMS informally interprets “unrestricted access” to mean that an entity may not  
37 reasonably refuse or delay access to billing records. CMS has declined to define how quickly an  
38 entity must give the physician access to his or her billing records after receiving a request, or when  
39 an entity may reasonably refuse to provide access, e.g., when a physician already has the records.<sup>4</sup>  
40 Instead, CMS suggests that entities use “common sense.”<sup>5</sup> Although CMS’ interpretation of  
41 “unrestricted access” may not be highly specific, it does appear to provide more direction for AMA  
42 advocacy than “always,” allows for flexibility and is thus not as likely to impose as great an  
43 administrative burden on physician practices or other physician organizations as the undefined term  
44 “always” might have.

45  
46 Second, requiring the AMA to advocate for an access standard other than “unrestricted access”  
47 could subject physician practices to an additional administrative burden. Medicare’s “unrestricted  
48 access” requirement has been in place for independent physician contractors since 2004 and  
49 physician employees since 2006.<sup>6</sup> Physician practices and other physician-led organizations may  
50 have long-standing policies and procedures in place delineating how their organizations comply  
51 with the unrestrictive access requirement. Asking the AMA to advocate for an access different

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

3  
4 Finally, the first resolve asks the AMA to advocate that licensed physicians always have access to  
5 all medical and billing records for their patients. . .including after termination. The Board does not  
6 believe that the AMA should advocate that entities like physician practices and physician-led  
7 organizations incur the administrative burden of an unlimited obligation to provide billing records  
8 to physicians after employment or an independent contract has ended, e.g., merely upon request of  
9 the physician. Instead, the Board recommends that the AMA adopt policy stating that, after  
10 termination of employment or other contractual arrangement, physicians should be given access to  
11 their billing records and associated medical records analogous to AMA policy with regard to post-  
12 termination access to patient medical records. Policy H-225.950 “AMA Principles for Physician  
13 Employment,” states in part:

14  
15       Where physician possession of all medical records of his or her patients is not already required  
16 by state law, the employment agreement should specify that the physician is entitled to copies  
17 of patient charts and records upon a specific request in writing from any patient, or when such  
18 records are necessary for the physician's defense in malpractice actions, administrative  
19 investigations, or other proceedings against the physician.<sup>7</sup>

20  
21 Absent state law or a patient request, Policy H-225.950 does not state that after termination, the  
22 physician should be given access to all of his or her patients’ medical records. Instead, the  
23 physician should be given patient medical records when necessary for the physician’s defense in  
24 malpractice actions, administrative investigations or other proceedings against the physician. The  
25 Board recommends adopting new policy taking a similar approach, namely, that a physician  
26 employer or other entity that bills on behalf of an employed or contracted physician should, post-  
27 employment or contract, be obligated to provide the physician with his or her billing records when  
28 necessary to defend malpractice actions, administrative investigations or other proceedings against  
29 the physician. Taking this approach would reduce the burden that an open-ended obligation might  
30 create for physician-owned or led entities and be consistent with existing AMA policy.

31  
32 *Resolution 226 Second Resolve*

33  
34 With regard to the second resolve, the Board agrees that the AMA should advocate that medical  
35 records and billing records should not be kept from a physician on the grounds that those records  
36 are proprietary or constitute trade secrets. This is particularly true given the physician’s need to  
37 ensure compliance with fraud and abuse laws, which outweigh any countervailing concerns  
38 regarding privilege or secrecy.

39  
40 *Model State Legislation*

41  
42 The Board has adopted state model legislation entitled the “Physician Access to Medical and  
43 Billing Records Act” to advocate as outlined in this board report. Any AMA member can access  
44 this model bill by e-mailing [arc@ama-assn.org](mailto:arc@ama-assn.org).

45  
46 **AMA POLICY**

47  
48 The AMA has several policies addressing issues that Resolution 226 raises. Policy H-190.971,  
49 “Physicians’ Right to Receive Billing and Remittance Information,” states that all physicians are  
50 entitled to receive detailed itemized billing and remittance information for medical services they  
51 provide, and that the AMA develop strategies to assist physicians who are denied such information.

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

17

18 RECOMMENDATIONS

19

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

22

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

29

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

38

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

Fiscal Note: Less than \$500

REFERENCES

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

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

#### 4. Hospital Medical Staff Relations

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

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

#### 5. Peer Review and Performance Evaluations

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

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

#### 6. Payment Agreements

- a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.
- b) Employed physicians have a responsibility to assure that bills issued for services they provide are accurate and should therefore retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.  
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

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1 INTRODUCTION

2  
3 Resolution 207-A-19, “Direct-to-Consumer Genetic Tests,” which was introduced by the Illinois  
4 Delegation and referred by the House of Delegates, asked that:

5  
6 Our American Medical Association regard research using consumer genome data derived from  
7 saliva or cheek swab samples as research on human subjects requiring consents in compliance  
8 with the Health and Human Services (HHS) Office for Human Research Protection (OHRP),  
9 and recommend an “opt in” option to allow more consumer choice in the consent process;

10  
11 Our AMA amend Policy H-315.983, “Patient Privacy and Confidentiality,” by addition to align  
12 with current research and privacy infringement findings, as follows:

13  
14 1. Our AMA affirms the following key principles that should be consistently implemented to  
15 evaluate any proposal regarding patient privacy and the confidentiality of medical information:  
16 (a) That there exists a basic right of patients to privacy of their medical information and  
17 records, and that this right should be explicitly acknowledged; (b) That patients' privacy should  
18 be honored unless waived by the patient in a meaningful way or in rare instances when strong  
19 countervailing interests in public health or safety justify invasions of patient privacy or  
20 breaches of confidentiality, and then only when such invasions or breaches are subject to  
21 stringent safeguards enforced by appropriate standards of accountability; (c) That patients'  
22 privacy should be honored in the context of gathering and disclosing information for clinical  
23 research and quality improvement activities, and that any necessary departures from the  
24 preferred practices of obtaining patients' informed consent and of de-identifying all data be  
25 strictly controlled; (d) That any information disclosed should be limited to that information,  
26 portion of the medical record, or abstract necessary to fulfill the immediate and specific  
27 purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of  
28 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of  
29 where care is received, while working with the Department of Health and Human Services  
30 (HHS) to stop the transfer of birthdates and state of residence by genetic testing companies and  
31 their affiliates, unless there is explicit user approval, to prevent re-identification of the test user  
32 by way of surname inference methods.

33 2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to  
34 the same right to privacy and confidentiality of personal medical information and medical  
35 records as other patients, (b) that when patients exercise their right to keep their personal  
36 medical histories confidential, such action should not be regarded as fraudulent or  
37 inappropriate concealment, and (c) that physicians and medical students should not be required

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

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

13  
14 4. Whenever possible, medical records should be deidentified for purposes of use in connection  
15 with utilization review, panel credentialing, quality assurance, and peer review.

16  
17 5. The fundamental values and duties that guide the safekeeping of medical information should  
18 remain constant in this era of computerization. Whether they are in computerized or paper  
19 form, it is critical that medical information be accurate, secure, and free from unauthorized  
20 access and improper use.

21  
22 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part  
23 of the medical record, be maintained.

24  
25 7. Genetic information should be kept confidential and should not be disclosed to third parties  
26 without the explicit informed consent of the tested individual. Our AMA regards studies using  
27 consumer genome data derived from saliva, cheek swab, or other human tissue samples as  
28 research on human subjects requiring consents in compliance with the HHS Office for Human  
29 Research Protections (OHRP). An "opt in" option is recommended to allow more consumer  
30 choice in the consent process.

31  
32 8. When breaches of confidentiality are compelled by concerns for public health and safety,  
33 those breaches must be as narrow in scope and content as possible, must contain the least  
34 identifiable and sensitive information possible, and must be disclosed to the fewest possible to  
35 achieve the necessary end.

36  
37 9. Law enforcement agencies requesting private medical information should be given access to  
38 such information only through a court order. This court order for disclosure should be granted  
39 only if the law enforcement entity has shown, by clear and convincing evidence, that the  
40 information sought is necessary to a legitimate law enforcement inquiry; that the needs of the  
41 law enforcement authority cannot be satisfied by non-identifiable health information or by any  
42 other information; and that the law enforcement need for the information outweighs the privacy  
43 interest of the individual to whom the information pertains. These records should be subject to  
44 stringent security measures.

45  
46 10. Our AMA must guard against the imposition of unduly restrictive barriers to patient  
47 records that would impede or prevent access to data needed for medical or public health  
48 research or quality improvement and accreditation activities. Whenever possible, de-identified  
49 data should be used for these purposes. In those contexts where personal identification is  
50 essential for the collation of data, review of identifiable data should not take place without an  
51 institutional review board (IRB) approved justification for the retention of 43 identifiers and

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

3  
4 11. Marketing and commercial uses of identifiable patients' medical information may violate  
5 principles of informed consent and patient confidentiality. Patients divulge information to their  
6 physicians only for purposes of diagnosis and treatment. If other uses are to be made of the  
7 information, patients must first give their uncoerced permission after being fully informed  
8 about the purpose of such disclosures.

9  
10 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups  
11 and the public health community, should continue its advocacy for privacy and confidentiality  
12 regulations, including: (a) The establishment of rules allocating liability for disclosure of  
13 identifiable patient medical information between physicians and the health plans of which they  
14 are a part, and securing appropriate physicians' control over the disposition of information from  
15 their patients' medical records. (b) The establishment of rules to prevent disclosure of  
16 identifiable patient medical information for commercial and marketing purposes; and (c) The  
17 establishment of penalties for negligent or deliberate breach of confidentiality or violation of  
18 patient privacy rights.

19  
20 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and  
21 policymakers at all levels of government about concerns and complexities of patient privacy  
22 and confidentiality in the variety of contexts mentioned.

23  
24 14. Disclosure of personally identifiable patient information to public health physicians and  
25 departments is appropriate for the purpose of addressing public health emergencies or to  
26 comply with laws regarding public health reporting for the purpose of disease surveillance.

27  
28 15. In the event of the sale or discontinuation of a medical practice, patients should be notified  
29 whenever possible and asked for authorization to transfer the medical record to a new  
30 physician or care provider. Only de-identified and/or aggregate data should be used for  
31 "business decisions," including sales, mergers, and similar business transactions when  
32 ownership or control of medical records changes hands.

33  
34 16. The most appropriate jurisdiction for considering physician breaches of patient  
35 confidentiality is the relevant state medical practice act. Knowing and intentional breaches of  
36 patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary  
37 gain, represents a violation of the professional practice of medicine.

38  
39 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal  
40 level that will afford patients protection against discrimination on the basis of genetic testing.  
41 The AMA will work with Congress and HHS to modify the Genetic Information  
42 Nondiscrimination Act of 2008 (GINA), which bans genome-based policy and hiring decisions  
43 by health insurance companies and employers, by adding Long-Term Care, Life Insurance, and  
44 Disability Insurance to the Act to prevent applicant rejection based on their genetic make up.

45  
46 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior  
47 written and signed consent from patients to use their personal data for marketing purposes. a.  
48 Our AMA supports privacy standards that would prohibit pharmaceutical companies,  
49 biotechnology companies, universities, and all other entities with financial ties to the genetic  
50 testing company from sharing identified information with other parties without the consent of  
51 the user. An exception would be made when requested by law enforcement authorities or when

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

5  
6 19. Our AMA supports privacy standards that require pharmacies and drug store chains to 50  
7 disclose the source of financial support for drug mailings or phone calls.

8  
9 20. Our AMA supports privacy standards that would prohibit pharmacies from using  
10 prescription refill reminders or disease management programs as an opportunity for marketing  
11 purposes.

12  
13 21. Our AMA will draft model state legislation requiring consent of all parties to the recording  
14 of a physician-patient conversation;

15  
16 Our AMA work with the Department of Health and Human Services or other relevant parties to  
17 modify the rules to prevent genetic testing entities from transferring information about the  
18 user's date of birth and state of residence to third parties which may result in the re-  
19 identification of the user based on surname inference;

20  
21 Our AMA work with Congress and the Department of Health and Human Services to extend  
22 the consumer protections of the Genetic Information Non-Discrimination Act (GINA) of 2008  
23 by adding long-term care, disability insurance, and life insurance to the Act, modeled after the  
24 laws of other states, such as California.

## 25 26 CURRENT AMA POLICY

27  
28 Existing AMA policy addresses direct-to-consumer (DTC) genetic testing and privacy (see  
29 Appendix for full text). AMA Policy D-480.987, "Direct-to-Consumer Marketing and Availability  
30 of Genetic Testing," recommends that genetic testing be carried out under the personal supervision  
31 of a qualified health professional and that advertisements disclose test limitations. AMA Policy  
32 H-480.941, "Direct-to-Consumer Laboratory Testing," advocates for vigilant oversight of DTC  
33 laboratory testing and encourages physicians to educate their patients about the risks of DTC tests.  
34 AMA Policy H-65.969, "Genetic Discrimination and the Genetic Information Nondiscrimination  
35 Act," supports education as well as legislation intended to provide more comprehensive  
36 protections. AMA Policies H-460.916, "Protection of Human Subjects in Research," and  
37 H-460.980, "Ethical and Societal Considerations in Research," encourage additional education on  
38 ethical principles for investigators in human subject research. AMA Policy H-315.983, "Patient  
39 Privacy and Confidentiality," affirms that genetic information should be kept confidential and  
40 should not be disclosed to third parties without explicit informed consent.

## 41 42 BACKGROUND

### 43 44 *DTC genetic testing landscape*

45  
46 Genetic tests have traditionally been ordered by a physician for specific conditions with clear  
47 diagnostic and other medical purposes. This report focuses on DTC genetic testing which may not  
48 require a physician order. Beginning with saliva or a cheek swab, DTC genetic tests can reveal  
49 DNA segments shared with other individuals, offering insights into familial relationships and  
50 ancestry. DTC genetic tests can also report specific variants associated with diverse traits and  
51 health conditions.

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

4  
5 While the FDA currently does not review all DTC genetic tests before they are offered to the  
6 public, those that disclose moderate to high risk health information, such as cancer screening  
7 results, are reviewed for evidence that the tests work as advertised.<sup>2</sup> In 2013, 23andMe stopped  
8 providing consumers with genetic health risk information after the FDA sent the company a letter.  
9 This action led other DTC companies to stop disclosing genetic health risks to consumers. In 2015,  
10 23andMe was cleared by the FDA to market tests that release results for health conditions  
11 including increased risk of cancer, and in 2018 was cleared for pharmacogenomic reports.<sup>3,4</sup> To  
12 date, 23andMe remains the only company that has received FDA clearance for a DTC genetic test.<sup>2</sup>

13  
14 Another approach has emerged called a “hybrid” or “DTC 2.0” model of consumer genetic testing  
15 that begins with a physician order for screening of healthy individuals.<sup>5-7</sup> Different models include  
16 those of AncestryDNA, Color Genomics, and Invitae, which may not be required to seek regulatory  
17 clearance from the FDA to return genetic health information, based on the inclusion of a physician  
18 order. These tests may also be offered through partnerships with employers and health systems, and  
19 include cancer risk and pharmacogenomic results.<sup>8,9</sup> In some cases, College of American  
20 Pathologists (CAP) accredited and Clinical Laboratory Improvement Amendments (CLIA)  
21 certified laboratories may provide what is considered clinical grade data that may be included in  
22 health records and used to support medical decisions.

#### 23 24 *Genetic databases for clinical research*

25  
26 Genetic databases and biobanks have been designed to support biomedical research by offering  
27 various forms of access to participant data. This research has contributed to uncovering the  
28 molecular basis for thousands of human diseases and has helped to advance drug discovery.<sup>10</sup>  
29 Database sizes are growing which may be necessary to power polygenic risk scores and other  
30 findings beyond single gene associations. Such database sizes may be not be feasible to build for a  
31 single study, so groups instead may work with common datasets.

32  
33 Shortcomings of the traditional biobank approach have included a lack of participant diversity, and  
34 a need to more frequently return results back to participants.<sup>11,12</sup> When biobanks seek to form  
35 external partnerships, particularly with industry, there may be public concern about data security  
36 and privacy.<sup>13</sup> Initiatives such as the 100,000 Genomes Project in the United Kingdom have begun  
37 leveraging their participant results to help advance clinical care.<sup>14</sup> However, a distinction between  
38 research and clinical grade genetic results may mean that some research findings should be  
39 considered only initial screening information that should undergo clinical confirmation prior to any  
40 changes in patient care.<sup>15</sup>

#### 41 42 *The All of Us Research Program*

43  
44 The National Institutes of Health (NIH)’s *All of Us* Research Program was launched in 2018 as part  
45 of President Obama’s Precision Medicine Initiative, as “an ambitious effort to gather data over time  
46 from 1 million or more people living in the United States.” The program does not focus on any  
47 subset of diseases or conditions. Instead, a key focus is recruiting participation from populations  
48 traditionally underrepresented in biomedical research, which has long been a challenge for the  
49 genetics field. By late-2019, more than 230,000 total participants were enrolled in *All of Us*, with  
50 most participants from underrepresented populations.<sup>16</sup>

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

5  
6 Participant data for the *All of Us* program are stored in a cloud environment where identifying  
7 information is removed. This platform will allow computation and interactive testing of hypotheses  
8 without access to any individual participant data, thus safeguarding against some potential forms of  
9 security breaches. Researchers apply for data access and make their names and descriptions of their  
10 projects publicly available. Participants will also have access to their own data including their  
11 physical measurements, survey data, and genomic results, and they can choose whether to share  
12 results with their physician.<sup>16</sup>

#### 13 14 *Research using consumer genomic data*

15  
16 Genetic testing companies such as 23andMe also can engage in peer-reviewed genetic research,  
17 leveraging their own genetic databases including in many cases partnerships with academics.<sup>20</sup> In  
18 addition, genetic testing companies have engaged in their own drug discovery and have partnered  
19 with industry via data sharing agreements. In 2018, 23andMe announced a \$300 million drug  
20 development partnership with GlaxoSmithKline.<sup>21</sup> In 2020, 23andMe sold the rights to license the  
21 first drug that the company had internally developed as a potential treatment for inflammation.<sup>22</sup>  
22 While users have been informed that they can opt out of having their data used for research at any  
23 time, around 80 percent of users have elected to participate.<sup>23</sup> Currently, users are assigned no  
24 rights or compensation for the company's research or commercial products.<sup>24</sup>

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

#### 33 34 *Third-party and forensic applications*

35  
36 DTC companies such as 23andMe and AncestryDNA allow users to download their own raw  
37 genomic data. These raw data files can then be uploaded to various third-party interpretation  
38 platforms which provide services such as mining the biomedical literature or genealogy tools. Use  
39 of third-party interpretation platforms has been identified as having the potential to increase a  
40 user's risks including validity of results and privacy.<sup>26-28</sup>

41  
42 In terms of privacy, increasingly it has been recognized that genetic data cannot be deidentified. A  
43 DNA profile alone may now be adequate to identify most individuals even in the absence of other  
44 identifying information, including individuals that have not previously participated in genetic  
45 testing.<sup>29</sup> This may increasingly be the case as DNA databases continue to grow with participation  
46 from biological relatives that may help uncover identities through DNA matches. It may also be  
47 difficult to place safeguards against additional potential uses of genetic data other than those  
48 originally intended. For example, an individual's DNA profile designed for a specific purpose such  
49 as forensics may be linked to additional genetic data that could reveal health and other sensitive  
50 information.<sup>30</sup>

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

9  
10 Terms of service from DTC companies have been shown to have tremendous variability around the  
11 use and sharing of genetic data.<sup>33</sup> Such terms may also be subject to change with little notice. In  
12 2019, Family Tree DNA surprised many users by announcing that it had been collaborating with  
13 the FBI and supporting queries via access to user genetic information, allegedly without informed  
14 consent from their users.<sup>34</sup> These revelations led to the Future of Privacy forum, which had released  
15 best practices in 2018 that prohibited the sharing of genetic data without consent or as required by  
16 law, to remove Family Tree DNA as a supporter.<sup>35</sup>

17  
18 The U.S. Department of Defense warned in 2019 that use of DTC genetic testing could place  
19 military service members at risk, allowing the enemy to target them via "mass surveillance and the  
20 ability to track individuals without their authorization or awareness," with unintended security  
21 consequences.<sup>36</sup> Accordingly, service members have been advised to refrain from using DTC  
22 genetic tests. Information about some genetic variants can also affect a service member’s career,  
23 which may be particularly problematic when the validity of some DTC genetic tests has been  
24 questioned.

25  
26 DTC genetic testing demand appears to have experienced a decline in 2019.<sup>37</sup> It is unclear whether  
27 this may be due to privacy or other consumer concerns. This development may signal saturation or a  
28 shift to more comprehensive models of genetic testing such as those offered by health systems.

### 29 30 *Genetic Nondiscrimination and Privacy Legislation*

31  
32 Federal legislation that covers genetic privacy in the U.S. includes the Health Insurance Portability  
33 and Accountability Act (HIPAA) and the Genetic Information Nondiscrimination Act (GINA). The  
34 HIPAA Privacy Rule applies to health plans, health care providers, and health information  
35 clearinghouses but not to third parties outside of health care.<sup>38</sup> GINA applies to health insurers and  
36 employers but not to other contexts such as life, disability, or long-term care insurance.<sup>39</sup>

37  
38 Various states including California also have additional laws enacted that extend genetic  
39 discrimination protections to other areas such as life insurance and educational settings.<sup>39</sup> The  
40 California Consumer Privacy Act (CCPA) may also offer additional privacy protections for some  
41 consumers. However, extending GINA’s protections to other contexts in all states would require an  
42 act of Congress.

### 43 44 *Human Subjects Research Legislation*

45  
46 Unlike earlier genetic research studies using a traditional model, researchers using DTC genetic  
47 data from 23andMe have argued that their work is not human subjects research as defined under  
48 the U.S. Department of Health and Human Services, which would require fully informed consent  
49 and institutional review board (IRB) approval of the research protocols.<sup>40</sup> Journal editors who  
50 published the study agreed that the researchers did not violate the Common Rule because they only

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

3  
4 *Physician guidance and related AMA efforts*

5  
6 The American College of Medical Genetics and Genomics has released a position statement on  
7 DTC genetic testing.<sup>41</sup> Additional guidance on this topic is available from the Association for  
8 Molecular Pathology<sup>42</sup> and the American Society of Human Genetics.<sup>43,44</sup> The *AMA Journal of*  
9 *Ethics* has published an issue on precision health including DTC genetic testing.<sup>45</sup> *JAMA* has also  
10 published a number of articles covering topics related to consumer genetic testing.<sup>46</sup>

11  
12 The AMA has several initiatives to help physicians navigate precision medicine including  
13 education, research, and advocacy.<sup>47</sup> The AMA has collaborated with The Jackson Laboratories  
14 and Scripps Research Translational Institute on a continuing medical education series called  
15 “Precision Medicine For Your Practice,” which includes a module called “Genomic Testing for the  
16 Healthy Individual.”<sup>48</sup> The AMA hosted a “Driving the Future of Precision Medicine Roundtable”  
17 in 2019 that examined the current landscape and innovative practices for precision medicine  
18 implementation. The AMA is also represented on the National Academies of Sciences,  
19 Engineering, and Medicine (NASSEM) Roundtable on Genomics and Precision Health and  
20 participated in a 2019 workshop on consumer genomics.<sup>49</sup>

21  
22 Previous Council on Science and Public Health reports have addressed DTC genetic tests and  
23 related issues including genetic discrimination, the Precision Medicine Initiative, and payment and  
24 coverage for precision medicine.<sup>50-52</sup> In 2019, the AMA sent a letter to the Department of Justice to  
25 oppose a proposal for the use of DNA testing for detained immigrants.<sup>53</sup> The AMA has also  
26 worked with states, including Delaware, to extend GINA protections.<sup>54</sup>

27  
28 CONCLUSION

29  
30 The AMA has extensive policy on human subject research, consent, and genetic discrimination.  
31 The current federal GINA protections are limited to health insurance and employment, leaving  
32 consumers in most states without protections for areas such as life, disability, or long-term care  
33 insurance. It is important that users of consumer genetic testing are aware of the potential risks of  
34 their participation, particularly as the numbers of participants and the various use cases continue to  
35 grow. Participants in consumer genetic testing should receive notice and provide consent whenever  
36 their genetic information is used or shared.

37  
38 RECOMMENDATIONS

39  
40 For purposes of clarity, the Board of Trustees recommends that the following statements be  
41 adopted in lieu of Resolution 207-A-19, and that the remainder of this report be filed.

- 42  
43 1. That our AMA adopt the following new policy:

44  
45 “Consumer Genetic Testing and Privacy”

46 Our AMA:

- 47  
48 (1) will work with relevant stakeholders to advance laws and regulations that prevent genetic  
49 testing entities without explicit, informed, and non-coerced user consent from transferring  
50 information about a user such as birthdates and state of residence to third parties which

- 1           may result in the re-identification of the user based on surname inference (New HOD  
2 Policy).  
3
- 4           (2) supports privacy standards that would prohibit pharmaceutical companies, biotechnology  
5 companies, universities, and all other entities with financial ties to the genetic testing  
6 company from sharing identifiable information, including DNA, with other parties without  
7 informed consent of the user. An exception would be made when requested for a duly  
8 executed court order or when compelled for public health or safety reasons as outlined in  
9 existing AMA policy including H-315.983, "Privacy and Confidentiality," and Medical  
10 Code of Ethics 4.1.4, "Forensic Genetics." If a data security or privacy breach occurs with  
11 a direct-to-consumer (DTC) genetic company or its collaborators, then the company has  
12 the responsibility to inform all users and relevant regulatory bodies of the breach and the  
13 impact of the unprotected private data on those individuals (New HOD Policy).  
14
- 15           (3) will advocate that research using consumer genomic data derived from saliva or cheek  
16 swabs or other human samples should be treated as research on human subjects requiring  
17 informed consent consistent with or similar to those required by the Health and Human  
18 Services (HHS) Office for Human Research Protection (OHRP), and recommend an "opt  
19 in" option to allow more consumer choice in the consent process (New HOD Policy).  
20
- 21           (4) will advocate for extending the consumer protections of the Genetic Information Non-  
22 Discrimination Act (GINA) of 2008 by adding long-term care, disability insurance, and life  
23 insurance to the Act, modeled after the laws of other states, such as California (New HOD  
24 Policy).  
25
- 26           2. That the following policies be reaffirmed: H-65.969, "Genetic Discrimination and the Genetic  
27 Information Nondiscrimination Act," H-185.972, "Genetic Information and Insurance  
28 Coverage," D-480.987, "Direct-to-Consumer Marketing and Availability of Genetic Testing,"  
29 H-480.941, "Direct-to-Consumer Laboratory Testing," H-460.916, "Protection of Human  
30 Subjects in Research," H-460.980, "Ethical and Societal Considerations in Research," and  
31 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

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1 INTRODUCTION

2

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

7

8 Resolution 208, “Net Neutrality and Public Health” reads as follows:

9

10 RESOLVED, That our American Medical Association advocate for policies that ensure  
11 internet service providers transmit essential healthcare data no slower than any other data on  
12 that network; and be it further

13

14 RESOLVED, That our AMA collaborate with the appropriate governing bodies to develop  
15 guidelines for the classification of essential healthcare data requiring preserved transmission  
16 speeds; and be it further

17

18 RESOLVED, That our AMA oppose internet data transmission practices that reduce market  
19 competition in the health ecosystem.

20

21 Resolution 211, “Effects of Net Neutrality on Public Health” reads as follows:

22

23 RESOLVED, That our American Medical Association amend current policy H-478.980,  
24 “Increasing Access to Broadband Internet to Reduce Health Disparities,” by addition and  
25 deletion as follows:

26

27 Increasing ~~Access to Broadband~~ Internet Access to Reduce Health Disparities

28

29 Our AMA: (1) will advocate for net neutrality; and (2) will advocate for the expansion of  
30 broadband and wireless connectivity to all rural and underserved areas of the U.S. while at all  
31 times taking care to protecting existing federally licensed radio services from harmful  
32 interference that can be caused by broadband and wireless services.

33

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

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

## 11 12 BACKGROUND

13  
14 Net neutrality is the principle guiding the strict regulations placed on internet service providers  
15 (ISPs) that prohibit or limit content-controlling behavior in order to ensure an equal and open  
16 internet for all.<sup>1</sup> In practice, this means that ISPs should not be able to move some data (for  
17 example, certain applications or streaming services) into “fast lanes” while blocking, slowing, or  
18 limiting in some fashion other data. In other words, ISPs (such as AT&T Internet Services, Cox  
19 Communications, Comcast and Verizon) should not be able to block a user from accessing a  
20 service such as Skype, Zoom, or slow down Netflix or Roku, in order to encourage the user to keep  
21 a cable package or buy a different video-streaming service.

22  
23 A core issue to net neutrality is how ISPs should be classified under the Communications Act of  
24 1934, if they should be Title I “information services” or Title II “telecommunications or common  
25 carrier services.” The classification affects the Federal Communications Commission’s (FCC)  
26 authority over ISPs. As Title II common carriers, the FCC would have significant ability to regulate  
27 ISPs, but not if they are classified as Title I. Title I information services are regulated by the  
28 Federal Trade Commission (FTC or Commission). In layman’s terms, “common carrier services”  
29 move data from one place of the customer’s choosing to another, and “information services”  
30 provide processing or storage services for that data. The debate over Title I vs. Title II  
31 classification continues even today.

32  
33 The FCC regulates interstate and international communications by radio, television, wire, satellite,  
34 and cable in all 50 states, the District of Columbia and U.S. territories. An independent U.S.  
35 government agency overseen by Congress, the FCC is the federal agency responsible for  
36 implementing and enforcing America’s communications law and regulations. The makeup of the  
37 five-member FCC changes with each U.S. President, and competing interests have ultimately led to  
38 the state of net neutrality flipping back and forth over the last several decades. With regard to the  
39 FTC, the Commission is headed by five Commissioners, nominated by the President and confirmed  
40 by the U.S. Senate, each serving a seven-year term. No more than three Commissioners can be of  
41 the same political party. The President chooses one Commissioner to act as Chairman.

## 42 43 DISCUSSION

### 44 45 *Federal Regulatory Activity*

46  
47 In the absence of any formal categorization of internet services, the FCC issued several statements  
48 regarding broadband regulation.

49  
50 In 2005, the FCC adopted four principles in order to “encourage broadband deployment and  
51 preserve and promote the open and interconnected nature of public Internet.”<sup>2</sup> The four principles

1 are as follows: (1) consumers are entitled to access the lawful Internet content of their choice; (2)  
2 consumers are entitled to run applications and services of their choice, subject to the needs of law  
3 enforcement; (3) consumers are entitled to connect their choice of legal devices that do not harm  
4 the network; and (4) consumers are entitled to competition among network providers, application  
5 and service providers, and content providers.<sup>3</sup> At that time, the FCC stated it would consider these  
6 principles during “policymaking activities.”  
7

8 In 2010, the Open Internet Order was passed by the FCC. The goal of the Open Internet Order was  
9 to “preserve the Internet as an open platform for innovation, investment, job creation, economic  
10 growth, competition, and free expression,” which ultimately revolved around three basic tenets:<sup>4</sup>  
11

- 12 • *Transparency*. Fixed and mobile broadband providers must disclose the network management  
13 practices, performance characteristics, and terms and conditions of their broadband services;<sup>5</sup>
- 14 • *No blocking*. Fixed broadband providers may not block lawful content, applications, services,  
15 or non-harmful devices; mobile broadband providers may not block lawful websites, or block  
16 applications that compete with their voice or video telephony services; and
- 17 • *No unreasonable discrimination*. Fixed broadband providers may not unreasonably  
18 discriminate in transmitting lawful network traffic.  
19

20 According to the FCC, broadband providers invested \$212 billion in the three years following  
21 adoption of the rules—from 2011 to 2013—more than in any three-year period since 2002.<sup>6</sup>  
22

23 Between 2005 and 2012, there were several Congressional attempts to pass legislation containing  
24 limitations on net neutrality. These attempts failed, largely due to the argument that the legislation  
25 would have benefited industry instead of consumers.  
26

27 The FCC in its February 26, 2015, open meeting voted 3-2, along party lines, to adopt new open  
28 internet rules and released these rules via an Open Internet Report and Order on Remand on March  
29 12, 2015.  
30

31 One of the most controversial aspects of the rules was the decision to reclassify broadband internet  
32 access service (BIAS) as telecommunications service under Title II, thereby subjecting ISPs to a  
33 more stringent regulatory framework. The FCC Order reclassifying ISPs as Title II services gave  
34 the FCC authority to enforce net neutrality. Specifically, the FCC’s 2015 Open Internet Order  
35 banned each of the following: Blocking, Throttling, and Paid Prioritization—applying the same  
36 rules to both fixed and mobile broadband Internet access service.<sup>7</sup>  
37

- 38 • *No Blocking*. The FCC noted at that time that “consumers who subscribe to a retail broadband  
39 Internet access service must get what they have paid for—access to all (lawful) destinations on  
40 the Internet.”<sup>8</sup> Thus, the Order adopted a straightforward ban:
  - 41 ○ A person engaged in the provision of broadband Internet access service, insofar as such  
42 person is so engaged, shall not block lawful content, applications, services, or nonharmful  
43 devices, subject to reasonable network management.
- 44 • *No Throttling*. The FCC noted that “the 2010 rule against blocking contained an ancillary  
45 prohibition against the degradation of lawful content, applications, services, and devices, on the  
46 ground that such degradation would be tantamount to blocking.”<sup>9</sup> The 2015 Order created a  
47 separate rule to guard against degradation targeted at specific uses of a customer’s broadband  
48 connection:
  - 49 ○ A person engaged in the provision of broadband Internet access service, insofar as such  
50 person is so engaged, shall not impair or degrade lawful Internet traffic on the basis of

- 1 Internet content, application, or service, or use of a non-harmful device, subject to  
2 reasonable network management.
- 3 • *No Paid Prioritization.* Paid prioritization occurs when a broadband provider accepts payment  
4 (monetary or otherwise) to manage its network in a way that benefits particular content,  
5 applications, services, or devices.<sup>10</sup> To protect against “fast lanes,” the 2015 Order adopted a  
6 rule that establishes that:
    - 7 ○ A person engaged in the provision of broadband Internet access service, insofar as such  
8 person is so engaged, shall not engage in paid prioritization.
- 9

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

20

- 21 • *Consumer Protection.* The Federal Trade Commission will police and take action against  
22 Internet service providers for anticompetitive acts or unfair and deceptive practices.
  - 23 • *Transparency.* Internet service providers must publicly disclose information regarding their  
24 network management practices, performance, and commercial terms of service. These  
25 disclosures must be made via a publicly available, easily accessible company website or  
26 through the FCC's website.
  - 27 • *Removes Unnecessary Regulations to Promote Broadband Investment.* Removes Title II  
28 regulations.
- 29

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

31

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

42

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

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

3  
4 *Current Congressional Activity*

5  
6 In early 2019, federal legislation was introduced that would address the net neutrality debate.  
7 However, only one such bill has progressed. The “Save the Internet Act of 2019”, H.R. 1644/S.  
8 682 would repeal the Declaratory Ruling, Report and Order, and Order in the matter of restoring  
9 internet freedom that was adopted by the Commission on December 14, 2017 (FCC 17–166) and  
10 restore the 2015 Order. H.R. 1644 passed (232-190) the House on April 10, 2019 and has been sent  
11 to the Senate for consideration.

12  
13 Republicans in Congress contend that the increased Internet use as a result of shelter-in-place  
14 orders is proof positive that the net neutrality rules were unnecessary. Democrats in Congress have  
15 turned their focus to the FCC’s various Internet connection programs to make sure people at all  
16 income levels, in all geographic areas across the U.S. have access to broadband. As a result of the  
17 changing Internet landscape due to the pandemic, it is likely that congressional leaders from both  
18 parties moving forward will increase their focus on bolstering broadband infrastructure across the  
19 country, as this endeavor has bipartisan support, rather than focusing on net neutrality policies  
20 specifically.

21  
22 *The Expansion of Telehealth Services as a Result of the COVID-19 Pandemic*

23  
24 Congress appropriated \$200 million to the FCC for the Telehealth Program as part of the  
25 Coronavirus Aid, Relief, and Economic Security (CARES) Act, to help health care providers  
26 provide connected care services to patients at their homes or mobile locations in response to the  
27 novel Coronavirus 2019 disease (COVID-19) pandemic.<sup>17</sup> The COVID-19 Telehealth Program  
28 will provide immediate support to eligible health care providers responding to the COVID-19  
29 pandemic by fully funding their telecommunications services, information services, and devices  
30 necessary to provide critical connected care services until the program’s funds have been  
31 expended or the COVID-19 pandemic has ended. The COVID-19 Telehealth Program is limited  
32 to nonprofit and public eligible health care providers.<sup>18</sup>

33  
34 As of May 20, 2020, the FCC’s COVID-19 Telehealth Program has approved funding for 132  
35 health care providers in 33 states plus Washington, DC for a total of just over \$50 million in  
36 funding.<sup>19</sup> The FCC is continuing to evaluate COVID-19 Telehealth Program applications and  
37 distribute additional funding on a rolling basis.

38  
39 The FCC’s Office of Managing Director and Wireline Competition Bureau (WCB) also is  
40 waiving the FCC’s red light rule<sup>20</sup> for COVID-19 Telehealth Program applicants to facilitate  
41 prompt review and processing of the maximum number of applications to the Program. The “red  
42 light” rule normally prevents the FCC from taking action on applications and other requests by  
43 entities with delinquent debts with the agency. While the FCC found good cause existed to  
44 waive the “red light” rule, the agency was clear that the waiver solely applied to the COVID-19  
45 Telehealth Program and did not affect the agency’s ability to take collection action against  
46 delinquent debtors.

47  
48 In addition, on May 22, 2020, U.S. Senators Brian Schatz (D-Hawaii), Lisa Murkowski (R-  
49 Alaska), John Boozman (R-Ark.), Angus King (I-Maine), Gary Peters (D-Mich.), Dan Sullivan  
50 (R-Alaska), Kevin Cramer (R-N.D.), and Ed Markey (D-Mass.) introduced the Health Care  
51 Broadband Expansion During COVID-19 Act. The bipartisan bill would direct \$2 billion to help

1 health care providers increase their broadband capacity and expand telehealth services during  
2 the current public health crisis.<sup>21</sup>

3  
4 AMA POLICY

5  
6 Existing AMA policy generally promotes increasing patient access to electronic health data,  
7 encouraging innovation and competition amongst technology vendors, and removing barriers to  
8 internet-based care. In 2020 the AMA developed and published a guidance document containing  
9 privacy principles.<sup>22</sup>

10  
11 *Policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities"*

12 Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and  
13 underserved areas of the U.S. while at all times taking care to protecting existing federally licensed  
14 radio services from harmful interference that can be caused by broadband and wireless services.

15 Citation: Res. 208, I-18;

16  
17 *Policy D-478.979, "Promoting Internet-Based Electronic Health Records and Personal Health*

18 *Records"* Our American Medical Association will advocate for the Centers for Medicare &  
19 Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect  
20 to use a patient portal or interface to a personal health record (PHR) and will work with CMS to  
21 educate physicians about the barriers to PHR implementation, how to best minimize risks  
22 associated with PHR use and implementation, and best practices for physician use of a patient  
23 portal or interface to a PHR.

24 Citation: (BOT Rep. 11, I-11)

25  
26 CONCLUSION

27  
28 The essential nature of broadband communication services that has been highlighted by the  
29 COVID-19 pandemic makes it clear that without affordable and high-quality broadband services,  
30 workforce participation, commerce, education, and telehealth usage, are drastically curtailed.  
31 Additionally, access to broadband is a social determinant of health—both in and of itself and in  
32 light of its intersection between education and employment opportunities—and therefore an  
33 important component of discussions around health equity.<sup>23</sup> The digital divide was already  
34 negatively affecting millions of Americans, but the COVID-19 crisis has placed an increased level  
35 of stress on an already fragile system especially in rural and underserved areas. Some argue that the  
36 surge in internet usage as a result of stay-at-home orders simply confirms that the FCC's existing  
37 policies and programs, combined with low levels of broadband competition, are not meeting the  
38 basic needs of Americans. While others contend that the U.S. has fared well during this dramatic  
39 surge in internet use as a result of shelter in place orders, much better than some European  
40 countries,<sup>24</sup> and regulators and Congress should re-focus their efforts on expanding infrastructure.  
41 Given the bolstering of the FCC's COVID-19 Telehealth Program funding and the expansion of  
42 telehealth policy through the Centers for Medicare & Medicaid Services<sup>25,26</sup> as a result of the  
43 pandemic, our AMA believes that we too should pivot and re-focus our efforts on advocating for  
44 the expansion of broadband infrastructure in rural and underserved urban communities across  
45 America. Our AMA believes that as these opportunities to expand broadband access and telehealth  
46 are adopted and implemented successfully during this health crisis, both Congress and the  
47 Administration will be hard pressed to roll these advances back post-pandemic.

1 RECOMMENDATIONS

2

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

Fiscal Note: None

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3. Id.
4. [https://docs.fcc.gov/public/attachments/FCC-10-201A1\\_Rcd.pdf](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>
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8. Id.
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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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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

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- 1 Whereas, Peer review is the task of self-monitoring and maintaining the administration of patient  
2 safety and quality of care, consistent with optimal standards of practice; and  
3  
4 Whereas, It is the mechanism by which the medical profession fulfills its obligation to ensure  
5 that its members are able to provide safe and effective care; and  
6  
7 Whereas, It is a mechanism for assuring the quality, safety, and appropriateness of hospital  
8 services. The duties of peer review are: addressing the standard of care, preventing patient  
9 harm, evaluating patient safety and quality of care, and ensuring that the design of systems or  
10 settings of care support safety and high quality care; and  
11  
12 Whereas, Proceedings include all of the activities and information and records of a peer review  
13 committee. Proceedings are not subject to discovery and no person who was in attendance at a  
14 meeting of a peer review organization shall be permitted or required to testify in any such civil  
15 action as to any evidence or other matters produced or presented during the proceedings of  
16 such organization or as to any findings, recommendations, evaluations, opinions, or other  
17 actions of such organization or any members thereof; and  
18  
19 Whereas, The proceedings, records, findings, and recommendations of a peer review  
20 organization are not subject to discovery. Information gathered by a committee is protected.  
21 Purely factual information, such as the time and dates of meetings and identities of any peer  
22 review committee attendees is protected. Peer review information otherwise discoverable from  
23 "original sources" cannot be obtained from the peer review committee itself; and  
24  
25 Whereas, A U.S. Senate Oversight Committee in investigating UNOS (United Network for  
26 Organ Sharing) has subpoenaed "all relevant materials to include peer-review related  
27 materials"; therefore be it  
28  
29 RESOLVED, That our American Medical Association use its full ability and influence to oppose  
30 any new attempt(s) to make peer review proceedings, regardless of the venue, discoverable,  
31 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: 202  
(N-21)

Introduced by: American College of Cardiology, American Society of Echocardiography,  
American Society of Nuclear Cardiology, Society of Cardiovascular  
Computed Tomography

Subject: Interstate Practice of Telemedicine

Referred to: Reference Committee B

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- 1 Whereas, The use of telemedicine has grown exponentially during the COVID pandemic to  
2 protect both patients and caregivers from spread of infectious disease; and  
3  
4 Whereas, The COVID pandemic has parenthetically increased our recognition of socioeconomic  
5 and racial disparities in the delivery of quality health care; and  
6  
7 Whereas, Incentives to reduce the high cost of medical care have led to shorter hospital stays,  
8 and increased use of outpatient facilities and home care with less intense in-person physician  
9 supervision; and  
10  
11 Whereas, Telemedicine has previously been proven effective in many scenarios, in remote or  
12 rural settings, urban areas with limited public transportation, in nursing homes, detention  
13 centers, prisons, and for people with physical and mental disabilities limiting their mobility; and  
14  
15 Whereas, Telemedicine may be especially helpful in addressing disparities in access to medical  
16 care based on economic, racial, ethnic and geographic factors; and  
17  
18 Whereas, There is a worsening shortage of physicians particularly in rural or urban communities  
19 that lack comprehensive, supportive, up-to-date medical services and cultural, educational, and  
20 recreational amenities outside the workplace; and  
21  
22 Whereas, Telemedicine has developed rapidly over the last decades into an integrated system  
23 of healthcare delivery that incorporates many different remote monitoring devices and other  
24 technologies that are not dependent on in- person or face-to-face patient encounters; and  
25  
26 Whereas, Many areas of medical practice, such as interpretation of images or performance of  
27 laboratory procedures, do not require personal physician-patient interaction; and  
28  
29 Whereas, Establishing an ongoing relationship with an individual physician to serve as a  
30 patient's medical home, coordinating that patient's care over time and across elements of the  
31 broader health system is ideal, but increasingly untenable in current medical practice; and  
32  
33 Whereas, Many patients now enter the health care system at freestanding clinics in pharmacies  
34 and elsewhere, with no physician in attendance; and  
35  
36 Whereas, Advanced practice nurses and physician assistants and other non-physician  
37 personnel now provide in person services previously delivered by physicians; and

1 Whereas, 70% of physicians are now employed by large groups, hospitals or insurance  
2 companies which also employ non-physicians to assist in patient care, using many varying  
3 protocols for physician supervision; and  
4

5 Whereas, Current AMA policy H-480.969 requires full and unrestricted licensure in the State  
6 where telemedicine is practiced, with certain exceptions and allowances; and  
7

8 Whereas, The Federation of State Medical Licensing Boards and the Interstate Medical  
9 Licensure Compact are engaged to facilitate integration of standard interstate practice  
10 requirements for the physician practice of telemedicine; and  
11

12 Whereas, A more comprehensive and timely approach to interstate licensing is needed to  
13 enable efficient provision of comprehensive telemedicine service across the spectrum of  
14 medical practice and across State borders; and  
15

16 Whereas, Policy objectives for telemedicine health care delivery should incorporate the best  
17 practices of individual States and current capabilities of telemedicine in various medical  
18 specialties into a single comprehensive policy that promotes accessible, quality, affordable,  
19 appropriately accredited and accountable care, distributed to all members of our society;  
20 therefore be it  
21

22 RESOLVED, The our American Medical Association convene a meeting of appropriate  
23 stakeholders, including but not limited to state medical boards, medical specialty societies, state  
24 medical societies, organizations representing advanced practice nurses, Centers for Medicare  
25 and Medicaid Services approved accrediting agencies, pharmacists and other team members to  
26 prepare a consensus document outlining a multi-disciplinary approach for delivery of  
27 responsible and effective telemedicine services in all of the United States. (Directive to Take  
28 Action)

Fiscal Note: Estimate cost of \$31,000 includes, staff, travel and meeting costs.

Received: 09/30/21

AUTHORS STATEMENT OF PRIORITY

We request this resolution receive high priority due to the immediacy of the COVID pandemic and the profound long-term effects adoption of telemedicine will have on the practice of medicine. Safety concerns related to COVID transmission have forced limitation of direct contact for medical care to essential services that can only be performed in-person. While telemedicine has been developing for many years, this crisis has accelerated its use and revealed many areas where telemedicine is applicable in many circumstances other than emergencies created by this pandemic. The delivery of telemedicine, often delivering care to patients living in remote or medically underserved locations, does not rely on the precise location of physical facilities, in many regards transcending State borders. State licensing requirements have been eased in many cases to accommodate interstate telemedicine delivery, but more uniform and permanent changes in the regulation of medical practice are urgently needed. A long-term strategy is also needed as telemedicine transitions to a prominent and permanent fixture in health care delivery.

## **RELEVANT AMA POLICY**

### **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)

### **Independent Practice of Medicine by Advanced Practice Registered Nurses H-35.988**

Our AMA, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the states requirements for licensure to engage in the practice of medicine and surgery in all of its branches. Our AMA opposes enactment of the Advanced Practice Registered Nurse (APRN) Multistate Compact, due to the potential of the APRN Compact to supersede state laws that require APRNs to practice under physician supervision, collaboration or oversight.

Citation: Sub. Res. 53, I-82; Reaffirmed: A-84; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 9, I-11; Modified: Res. 214, I-17; Modified: BOT Rep. 15, A-18;

### **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

### **Opposition to the Department of Veterans Affairs Proposed Rulemaking on APRN Practices D-35.979**

1. Our AMA will express to the U.S. Department of Veterans Affairs (VA) that the plan to substitute physicians by using Advanced Practice Registered Nurses (APRNs) in independent practice, not in physician-led teams, is antithetical to multiple established policies of our AMA and thus should not be implemented.
  2. Our AMA staff will assess the feasibility of seeking federal legislation that prevents the VA from enacting regulations for veterans' medical care that is not consistent with physician-led health care teams or to mandate that the VA adopt policy regarding the same.
  3. Our AMA will call upon Congress and the Administration to disapprove or otherwise overturn rules and regulations at the federal level that would expand the scope of practice of APRNs, and comment to the Director of Regulation Management within the Department of Veterans Affairs of this position during the current comment period.
  4. Our AMA will collaborate with other medical professional organizations to vigorously oppose the final adoption of the VA's proposed rulemaking expanding the role of APRNs within the VA.
- Citation: Res. 239, A-16;

### **COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963**

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services

wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

Citation: Alt. Res. 203, I-20; Reaffirmed: CMS Rep. 7, A-21

#### **Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980**

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States 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; Reaffirmed: CMS Rep. 7, A-21

#### **Established Patient Relationships and Telemedicine D-480.964**

Our AMA will:

- 1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services;
- (2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact;
- (3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, "Coverage of and Payment for Telemedicine"; and
- (4) continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946.

Citation: CMS Rep. 1, I-19; Appended: CMS Rep. 8, A-21

#### **State Authority and Flexibility in Medical Licensure for Telemedicine D-480.999**

Our AMA will continue its opposition to a single national federalized system of medical licensure.

Citation: (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

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

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical

students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Citation: CME Rep. 04, I-18;

### **The Promotion of Quality Telemedicine H-480.969**

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

- (a) exemption from such a licensure requirement for physician-to-physician consultations;
- (b) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient;
- (c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified; and
- (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties).

Citation: CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19; Modified: CMS Rep. 8, A-21

### **Coverage of and Payment for Telemedicine H-480.946**

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

- a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
  - A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
  - A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree

to supervise the patient's care; or

- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

e) The delivery of telemedicine services must be consistent with state scope of practice laws.

f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

g) The standards and scope of telemedicine services should be consistent with related in-person services.

h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.

j) The patient's medical history must be collected as part of the provision of any telemedicine service.

k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.

l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.

m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.

4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.

5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.

6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.

7. Our AMA encourages national medical specialty societies to leverage and potentially

collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. Citation: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19; Reaffirmed: CMS Rep. 8, A-21

#### **Telemedicine Encounters by Third Party Vendors D-480.968**

1. Our AMA will develop model legislation and/or regulations requiring telemedicine services or vendors to coordinate care with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and/or treating physicians and providing to the treating physician a copy of the medical record, with the patient's consent.
2. The model legislation and/or regulations will also require the vendor to abide by laws addressing the privacy and security of patients' medical information
3. Our AMA will include in that model state legislation the following concepts based on AMA policy: (a) A valid patient-physician relationship must be established before the provision of telemedicine services; (b) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (c) The standards and scope of telemedicine services should be consistent with related in-person services.
4. Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients.

Citation: Res. 234, A-16;

#### **Evolving Impact of Telemedicine H-480.974**

Our AMA:

- (1) will evaluate relevant federal legislation related to telemedicine;
- (2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
- (3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
- (4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
- (5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
- (6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
- (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
- (8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
- (9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association ([www.americantelemed.org](http://www.americantelemed.org)) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

Citation: CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT

Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18;

### **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 physicians' fundamental 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 patient's 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 patient's 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 patients 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: 203  
(N-21)

Introduced by: Medical Student Section

Subject: Poverty-Level Wages and Health

Referred to: Reference Committee B

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1 Whereas, Poverty has been shown to be an independent predictor of both physical and mental  
2 health in adults and children, in addition to causing a decreased life expectancy<sup>1-12</sup>; and  
3

4 Whereas, People living in poverty are more likely to skip medical visits, medication doses, and  
5 meals, compounding the health inequities they experience<sup>4,13</sup>; and  
6

7 Whereas, In 2019, 34 million people in the United States were living in poverty, and the U.S.  
8 poverty rate exceeded that of most peer or developed countries<sup>14-16</sup>; and  
9

10 Whereas, The federal minimum wage was instituted in 1938 to create a minimum standard of  
11 living and to protect the health and well-being of employees<sup>17,18</sup>; and  
12

13 Whereas, The federal U.S. minimum wage has not increased since 2009, while average yearly  
14 inflation increased steadily during that time, such that the real value of the minimum wage is  
15 now 17% less than it was in 2009 and 31% less than it was in 1968<sup>19-21</sup>; and  
16

17 Whereas, An American family with two children and two adults working full-time jobs at the  
18 federal minimum wage would be roughly at the U.S. poverty level, and furthermore any single  
19 parent working a full-time job at the federal minimum wage would be below the federal poverty  
20 level<sup>22</sup>; and  
21

22 Whereas, Due to longstanding systemic and structural discrimination, Black, Indigenous, Latinx,  
23 and other people of color, women, LGBTQ+ individuals, and people with disabilities are more  
24 likely to be vulnerable to poverty and to be working jobs that make only minimum wage<sup>21,23-29</sup>;  
25 and  
26

27 Whereas, Researchers have documented associations between increased wages and  
28 decreases in suicide mortality, decreases in hypertension and heart disease, better birth  
29 outcomes, decreased teen birthrates, lower rates of sexually-transmitted infections among  
30 women, lower rates of new HIV infection, improvement in self-reported health and fewer days  
31 with functional limitations, decreases in smoking prevalence, decreases in youth binge drinking,  
32 and increased life expectancy<sup>30-43</sup>; and  
33

34 Whereas, A low minimum wage results in an increased number of patients relying on Medicaid,  
35 resulting in lower overall reimbursements for physicians<sup>44,45</sup>; and  
36

37 Whereas, The numerous states and localities that have raised their minimum wage above the  
38 federal minimum have not incurred adverse impacts on their rates of employment<sup>46-49</sup>; and

1 Whereas, Multiple bills aimed at raising the federal minimum wage have been proposed and  
2 debated in recent years<sup>50</sup>; and  
3

4 Whereas, Our AMA recognizes the importance and impact of social determinants on health  
5 (H-165.822), recognizes health is a basic human right and that the provision of healthcare  
6 services is an obligation of an ethical civil society (H-65.960), and encourages screening for  
7 social and economic risk factors (H-160.909), but has no policy supporting federal minimum  
8 wage regulation for the betterment of individual and public health; therefore be it  
9

10 RESOLVED, That our American Medical Association support federal minimum wage regulation  
11 such that the minimum wage increases at least with inflation in order to prevent full-time workers  
12 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

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- 1 Whereas, Forced medical repatriation is the involuntary return of civilians in need of medical  
2 treatment to their country of origin by healthcare professionals<sup>1</sup>; and  
3
- 4 Whereas, Forced medical repatriation results in an involuntary transfer of a patient to a foreign  
5 country, provoking an unwarranted intersection between immigration enforcement and the  
6 healthcare system<sup>2</sup>; and  
7
- 8 Whereas, Of the estimated 10.5 million undocumented immigrants in the United States in 2017,  
9 a study found expenditures on immigrants in 2016 accounted for less than 10% of the overall  
10 healthcare spending in a population with the highest risk of being uninsured among the non-  
11 elderly population<sup>2-4</sup>; and  
12
- 13 Whereas, Under the Emergency Medical Treatment and Labor Act of 1986 (EMTALA), federally  
14 funded health institutions with emergency care capabilities are mandated to treat all patients  
15 with emergent medical conditions who present to their facility until deemed stable, regardless of  
16 their insurance coverage or financial status<sup>5</sup>; and  
17
- 18 Whereas, Once deemed stable, medical centers must consider medical repatriation if no long-  
19 term care alternative is available to the patient as a cost-saving mechanism<sup>6</sup>; and  
20
- 21 Whereas, Care centers like St. Joseph's Hospital and Medical Center in Phoenix, Arizona,  
22 partake in forced medical repatriation for undocumented immigrant patients and a Florida  
23 patient experienced involuntary deportation prior to the completion of their appeal or asylum  
24 verdict<sup>7-9</sup>; and  
25
- 26 Whereas, Forced medical repatriation has led to serious medical consequences for patients,  
27 including the exacerbation of existing medical conditions<sup>10,11</sup>; and  
28
- 29 Whereas, Patients experienced a lapse and deterioration of care due to the inability of the  
30 patient's country of origin to provide adequate treatment and concurrent separation from their  
31 community in the U.S. during a time which may require emotional, physical and financial  
32 support<sup>6,7,9,12</sup>; and  
33
- 34 Whereas, Hospitals fail to inform patients, or their guardians of potential adverse medical  
35 consequences related to repatriation<sup>7,13</sup>; and  
36
- 37 Whereas, Forced medical repatriation increases health disparities among migrant communities  
38 and deters immigrants from seeking necessary medical services<sup>14,15</sup>; and

1 Whereas, Forced medical repatriation often violates the Centers for Medicare and Medicaid  
2 Services' Conditions of Participation regulation which commits hospitals to ensure patients have  
3 the right to conduct informed decisions regarding their care<sup>16,17</sup>; and  
4

5 Whereas, Forced medical repatriation violates the patient's constitutional right to due process,  
6 especially if the patient is able to claim asylum<sup>18</sup>; and  
7

8 Whereas, The *AMA Journal of Ethics* encourages health care systems to seek routes of care to  
9 avoid forced medical repatriation and the *AMA Code of Ethics* Opinion 1.1.8 states that  
10 "physicians should resist any discharge requests that are likely to compromise a patient's  
11 safety" and that the "discharge plan should be developed without regard to socioeconomic  
12 status, immigration status, or other clinically irrelevant considerations"<sup>2,19,20</sup>; and  
13

14 Whereas, The AMA is pursuing policy focused on alternative routes for immigrant healthcare  
15 through Health Care Payment for Undocumented Persons (D-440.985) and Federal Funding for  
16 Safety Net Care for Undocumented Aliens (H-160.956)<sup>21,22</sup>; and  
17

18 Whereas, Data on repatriation of civilians is not reported through any government agency or  
19 otherwise, and there is a lack of documentation<sup>7,23</sup>; therefore be it  
20

21 RESOLVED, That our American Medical Association ask the Department of Health and Human  
22 Services to collect and de-identify any and all instances of medical repatriations from the United  
23 States to other countries by medical centers to further identify the harms of this practice  
24 (Directive to Take Action); and be it further  
25

26 RESOLVED, That our AMA denounce the practice of forced medical repatriation. (New HOD  
27 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

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- 1 Whereas, Rape and/or sexual assault is common in the United States, with between 135,755  
2 and 393,980 rapes and/or sexual assaults committed in 2017 alone<sup>1,2</sup>; and  
3
- 4 Whereas, 43.6% of women and 24.8% of men have experienced some form of sexual violence,  
5 including unwanted sexual contact of any kind, in their lifetimes<sup>3</sup>; and  
6
- 7 Whereas, Rape and sexual assault are associated with a wide range of medical and  
8 psychological sequelae, including direct physical trauma, PTSD, depression, social phobias,  
9 mood regulation deficiencies, impaired sexual function, anxiety, self-harm, suicidal ideation and  
10 suicide attempts<sup>4-14</sup>; and  
11
- 12 Whereas, Data suggests that a significant proportion of rapes and/or sexual assaults are  
13 committed by serial offenders<sup>15-19</sup>; and  
14
- 15 Whereas, Identification and incarceration of perpetrators of violent sexual crimes reduces the  
16 incidence of future sexual violence committed by these serial offenders<sup>17-23</sup>; and  
17
- 18 Whereas, Sexual assault evidence kits (SAEKs), which refer to kits used to collect and store  
19 evidence from a victim of sexual assault during a sexual assault forensic examination, are  
20 extremely useful in the identification and prosecution of perpetrators of violent sexual crime and  
21 are positively associated with successful prosecutions<sup>17,19,22,23-27</sup>; and  
22
- 23 Whereas, Even when suspects cannot be immediately identified on the basis of the DNA  
24 signature derived from a SAEK, law enforcement officials can upload the DNA profile to the  
25 Federal Bureau of Investigation's Combined DNA Index System (CODIS), which can assist in  
26 the later identification of the perpetrator<sup>28</sup>; and  
27
- 28 Whereas, Despite the obvious utility of testing SAEKs, many remain untested and stored in law  
29 enforcement evidence warehouses ("backlogged"), with estimates placing the number of  
30 backlogged kits as high as 200,000 nationwide<sup>19,29</sup>; and  
31
- 32 Whereas, The cause of backlogged SAEKs have been attributed to lack of standardized policies  
33 and procedures, including federal guidelines, inadequate training of law enforcement officers,  
34 outdated laboratory policies and lack of resources, such as funding<sup>30</sup>; and  
35
- 36 Whereas, The United States Department of Justice's Violence Against Women Act of 1994  
37 (VAWA) and its subsequent reauthorizations provides grants to programs offering medical  
38 services to sexual assault survivors contingent on those programs incurring the full cost of  
39 forensic medical exams through the offices of State Attorney's General<sup>31-33</sup>; and

1 Whereas, Standardized insurance billing procedures that include copays and other cost-sharing  
2 payments cause victims of sexual assault to be billed for part of the cost of testing forensic  
3 evidence, notwithstanding federal mandates like VAWA<sup>34,35</sup>; and  
4

5 Whereas, The Bureau of Justice Assistance in the US Department of Justice administers the  
6 Sexual Assault Kit Initiative (SAKI), a grant program that assists police departments in testing  
7 backlogged SAEKs, has resulted in the disbursement of \$43 million and the testing of 50,500  
8 kits<sup>40-42</sup>; and  
9

10 Whereas, Counties that have voluntarily worked to test all backlogged SAEKs in their  
11 possession have been extraordinarily successful in solving previously unsolved rapes and  
12 sexual assaults<sup>17,19,21,22,36-40</sup>; and  
13

14 Whereas, Many of these SAEKs, if tested earlier, would have led to the identification and  
15 incarceration of serial offenders that would have prevented later assaults<sup>17,19-22,36-38</sup>; and  
16

17 Whereas, The \$9.6 million SAEK testing initiative in Cuyahoga County, Ohio financed new  
18 forensic examinations in addition to comprehensive coverage of investigations on  
19 backlogged kits with a net estimated savings of \$38.7 million, highlighting the cost effectiveness  
20 of testing SAEKs<sup>41,42</sup>; and  
21

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

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

3  
4 H-80.999 – SEXUAL ASSAULT SURVIVORS

- 5 1. Our AMA supports the preparation and dissemination of information and best  
6 practices intended to maintain and improve the skills needed by all practicing  
7 physicians involved in providing care to sexual assault survivors.  
8 2. Our AMA advocates for the legal protection of sexual assault survivors' rights and  
9 work with state medical societies to ensure that each state implements these  
10 rights, which include but are not limited to, the right to: (a) receive a medical  
11 forensic examination free of charge, which includes but is not limited to HIV/STD  
12 testing and treatment, pregnancy testing, treatment of injuries, and collection of  
13 forensic evidence; (b) preservation of a sexual assault evidence collection kit for  
14 at least the maximum applicable statute of limitations (c) notification of any  
15 intended disposal of a sexual assault evidence kit with the opportunity to be  
16 granted further preservation; (d) be informed of these rights and the policies  
17 governing the sexual assault evidence kit; and (e) access to emergency  
18 contraception information and treatment for pregnancy prevention.  
19 3. Our AMA will collaborate with relevant stakeholders to develop recommendations  
20 for implementing best practices in the treatment of sexual assault survivors,  
21 including through engagement with the joint working group established for this  
22 purpose under the Survivor's Bill of Rights Act of 2016.  
23 4. Our AMA will advocate for increased post-pubertal patient access to Sexual  
24 Assault Nurse Examiners, and other trained and qualified clinicians, in the  
25 emergency department for medical forensic examinations.  
26 5. Our AMA will advocate at the state and federal level for (a) the immediate  
27 processing of all "backlogged" and new sexual assault examination kits; and (b)  
28 additional funding to facilitate the immediate testing of sexual assault evidence  
29 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

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1 Whereas, The 2018 American Community Survey (ACS) reported that about 10.6 million  
2 undocumented immigrants were living the United States<sup>1</sup>; and  
3

4 Whereas, Since the beginning of the COVID-19 pandemic, there have been at least 48  
5 immigration policy changes that have not only affected international travel, student visas, and  
6 immigration, and asylum processes, but also caused significant confusion for immigration  
7 lawyers<sup>2-4</sup>; and  
8

9 Whereas, The suspension of the United States Custom and Immigration Services (USCIS)  
10 during the COVID-19 pandemic has led to a back-up in the processing of necessary  
11 documentation, which has left many unable to access certain benefits necessary for work,  
12 receiving healthcare, and accessing public benefits<sup>5</sup>; and  
13

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

19 Whereas, The federal government used statutes and the Tariff Act of 1930 in order to create  
20 rules from the Centers for Disease Control and Prevention (CDC) and CBP that restricted both  
21 entry at the northern and southern borders and barred asylum seekers from entering the country  
22 due to public health threats, despite evidence suggesting that such restrictions are ineffective  
23 and may even divert resources from other interventions<sup>5</sup>; and  
24

25 Whereas, Immigration courts closed at the beginning of the COVID-19 pandemic and postponed  
26 hearings for detained people, prolonging their stay in detention centers<sup>4,5</sup>; and  
27

28 Whereas, The relief packages that were provided by the government during the pandemic either  
29 provided little or no coverage to immigrants and their families, leaving them with few options for  
30 testing and treatment<sup>5,7</sup>; and  
31

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

1 Whereas, Undocumented immigrants typically work low-earning jobs and are unable to receive  
2 unemployment insurance or government stimulus checks during national crises<sup>5,9</sup>; and  
3

4 Whereas, The Coronavirus Aid, Relief, and Economic Security (CARES) act limited the ability to  
5 receive a stimulus payment to individuals with a social security number, which limits many  
6 immigrants who file taxes using Individual Taxpayer Identification Numbers (ITIN)<sup>1,5,8</sup>; and  
7

8 Whereas, Lapses in work authorization due to slowed processing times and suspension of  
9 required processing services may result in immigrants being unemployed or losing benefits  
10 offered by their employer<sup>5,8</sup>; and  
11

12 Whereas, Both the FFCRA and the CARES act expanded Unemployment Insurance (UI)  
13 programs, but due to lapses in work authorizations, many immigrants may either not qualify or  
14 lose access to this vital benefit<sup>1</sup>; and  
15

16 Whereas, Previous immigration law changes, such as the February 2020 Public Charge rule,  
17 penalized immigrants for using non-cash public assistance like Medicaid, the Supplemental  
18 Nutrition Assistance Program (SNAP), the Children's Health Insurance Program (CHIP), several  
19 housing programs, and federal poverty level determination by threatening inadmissibility or  
20 inability to be granted legal permanent residency in the United States<sup>10,11</sup>; and  
21

22 Whereas, These changes not only discourage use of publicly funded healthcare and welfare  
23 services even among immigrant families to which the rule does not technically apply due to fear  
24 and confusion, but also mislead countless immigrant parents to remove their U.S. citizen  
25 children from health care insurance, likely leading to unnecessary child morbidity and  
26 mortality<sup>10,12-15</sup>; and  
27

28 Whereas, Decreased participation in public benefit programs would contribute to a greater  
29 uninsured population, a decrease in the use of both preventive and curative health services, and  
30 negatively affect the health outcomes and financial stability of nearly 22 million noncitizens  
31 currently residing in the U.S.<sup>10,16,17</sup>; and  
32

33 Whereas, On March 27, 2020, the USCIS announced that testing or treatment related to the  
34 COVID-19 pandemic would not count as a public charge<sup>18,19</sup>; and  
35

36 Whereas, Although two filed lawsuits have prevented this ruling from being enacted further,  
37 there remains a concern on the potential for future immigration policy to discriminate based on  
38 poverty level, housing status, and the need for public benefits<sup>17-19</sup>; and  
39

40 Whereas, Increased fear of deportation among families, even if only one family member is a  
41 non-citizen immigrant, not only causes decreased health care utilization but also causes  
42 increased behavioral issues in children<sup>17</sup>; and  
43

44 Whereas, The 3rd AMA Principle of Medical Ethics states, "A physician shall respect the law  
45 and also recognize a responsibility to seek changes in those requirements which are contrary to  
46 the best interests of the patient" <sup>[10]</sup>; and  
47

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

1 Whereas, Our AMA joined other health care organizations in submission of amicus briefs and  
2 comment letters opposing the new public charge regulations, stating “there is no evidence that  
3 chilling the use of health and nutrition benefits will result in an increase in income, employment  
4 or educational status of immigrants... These sweeping and detrimental changes will ultimately  
5 result in far greater costs to the public’s health than any purported benefit offered by DHS” <sup>[11]</sup>;  
6 and  
7

8 Whereas, Our AMA has set policy precedent to act on behalf of the health of immigrants,  
9 refugees, migrant workers, and asylum seekers (AMA Policy H-350.957), and has joined other  
10 health care organizations in submitting amicus briefs and comment letters opposing the new  
11 public charge regulations, stating “there is no evidence that chilling the use of health and  
12 nutrition benefits will result in an increase in income, employment or educational status of  
13 immigrants... These sweeping and detrimental changes will ultimately result in far greater costs  
14 to the public’s health than any purported benefit offered by DHS”<sup>11</sup>; therefore be it  
15

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

- 19 (1) oppose the slowing or halting of the release of individuals and families that are currently part  
20 of the immigration process; and
- 21 (2) oppose continual detention when the health of these groups is at risk and supports releasing  
22 immigrants on recognizance, community support, bonding, or a formal monitoring program  
23 during national crises that impose a health risk; and
- 24 (3) support the extension or reauthorization of visas that were valid prior to a national crisis if  
25 the crisis causes the halting of immigration processing; and
- 26 (4) oppose utilizing public health concerns to deny of significantly hinder eligibility for asylum  
27 status to immigrants, refugees, or migrant workers without a viable, medically sound  
28 alternative solution (New HOD Policy); and be it further

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

3  
4 **Addressing Immigrant and Refugee Health Disparities H-350.957**

5  
6 1. Our American Medical Association recognizes the unique health needs of  
7 immigrants and refugees and encourages the exploration of issues related to  
8 immigrant and refugee health and supports legislation and policies that address the  
9 unique health needs of immigrants and refugees.

10  
11 2. Our AMA: (A) urges federal and state government agencies to ensure standard  
12 public health screening and indicated prevention and treatment for immigrant  
13 children, regardless of legal status, based on medical evidence and disease  
14 epidemiology; (B) advocates for and publicizes medically accurate information to  
15 reduce anxiety, fear, and marginalization of specific populations; and (C) advocates  
16 for policies to make available and effectively deploy resources needed to eliminate  
17 health disparities affecting immigrants, refugees or asylees.

18  
19 3. Our AMA will call for asylum seekers to receive all medically appropriate care,  
20 including vaccinations in a patient centered, language and culturally appropriate way  
21 upon presentation for asylum regardless of country of origin.

22  
23 4. Our AMA opposes any rule, regulation, or policy that would worsen health  
24 disparities among refugee or immigrant populations by forcing them to choose  
25 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

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

5 Whereas, In regard to infectious pathogens, immunization of a large portion of the population  
6 can lead to vaccine-induced “herd immunity”, a marked decrease in transmissibility because of  
7 the paucity of viable disease hosts, that can eliminate a pathogen from circulation in a  
8 population or protect those who are to be immunized for medical reasons, and increasing  
9 vaccine uptake enough to achieve herd immunity requires that the vast majority of jurisdictions  
10 have imposed vaccination mandates<sup>3,4</sup>; and  
11

12 Whereas, All jurisdictions offer medical contraindication exemptions to mandates, defined as an  
13 exemption due to “a medical condition that prevents them from receiving a vaccine,” and some  
14 also offer personal belief or religious exemptions to mandates<sup>5,6</sup>; and  
15

16 Whereas, The process for obtaining a medical vaccine exemption differs from state to state,  
17 with some states allowing any healthcare practitioner to provide a medical exemption, and some  
18 specifying who qualifies as a healthcare provider, which may include medical doctors, nurse  
19 practitioners, or physician assistants<sup>4</sup>; and  
20

21 Whereas, In light of increasing medical exemptions for vaccines, in 2019 California enacted  
22 Senate Bill 276 which called for an electronic, standardized medical exemption form that allows  
23 only licensed physicians, surgeons, and registered nurses to prescribe medical exemptions for  
24 vaccines, after which the California Department of Public Health would determine whether these  
25 medical exemptions are in compliance with the Centers for Disease Control and Prevention  
26 guidelines<sup>7</sup>; and  
27

28 Whereas, Under California law, naturopathic providers (who have also been called naturopathic  
29 practitioners, naturopathic doctors, or naturopathic physicians) are not considered “licensed  
30 physicians” and are not allowed to grant medical exemptions, while other states, such as  
31 Washington, allow naturopathic providers to provide medical vaccine exemptions<sup>8-12</sup>; and  
32

33 Whereas, Although AMA policy defines physicians as those with MD or DO degrees  
34 (H-160.949), in states allowing naturopathic providers to approve medical exemptions,  
35 naturopathic providers are allowed to provide vaccine exemptions due to the states’ definition of  
36 medical authority; and  
37

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

1 practitioners actively recommend vaccination, and as many as 7% of naturopathic practitioners  
2 actively recommend against vaccination, raising concerns around allowing their access to  
3 writing vaccine exemptions<sup>10,13,14</sup>; and  
4

5 Whereas, Given that some states have already re-defined “medical authority” to include  
6 naturopathic providers, it is possible that there may be further revisions naming other providers  
7 as “medical authorities” allowed to give vaccine exemptions, and other complementary or  
8 alternative medicine providers, like chiropractors and homeopaths, have documented similar or  
9 higher rates of reluctance to recommend vaccination or recommending against vaccination<sup>14</sup>;  
10 and  
11

12 Whereas, This issue has become even more timely and urgent given the ongoing COVID-19  
13 pandemic and the misinformation being spread about available, safe, and effective vaccines  
14 that can prevent SARS-CoV-2 infection; therefore be it  
15

16 RESOLVED, That our American Medical Association oppose medical vaccine exemptions by  
17 non-physicians by amending Policy H-440.970, “Nonmedical Exemptions from Immunizations,”  
18 by addition to read as follows:  
19

20 **Nonmedical Exemptions from Immunizations, H-440.970**

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

---

- 1 Whereas, Almost 4% of women newly admitted to U.S. prisons are pregnant, and 92% of  
2 pregnancy outcomes in prisons resulted in live births<sup>1,2</sup>; and  
3
- 4 Whereas, Twenty-five percent of justice juvenile residential facilities house at least one pregnant  
5 youth<sup>3</sup>; and  
6
- 7 Whereas, Limited data is available regarding health outcomes of incarcerated pregnant people  
8 despite the high frequency of pre-existing health conditions in incarcerated populations and the  
9 established relationship between incarceration and exacerbation of pre-existing medical  
10 conditions<sup>4-7</sup>; and  
11
- 12 Whereas, State and federal Maternal Mortality Review Committees and the CDC's surveillance  
13 reports on maternal mortality and morbidity already use data from surveillance of perinatal  
14 outcomes to improve understanding of disparities among racial groups and inform the  
15 development of policies and initiatives aimed at meeting the needs of high-risk populations, but  
16 data on incarceration status is not included in this surveillance<sup>6-18</sup>; and  
17
- 18 Whereas, Quality improvement research can improve care for vulnerable populations, and data  
19 from surveillance of perinatal outcomes and studies regarding the accessibility and quality of  
20 healthcare available to pregnant incarcerated people would expand the current knowledge of  
21 disparities within this particularly vulnerable group<sup>19-22</sup>; and  
22
- 23 Whereas, There are currently no standard methodologies or requirements for collecting data on  
24 incarcerated pregnant people and, prior to 2016, had been no organized review of pregnancy  
25 outcomes of incarcerated people in the United States<sup>23</sup>; and  
26
- 27 Whereas, Incarcerated pregnant people are often deprived of prenatal care, adequate nutrition,  
28 access to appropriate accommodations, and timely medical care, all of which are known to  
29 contribute to poor health outcomes<sup>5,6,24-29</sup>; and  
30
- 31 Whereas, The American College of Obstetricians and Gynecologists (ACOG) has established  
32 guidelines on prenatal and postnatal care for incarcerated women, including assessing  
33 pregnancy risk, providing medication-assisted treatment for opioid use disorder in pregnant  
34 people, and avoiding the use of restraints on people that are pregnant or within six weeks of  
35 postpartum, but data have shown that many incarcerated women do not receive care in  
36 accordance with these guidelines<sup>6,23,30</sup>; and  
37
- 38 Whereas, Complications during pregnancy and delivery, such as preeclampsia, intrauterine  
39 growth restriction, and intrauterine fetal death, are more likely to occur in women that have an  
40 opioid addiction and do not receive adequate withdrawal treatment<sup>31</sup>; and

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

5  
6 Whereas, The US Government Accountability Office reported in 2021 that the US Marshals  
7 Service and Bureau of Prisons' Detention Standards and Policies either do not align or only  
8 partially align with national guidance recommendations on the treatment and care of pregnant  
9 people, and the US Bureau of Prisons and most state correctional facilities do not require  
10 specific or explicit guidelines for perinatal care or nutrition<sup>35,36</sup>; and

11  
12 Whereas, The American College of Obstetricians and Gynecologists (ACOG) and the American  
13 Academy of Pediatrics (AAP) recommend exclusive breastfeeding for the first six months of a  
14 baby's life<sup>37,38</sup>; and

15  
16 Whereas, Breast milk has established benefits for the baby, including reduced risks of infection,  
17 such as otitis media and pneumonia; other health conditions, such as obesity, type 1 and type 2  
18 diabetes mellitus, asthma, and sudden infant death syndrome (SIDS); as well as established  
19 benefits of breastfeeding and breast milk expression for the mother, including reduced risk of  
20 breast and ovarian cancer, type 2 diabetes mellitus, and hypertension<sup>37-40</sup>; and

21  
22 Whereas, Breastfeeding has been associated with improved cognitive and emotional abilities,  
23 increased brain development in children, and improved mother-child relationship<sup>41</sup>; and

24  
25 Whereas, The cost of infant formula is up to \$1,500 per year; alternatively, feeding a baby with  
26 pasteurized donor human milk costs an average of \$4.50 per ounce, and further, the cost of  
27 healthcare in a breastfed baby's first year of life is, on average, \$331 less than a formula-fed  
28 baby<sup>42-46</sup>; and

29  
30 Whereas, Pumping breast milk can promote a greater maternal-infant bond and improve the  
31 health of both the mother and infant<sup>47</sup>; and

32  
33 Whereas, A woman's right to breastfeed or express breast milk in any private or public location  
34 is protected by law in all 50 states of the United States; however, for mothers in prison, there  
35 are significant barriers to expressing and storing breast milk, such as requiring presence of a  
36 prison guard, time restrictions, and insufficient equipment<sup>48,49</sup>; and

37  
38 Whereas, Most women who give birth while incarcerated are separated from their child after  
39 hospital discharge and usually without sufficient education on breastfeeding<sup>50</sup>; and

40  
41 Whereas, Restricting mothers from breastfeeding and/or expressing breast milk while  
42 incarcerated will decrease their milk supply, hindering their ability to directly breastfeed<sup>51</sup>; and

43  
44 Whereas, In 2017, the National Commission on Correctional Health Care called on correctional  
45 facilities to support programs for incarcerated women to breastfeed their babies directly or pump  
46 breast milk and store it for later delivery to the infant<sup>52</sup>; and

47  
48 Whereas, The protections for incarcerated mothers to express milk may be established on a  
49 state-by-state basis, but only California, Connecticut, New Mexico, New York, and Washington  
50 have laws offering protections, although still with limitations<sup>48,53-58</sup>; and

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

7  
8 RESOLVED, That our American Medical Association encourage research efforts to characterize  
9 the health needs for pregnant inmates, including efforts that utilize data acquisition directly from  
10 pregnant inmates (New HOD Policy); and be it further

11  
12 RESOLVED, That our AMA support legislation requiring all correctional facilities, including those  
13 that are privately-owned, to collect and report pregnancy-related healthcare statistics with  
14 transparency in the data collection process (New HOD Policy); and be it further

15  
16 RESOLVED, That our AMA amend policy H-430.990 by addition to read as follows:

17  
18 Bonding Programs for Women Prisoners and their Newborn Children H-430.990  
19 Because there are insufficient data at this time to draw conclusions about the long-term  
20 effects of prison nursery programs on mothers and their children, the AMA supports and  
21 encourages further research on the impact of infant bonding programs on incarcerated  
22 women and their children. However, since there are established benefits of breast milk  
23 for infants and breast milk expression for mothers, the AMA advocates for policy and  
24 legislation that extends the right to breastfeed and/or pump and store breast milk to  
25 include incarcerated mothers. The AMA recognizes the prevalence of mental health and  
26 substance abuse problems among incarcerated women and continues to support  
27 access to appropriate services for women in prisons. The AMA recognizes that a large  
28 majority of incarcerated females who may not have developed appropriate parenting  
29 skills are mothers of children under the age of 18. The AMA encourages correctional  
30 facilities to provide parenting skills and breastfeeding/breast pumping training to all  
31 female inmates in preparation for their release from prison and return to their children.  
32 The AMA supports and encourages further investigation into the long-term effects of  
33 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

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1 *Disclaimer: We acknowledge that not all persons who experience menstrual bleeding and need*  
2 *menstrual hygiene products are women, and that the following applies to all individuals who*  
3 *experience menstrual bleeding and require these products.*  
4

5 Whereas, Feminine hygiene products, also known as menstrual care products, are classified as  
6 tampons, pads, liners, cups, sponges, or similar products used by individuals with respect to  
7 menstruation or other genital-tract secretions<sup>1,2</sup>; and  
8

9 Whereas, In 2018, the estimated average life-time cost of menstrual products for an individual in  
10 the United States was \$1,773.33<sup>3</sup>; and  
11

12 Whereas, Two-thirds of low-income women in the United States of America were unable to  
13 afford menstrual products in 2018, and low-income women who are food insecure are more  
14 likely to struggle with the choice to either buy food or menstrual hygiene products due to  
15 financial strain, and often make the choice for the former<sup>4,5</sup> and  
16

17 Whereas, The FDA advises that tampons should never be used for more than 8 hours at a time  
18 due to risks of bacterial growth that could result in toxic shock syndrome and because  
19 unhygienic menstruation practices are a risk factor for secondary infertility<sup>6,7</sup>; and  
20

21 Whereas, One study showed that one third of low-income women in St. Louis, Missouri used  
22 unhygienic menstrual practices such as “strips of cloth, rags, tissues, or toilet paper” due to  
23 menstrual hygiene product inaccessibility, and other studies have shown that such practices,  
24 including using reusable cloths and insufficient changing of menstrual napkins, increase the  
25 likelihood of contracting reproductive and urinary tract infections<sup>5,8,9</sup> and  
26

27 Whereas, Women who cannot afford menstrual hygiene products are more likely to suffer from  
28 moderate/severe depression<sup>10</sup>; and  
29

30 Whereas, Studies have shown that low-income women are concerned about the high cost of  
31 menstrual hygiene products, and are frustrated that their benefits from the Supplemental  
32 Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women,  
33 Infants, and Children (WIC) cannot be used to purchase menstrual hygiene supplies, even  
34 though these are necessities for women<sup>5</sup>; and  
35

36 Whereas, Organizations including the United Nations and Human Rights Watch have classified  
37 menstrual hygiene as a human rights issue<sup>11</sup>; and  
38

39 Whereas, School-aged children in the United States who are unprepared for menarche have  
40 increased rates of depression, substance abuse, delinquency, and school dropout<sup>12</sup>; and

1 Whereas, One in five school-aged girls in the United States have left school early or missed an  
2 entire day of school due to lack of access to menstrual products, and roughly three out of four  
3 working women have left work early to obtain needed menstrual products<sup>13,14</sup>; and  
4

5 Whereas, OSHA requires employers to provide all workers with sanitary and immediately-  
6 available toilet facilities (restrooms) according to sanitation standards 29 CFR 1910.141, 29  
7 CFR 1926.51 and 29 CFR 1928.110<sup>15</sup>; and  
8

9 Whereas, Like toilets and toilet paper, menstrual hygiene products are necessary to effectively  
10 and sanitarly manage natural and unavoidable bodily functions<sup>16</sup>; and  
11

12 Whereas, Similar to menstrual product shortages, families may experience diaper need, and  
13 families experiencing diaper need may provide fewer diaper changes, increasing the risk for  
14 pediatric urinary tract infections and diaper dermatitis, as well as more frequent pediatric care  
15 visits, and diaper need is associated with maternal stress and depression<sup>17,18</sup>; and  
16

17 Whereas, A sufficient supply of diapers costs an average of \$936 a year per child, and in a  
18 survey of pregnant women, almost 30% reported diaper need<sup>17</sup>; and  
19

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

24 Whereas, Oregon recently introduced State Senate Bill 717 which, if passed, would require an  
25 additional \$10 per month to SNAP recipients specifically for personal hygiene products, and in  
26 2019, H.R.1882 (Menstrual Equity for All Act of 2019), introduced to the United States House of  
27 Representatives, proposed that Medicaid cover the cost of feminine hygiene products<sup>18,19</sup> and  
28 HB 4874 has been brought forth to the Illinois House of Representatives and requires the  
29 Department of Human Services to permit the coverage of feminine hygiene products under  
30 SNAP, WIC, and the Temporary Assistance for Needy Families<sup>24</sup>; and  
31

32 Whereas, Multiple pieces of legislation have highlighted the movement towards menstrual  
33 equity for all by calling for free and accessible menstrual products in public schools, establishing  
34 menstrual hygiene products as medical necessities, and allowing purchases for menstrual care  
35 products to be eligible for reimbursement through Health Flexible Spending Arrangements and  
36 Health Reimbursement Arrangements<sup>25,26</sup>; and  
37

38 Whereas, Our AMA urges continued adequate funding of WIC (H-245.979, H-245.989),  
39 supports feminine hygiene products as a medical necessity (H-525.974), supports legislation to  
40 remove all sales tax on feminine hygiene products (H-270.953), and affirms local medical  
41 societies establishing relationships with schools to aid in health education, particularly in  
42 personal hygiene (H-170.996); therefore be it  
43

44 RESOLVED, That our American Medical Association recognize the adverse physical and  
45 mental health consequences of limited access to menstrual products for school-aged individuals  
46 (New HOD Policy); and be it further  
47

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

1 RESOLVED, That our AMA advocate for federal legislation and work with state medical  
2 societies to increase access to menstrual hygiene products, especially for recipients of public  
3 assistance (Directive to Take Action); and be it further  
4

5 RESOLVED, That our AMA encourage public and private institutions as well as places of work  
6 and education to provide free, readily available menstrual care products to workers, patrons,  
7 and students (New HOD Policy); and be it further  
8

9 RESOLVED, That our AMA amend H-525.974, "Considering Feminine Hygiene Products as  
10 Medical Necessities," by addition and deletion to read as follows:  
11

12 CONSIDERING FEMININE HYGIENE PRODUCTS AS MEDICAL NECESSITIES, H-  
13 525.974

14 Our AMA will: (1) encourage the Internal Revenue Service to classify feminine  
15 hygiene products as medical necessities; ~~and~~ (2) work with federal, state, and  
16 specialty medical societies to advocate for the removal of barriers to feminine hygiene  
17 products in state and local prisons and correctional institutions to ensure incarcerated  
18 women be provided free of charge, the appropriate type and quantity of feminine  
19 hygiene products including tampons for their needs; and (3) encourage the American  
20 National Standards Institute, the Occupational Safety and Health Administration, and  
21 other relevant stakeholders to establish and enforce a standard of practice for  
22 providing free, readily available menstrual care products to meet the needs of  
23 workers. (Modify Current HOD Policy)  
24

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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## 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

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1 Whereas, Chronic nuisance ordinances (CNOs) are municipal laws that aim to lower the crime  
2 rate taking place on rental properties by penalizing property owners if repeated incidents of  
3 nuisance activity occur over a set period of time (typically, 12 months)<sup>1</sup>; and  
4

5 Whereas, CNOs are part of a phenomenon called “third-party policing,” through which cities  
6 require private citizens – in this case property owners – to address criminal or otherwise  
7 undesirable behaviors<sup>1</sup>; and  
8

9 Whereas, Punishments for violating CNOs may range from warning letters and fines to evictions  
10 and building closures, and often involve a “nuisance point system” where a certain number of  
11 accumulated points will result in eviction and other actions<sup>1</sup>; and  
12

13 Whereas, What qualifies as nuisance activity can vary widely between municipalities, though  
14 commonly defined as the amount of contact with emergency services, first responders, and  
15 police, for criminal behavior that occurs on or near the property, or “alleged nuisance conduct”  
16 (assault, harassment, stalking, disorderly conduct, city code violations, noise violations, and  
17 others)<sup>2</sup>; and  
18

19 Whereas, CNOs have been enacted by an estimated 2,000 municipalities across 44 states as of  
20 2014 <sup>3</sup>; and  
21

22 Whereas, Nuisance ordinances often apply even when a resident was the victim, and not the  
23 source, of the nuisance activity<sup>3,17</sup>; and  
24

25 Whereas, CNOs punish tenants who require police and emergency medical assistance by  
26 making eviction a consequence of police responses to their homes<sup>1</sup>; and  
27

28 Whereas, The reason for calling the police is not taken into account by most CNOs, so people  
29 who experience mental health crises may be deemed perpetrators of nuisance activity for  
30 seeking emergency medical assistance at a frequency beyond the threshold established in the  
31 CNO and may be threatened with eviction by their landlords<sup>1</sup>; and  
32

33 Whereas, Cities have fined group homes (organizations that provide community-based  
34 residences for people with disabilities) after staff sought police or emergency services  
35 assistance responding to their residents’ medical emergencies<sup>15</sup>; and  
36

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

1 Whereas, CNO nuisance behavior can include the aesthetic appearance of property, such as  
2 litter, an un-mowed lawn, or an “unsightly” yard, which can be applied against residents whose  
3 physical, mental, or health-related disabilities prevent them from meeting their municipality’s  
4 maintenance standards<sup>1</sup>; and

5  
6 Whereas, In June 2017, an appellate court struck down the Village of Groton’s nuisance law as  
7 unconstitutional under the First Amendment, the reasoning being that it deterred tenants from  
8 seeking police assistance, and discouraged people, including domestic violence victims, from  
9 reaching out for help<sup>4</sup>; and

10  
11 Whereas, Surveys of nuisance ordinance enforcement from across the country suggest that  
12 chronic nuisance ordinances disproportionately impact people of color<sup>2</sup>; and

13  
14 Whereas, Between 2012 and 2018, the city of Rochester, NY issued nearly five times as many  
15 nuisance enforcement actions in the quarter of the city with the highest concentration of people  
16 of color as it did in the quarter with the lowest concentration of people of color<sup>2</sup>; and

17  
18 Whereas, A lawsuit filed in August 2017 by a fair housing organization in Peoria, Illinois  
19 revealed that properties in predominantly black neighborhoods were more than twice as likely to  
20 be cited under the city’s nuisance ordinance as white neighborhoods<sup>5</sup>; and

21  
22 Whereas, A two-year study of Milwaukee, Wisconsin found that properties in predominantly  
23 black neighborhoods were over two and a half times as likely to receive a nuisance citation as  
24 properties in predominantly white neighborhoods, even when the neighborhoods made similar  
25 numbers of calls<sup>6</sup>; and

26  
27 Whereas, Women with disabilities have a 40% greater chance of experiencing domestic  
28 violence than women without disabilities<sup>8</sup>; and

29  
30 Whereas, There are an estimated 1.3 million women who are the victims of assault by an  
31 intimate partner annually, and women have a 25% lifetime risk of intimate partner violence<sup>7</sup>; and

32  
33 Whereas, Congress acknowledges that “women and families across the country are being  
34 discriminated against, denied access to, and even evicted from public and subsidized housing  
35 because of their status as victims of domestic violence”<sup>7</sup>; and

36  
37 Whereas, Domestic violence advocates’ efforts in the past decades have been focused on  
38 educating law enforcement on how to approach and aid victims in escaping the cycle of  
39 domestic violence while maintaining their housing<sup>3</sup>; and

40  
41 Whereas, This initiative is directly being threatened by CNOs, as calls about domestic  
42 disturbances can result in the eviction of everyone in the household<sup>3,10-13</sup>; and

43  
44 Whereas, Nuisance ordinances frequently fail to make exceptions for police calls made by  
45 residents experiencing domestic violence even in cases where exceptions exist, calls placed by  
46 survivors of domestic violence are regularly miscategorized and the tenants are punished under  
47 the CNO regardless<sup>9</sup>; and

48  
49 Whereas, Such punishment of domestic violence-related calls for police and medical services  
50 discourages victims of domestic violence from seeking help in future assaults<sup>10</sup>; and

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

5  
6 Whereas, The data on whether CNOs are effective at accomplishing their goals of reducing  
7 nuisance activity is limited<sup>6,9,12</sup>; and

8  
9 Whereas, Even though Cincinnati reported an overall 22% decrease in nuisance calls from  
10 2006-2010, it is unknown whether this drop is due to underreporting or actual decreases in such  
11 behavior<sup>12</sup>; and

12  
13 Whereas, Housing instability and eviction is associated with a higher risk of depression, anxiety,  
14 and even suicide<sup>14,18</sup>; and

15  
16 Whereas, Individuals who lost legal rights to their housing and whose landlords applied for  
17 eviction proceedings were four times more likely to commit suicide (OR = 4.42) compared to  
18 individuals who had not experienced eviction<sup>16</sup>; and

19  
20 Whereas, The disproportionate impact of CNOs on people of color, with disabilities, and/or  
21 victims of domestic violence limit the opportunities for these tenants to find affordable housing in  
22 the future, regardless of the circumstances in which they occurred<sup>13</sup>; therefore be it

23  
24 RESOLVED, That our American Medical Association advocate for amendments to chronic  
25 nuisance ordinances that ensure calls made for safety or emergency services are not counted  
26 towards nuisance designations (Directive to Take Action); and be it further

27  
28 RESOLVED, That our AMA support initiatives to: (a) gather data on chronic nuisance ordinance  
29 enforcement; and (b) make that data publicly available to enable easier identification of  
30 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

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1 Whereas, “Mental health courts” are correctional diversion and rehabilitation programs used by  
2 state and local courts to support individuals with mental illness in the justice system<sup>1-7</sup>; and  
3

4 Whereas, Mental health courts connect individuals with mental illness to mental health  
5 treatment, as an alternative to incarceration or other legal sentences and penalties<sup>1-7</sup>; and  
6

7 Whereas, Two pieces of federal Congressional legislation, the America’s Law Enforcement and  
8 Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act  
9 of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and  
10 resources in the justice system and to establish grants to fund mental health court programs<sup>8-9</sup>;  
11 and  
12

13 Whereas, The continued funding of MIOTCRA programs over the last two decades has been  
14 dependent on Congressional appropriations<sup>10</sup>; and  
15

16 Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in  
17 the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA)  
18 in the Department of Justice administer grants to fund state and local mental health courts<sup>11,12</sup>;  
19 and  
20

21 Whereas, Research demonstrates that mental health courts appear to be associated with  
22 reductions in recidivism, length of incarceration, severity of charges, risk of violence, and  
23 rehospitalization among individuals with mental illness in the justice system<sup>3,13-26</sup>; and  
24

25 Whereas, SAMHSA published a 2015 report noting that because “the vast majority of individuals  
26 who come into contact with the criminal justice system appear” before municipal courts and  
27 “many of these individuals have mental illness and co-occurring substance use disorders,”  
28 municipal courts may be an especially effective “and often overlooked” method of diversion of  
29 individuals with mental illness from the justice system<sup>26</sup>; and  
30

31 Whereas, In addition to SAMHSA and BJA, several nonprofit advocacy organizations, including  
32 Mental Health America, the National Alliance on Mental Illness, the Treatment Advocacy Center,  
33 the National Sheriffs’ Association, the Council on State Governments, and the National Center  
34 for State Courts, support the use of mental health courts<sup>2,27-32</sup>; and  
35

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

1 Whereas, Because mental health courts are dependent on participation from national, state, and  
2 local governmental agencies, justice systems, and mental health service organizations and on  
3 the appropriation of public funds, including federal monies for MIOTCRA programs and grants  
4 administered by SAMHSA and BJA<sup>10-12</sup>, the AMA can play a role in advocating for the continued  
5 support and funding of mental health courts by policymakers; and  
6

7 Whereas, Courts that connect individuals with mental illness to treatment as an alternative to  
8 incarceration exist under many different names, with each focused on different types of mental  
9 illness, including “mental health courts” (for mental illness in general), “drug courts” (for  
10 substance use disorders), and “sobriety” or “sober courts” (for alcohol use disorder and  
11 sometimes certain other substance use disorders)<sup>32-35</sup>; and AMA policy should be inclusive of all  
12 these different types; and  
13

14 Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts,  
15 which are similar in function to mental health courts but narrower in scope, “for individuals with  
16 addictive disease who are convicted of nonviolent crimes”; and  
17

18 Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran  
19 courts, which are similar in function to mental health courts but narrower in scope, “for veterans  
20 who commit criminal offenses that may be related to a neurological or psychiatric disorder”; and  
21

22 Whereas, At I-19, HOD Reference Committee B originally recommended amending Resolution  
23 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with  
24 previous Policy H-100.955 on drug courts<sup>36-37</sup>; and  
25

26 Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was  
27 extracted in our HOD to remove the restriction on only using veteran courts for nonviolent  
28 offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could  
29 potentially be used for criminal offenses in general and not only for nonviolent offenses<sup>36</sup>; and  
30

31 Whereas, To be consistent with our HOD’s most recent debate on this matter, Policy H-100.955  
32 on drug courts and any future AMA policy on alternatives to incarceration for individuals with  
33 mental illness should not be limited to only nonviolent offenses; therefore be it  
34

35 RESOLVED, That American Medical Association Policy H-100.955, “Support for Drug Courts,”  
36 be amended by addition and deletion to read as follows:  
37

38 **Support for Mental Health Drug Courts, H-100.955**

39 Our AMA: (1) supports the establishment and use of mental health drug courts,  
40 including drug courts and sobriety courts, as an effective method of intervention for  
41 individuals with mental illness involved in the justice system within a comprehensive  
42 system of community-based services and supports ~~addictive disease who are~~  
43 ~~convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health  
44 drug courts at the state and local level in the United States; and (3) encourages mental  
45 health drug courts to rely upon evidence-based models of care for those who the judge  
46 or court determine would benefit from intervention rather than incarceration. (Modify  
47 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.

### **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

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

3  
4 Whereas, Additional threats to Medicare, including PAYGO, will create a perfect storm in  
5 January 2022 as some practices face a total of 9.75% cuts to their Medicare reimbursement.

6  
7 Whereas, Practices have not yet recovered from the financial strain of the COVID-19 pandemic.

8  
9 RESOLVED, That our American Medical Association prioritize strong advocacy in opposition to  
10 the application of sequestration to Medicare, including to drugs administered under Medicare  
11 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

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1 Whereas, Beginning in 2020, Centers for Medicare and Medicaid Services (CMS) will be  
2 demanding that “providers” utilize approved “technology” using practice guidelines when  
3 ordering imaging studies; and  
4

5 Whereas, Such guidelines represent an unfunded mandate for physicians already struggling  
6 with massive governmental regulatory burden and underpayment; and  
7

8 Whereas, These technologies or “Augmented Intelligence,” are limited in their ability to apply  
9 clinical context, thus limiting a physician’s ability to order appropriate testing under unique  
10 circumstances and stagnating their work-flow, placing patients at risk; and  
11

12 Whereas, The technology required for this mandatory decision support is extremely expensive,  
13 especially for smaller and independent physician practices; therefore be it  
14

15 RESOLVED, That our American Medical Association advocate for policies that allow for  
16 physician judgment and documented medical decision-making to supersede government  
17 regulation--including the utilization of Augmented Intelligence--in instances of disputes in patient  
18 care (Directive to Take Action); and be it further  
19

20 RESOLVED, That our AMA advocate for policies that require “proof of concept,” in the form of  
21 independently demonstrated quality improvement, prior to the implementation of any  
22 government, insurance company or other third party mandate or regulation on patient care and  
23 the physician-patient relationship (Directive to Take Action); and be it further  
24

25 RESOLVED, That our AMA advocate for policies requiring government, insurance company or  
26 other third party entities to fully fund any mandates or regulations imposed on patient care and  
27 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

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- 1 Whereas, Contractor Advisory Committees (CACs) and other stakeholders have played an  
2 important role in review of policy changes put forth by Medicare Administrative Contractors  
3 (MACs); and  
4
- 5 Whereas, The Local Coverage Determination (LCD) process historically has considered  
6 comment and input from a Contractor Advisory Committee, and, in most cases, LCDs require a  
7 45-day comment period; and  
8
- 9 Whereas, Our AMA has strong policy in support of robust MAC processes for transparency and  
10 stakeholder engagement, including engagement of CACs, in reviewing Local Coverage  
11 Determinations (LCDs), and in support of local Medicare CACs in their role as policy advisers;  
12 and  
13
- 14 Whereas, The 21<sup>st</sup> Century Cures Act included provisions intended to modernize and strengthen  
15 the LCD review process and ensure transparency and stakeholder engagement in MACs'  
16 decision making processes, and the Medicare Program Integrity Manual Chapter 13 finalized  
17 requirements of the LCD modernization process; and  
18
- 19 Whereas, The 21<sup>st</sup> Century Cures Act and related regulations demonstrate the intent of  
20 Congress and CMS to ensure processes for meaningful stakeholder review and input for  
21 substantive policy changes; and  
22
- 23 Whereas, Some MACs have used Local Coverage Articles (LCAs) to unilaterally issue policy  
24 changes that might have the effect of restricting coverage or access, without an attached,  
25 supportive LCD, arguing they are only providing billing instructions, when in reality changes  
26 could reasonably be expected to have the effect of restricting coverage. In most cases LCAs are  
27 coupled with LCDs or a National Coverage Determination (NCD), and the LCA only provides  
28 such additional coding/billing or other information as may be needed to implement the coverage  
29 policy determined in the LCD or NCD; and  
30
- 31 Whereas, MACs issuing changes in coverage policy through LCAs without issuing a proposed  
32 LCD are circumventing the notice-and-comment period required of LCDs and other substantive  
33 rulemaking, bypassing the stakeholder engagement and transparency in decision making that  
34 was intended by Congress; and

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

5  
6 Whereas, The evidentiary requirements of LCDs are not required in an LCA, and LCAs  
7 unilaterally issued without LCDs lack transparency and also do not allow stakeholders to review  
8 data or decision criteria, or to submit formal requests for reconsideration of the coverage policy;  
9 and

10  
11 Whereas, These actions by MACs are counter to and not in the spirit of the transparency and  
12 increased stakeholder engagement and review intended by Congress in revising the LCD  
13 process by way of the 21st Century Cures Act, nor of CMS' improvements to the LCD process  
14 following stakeholder feedback to its Request for Information (RFI) in the CY 2018 Physician  
15 Fee Schedule; and

16  
17 Whereas, The significant changes to LCD procedures stemming from the 21st Century Cures  
18 Act also allow MACs to change their engagement with traditional CACs, and CACs are no  
19 longer being engaged by MACs to function in their roles in reviewing and commenting on  
20 proposed policy changes and therefore no longer have a meaningful function; therefore be it

21  
22 RESOLVED, That our American Medical Association oppose Medicare Administrative  
23 Contractors (MACs) issuing Local Coverage Articles (LCAs) that could have the effect of  
24 restricting coverage or access without providing data and evidentiary review or without issuing  
25 associated Local Coverage Determinations (LCDs) and following required stakeholder  
26 processes (New HOD Policy); and be it further

27  
28 RESOLVED, That our AMA advocate and work with the Centers for Medicare and Medicaid  
29 Services (CMS) to ensure no LCAs that could have the effect of restricting coverage or access  
30 are issued by MACs without the MAC providing public data, decision criteria, and evidentiary  
31 review and allowing comment, or without an associated LCD and the required LCD stakeholder  
32 review and input processes, through the modernization requirement of the 21<sup>st</sup> Century Cures  
33 Act (Directive to Take Action); and be it further

34  
35 RESOLVED, That our AMA advocate to CMS that the agency immediately invalidate any LCAs  
36 that it identifies as potentially restricting coverage or access and that were issued without the  
37 MACs providing public data, decision criteria, and evidentiary review, or that were issued  
38 without an associated LCD and the required stakeholder processes, and that CMS require  
39 MACs to restart those processes taking any such proposed changes through LCDs and  
40 associated requirements for stakeholder engagement, public data, and evidentiary review  
41 (Directive to Take Action); and be it further

42  
43 RESOLVED, That our AMA advocate that Congress consider clarifying legislative language that  
44 reinstates a role for local Contractor Advisory Committees in review processes going forward,  
45 addressing unintended outcomes of changes in 21<sup>st</sup> Century Cures Act that allowed local CACs  
46 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

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- 1 Whereas, Pharmacy Benefit Managers (PBMs) are third-parties that are contracted by payers to  
2 create and manage drug formularies; and  
3  
4 Whereas, PBMs are middle men in the drug supply chain and act in a way that lacks  
5 transparency and can create perverse incentives that increase drug prices; and  
6  
7 Whereas, Our AMA has existing policy supporting the regulation of PBMs by state legislatures  
8 and insurance commissioners<sup>1</sup>; and  
9  
10 Whereas, Our AMA has not updated its Health Care Reform Objectives or the AMA Vision for  
11 Health System Reform to reflect this policy; and  
12  
13 Whereas, Our AMA has not placed PBM reform among its highest state legislative priorities;  
14 and  
15  
16 Whereas, The Supreme Court decision in *Rutledge v. PCMA* has given states greater authority  
17 to regulate the activities of PBMs; and  
18  
19 Whereas, It is imperative that states use this broadened authority to regulate abusive PBM  
20 practices, therefore be it  
21  
22 RESOLVED, That our American Medical Association make Pharmacy Benefit Manager (PBM)  
23 reform a state legislative priority (Directive to Take Action); and be it further  
24  
25 RESOLVED, That our AMA draft model PBM legislation or adopt model legislation from other  
26 organizations (Directive to Take Action); and be it further  
27  
28 RESOLVED, That our AMA actively advocate for the passage of PBM reform in state  
29 legislatures across the country (Directive to Take Action); and be it further  
30  
31 RESOLVED, That our AMA update its Health Care Reform Objectives and the AMA Vision for  
32 Health System Reform to reflect this priority change and the importance of effective PBM  
33 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

<sup>i</sup> 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

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- 1 Whereas, Patients are often not explicitly informed when seeking medical care what the  
2 qualifications are of the person treating them<sup>1</sup>; and  
3  
4 Whereas, Physicians are being forced or coerced into “supervising” midlevel providers either  
5 directly or indirectly, by using it as a requirement for physician employment<sup>1</sup>; and  
6  
7 Whereas, Physicians are being asked to “supervise,” in name only, unreasonably high numbers  
8 of midlevel providers opening them up to liability issues<sup>1</sup>; and  
9  
10 Whereas, There have been instances where physicians’ licenses have been used, unbeknownst  
11 to the physician, to document “supervision” of midlevel providers and also instances where  
12 midlevel providers do not even know the identity of their documented “supervising” physician<sup>1</sup>;  
13 and  
14  
15 Whereas, Midlevel providers/non-physicians have pushed for changes in legislation requiring  
16 “supervision” by physicians be changed to “collaboration” with physicians in effort to equate their  
17 training<sup>1</sup>; therefore be it  
18  
19 RESOLVED, That our American Medical Association reaffirm Policies H-160.947 and  
20 H-160.950 (Reaffirm HOD Policy); and be it further  
21  
22 RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are  
23 notified in writing when their license is being used to “supervise” midlevel providers (Directive to  
24 Take Action); and be it further  
25  
26 RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a  
27 condition for physician employment and in physician employment contracts, especially when  
28 physicians are not provided adequate resources and time for this responsibility (New HOD  
29 Policy); and be it further  
30  
31 RESOLVED, That our AMA advocate for the right of physicians to deny “supervision” to any  
32 midlevel provider whom they deem a danger to patient safety and the ability to report unsafe  
33 care provided by mid-levels to the appropriate regulatory board with whistleblower protections  
34 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

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- 1 Whereas, Advanced practice providers and allied health professionals are required under the  
2 laws of many states to be supervised to some degree by a physician; and  
3  
4 Whereas, News reports and articles note instances of thoracic surgeons and obstetrician/  
5 gynecologists supervising social workers in the provision of group therapy<sup>1</sup> and plastic surgeons  
6 supervising physician assistants who advertise themselves as “dermatologists”<sup>2</sup>; and  
7  
8 Whereas, Widely known anecdotal evidence suggests numerous advanced practice providers  
9 practicing in various fields while being nominally supervised by physicians not trained in those  
10 fields; and  
11  
12 Whereas, Physicians without appropriate training supervising advanced practice providers  
13 outside of their expertise defeats the purpose of scope-of-practice laws and endangers patients;  
14 therefore be it  
15  
16 RESOLVED, That our American Medical Association conduct a systematic study to collect and  
17 analyze publicly available physician supervision data from all sources to determine how many  
18 allied health professionals are being supervised by physicians in field which are not a core part  
19 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

- 
- 1 Whereas, The book *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant*  
2 *in Healthcare* by Niran Al-Agba, MD and Rebekah Bernard, MD published in 2020, seeks to  
3 educate patients about the safety of the providers treating them and empower physicians to  
4 regain control of the practice of medicine<sup>1</sup>; and  
5  
6 Whereas, The corporatization of medicine, at the expense of quality, safe healthcare, has led to  
7 physicians being fired and replaced by midlevel providers, especially in states with legislatively  
8 awarded independent practice for midlevel providers<sup>1</sup>; and  
9  
10 Whereas, The corporate practice of medicine has created a situation in which physicians are  
11 expected to “train their replacements”; and  
12  
13 Whereas, Post-graduate programs for midlevel providers expand while physician post-graduate  
14 training programs stay stagnant or close<sup>1</sup>; therefore be it  
15  
16 RESOLVED, That our American Medical Association study the impact that individual physician  
17 scope of practice advocacy has had on physician employment and contract terminations  
18 (Directive to Take Action); and be it further  
19  
20 RESOLVED, That our AMA study the views of patients on physician and non-physician care to  
21 identify best practices in educating the general population on the value of physician-led care  
22 (Directive to Take Action); and be it further  
23  
24 RESOLVED, That our AMA study the utility of a physician-reported database to track and report  
25 institutions that replace physicians with midlevel providers in order to aid patients in seeking  
26 physician-led medical care as opposed to care by midlevel providers practicing without  
27 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

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- 1 Whereas, A survey in 2017 published in Worldviews Evidence Based Nursing revealed that a  
2 majority of the 2,300 nurse respondents did not feel competent in evidence-based practice<sup>1</sup>; and  
3  
4 Whereas, Physicians that speak out about the differences in training received by physicians vs.  
5 by mid-level providers are being fired, labeled “disrespectful” or labeled “not team players” in the  
6 interdisciplinary team treating patients<sup>1</sup>; and  
7  
8 Whereas, More non-physician post-graduate training programs are being formed across the  
9 nation; there is still no mandatory requirement for non-physicians to pursue post-graduate  
10 training<sup>1</sup>; and  
11  
12 Whereas, Physicians are expected to continue to maintain certification by proving they continue  
13 to educate themselves; mid-level providers are not held to the same standard<sup>1</sup>; and  
14  
15 Whereas, Currently mid-levels providers can switch between specialties and subspecialties of  
16 medicine and surgery without any formal or regulated training or education<sup>1</sup>; and  
17  
18 Whereas, Physicians are limited in their practice abilities by the post-graduate training they  
19 receive<sup>1</sup>; therefore be it  
20  
21 RESOLVED, That our American Medical Association study, using surveys among other tools  
22 that protect identities, how commonly bias against physician-led healthcare is experienced  
23 within undergraduate medical education and graduate medical education, interprofessional  
24 learning and team building work and publish these findings in peer-reviewed journals (Directive  
25 to Take Action); and be it further  
26  
27 RESOLVED, That our AMA work with the Liaison Committee on Medical Education and the  
28 Accreditation Council for Graduate Medical Education to ensure all physician undergraduate  
29 and graduate training programs recognize and teach physicians that they are the leaders of the  
30 healthcare team and are adequately equipped to diagnose and treat patients independently only  
31 because of the intensive, regulated, and standardized education they receive (Directive to Take  
32 Action); and be it further  
33  
34 RESOLVED, That our AMA study the harms and benefits of establishing mandatory  
35 postgraduate clinical training for nurse practitioners and physician assistants prior to working  
36 within a specialty or subspecialty field (Directive to Take Action); and be it further  
37  
38 RESOLVED, That our AMA study the harms and benefits of establishing national requirements  
39 for structured and regulated continued education for nurse practitioners and physician  
40 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

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- 1 Whereas, Led by the Society of Pediatric Radiology (SPR), the Image Gently Alliance was  
2 formed in late 2006 with the goal of “changing practice by raising awareness of the opportunities  
3 to lower radiation dose in the imaging of children” (1); and  
4
- 5 Whereas, The SPR recruited other organizations/members of the imaging team into the alliance  
6 in 2007 including the American College of Radiology (ACR), American Association of Physicists  
7 in Medicine (AAPM), and American Society of Radiologic Technologists (ASRT) (1); and  
8
- 9 Whereas, The practice of shielding reproductive organs and in utero fetuses began in the 1950s  
10 given concerns about the long-term effects of radiation and the potential for passing on genetic  
11 mutations through genetic inheritance (2,3); and  
12
- 13 Whereas, In response to these concerns, state and federal laws and regulations have been  
14 created requiring the use of gonad shields in medical imaging studies (4,5); and  
15
- 16 Whereas, Through technological advances, medical physicists estimate the dose from routine  
17 diagnostic imaging to reproductive organs has been reduced by 95% without compromising  
18 diagnostic quality (2,3); and  
19
- 20 Whereas, Technological advances and optimization have resulted in marginal hereditary risk  
21 reduction from gonad shielding ranging from  $1 \times 10^{-6}$  in women and  $5 \times 10^{-6}$  in men (6); and  
22
- 23 Whereas, Research on radiation dosing has shown that routine diagnostic imaging does not  
24 produce harmful levels of radiation to patients and fetuses (2,3); and  
25
- 26 Whereas, Modern mechanisms to optimize imaging parameters such as automatic exposure  
27 control (AEC) are negatively affected by shielding (7); and  
28
- 29 Whereas, The gonad shield results in decreased activity on the detector, triggering AEC to  
30 increase radiation output, which results in increased exposure and patient dose along with the  
31 degradation of image quality (7); and  
32
- 33 Whereas, The gonad shield produces artifacts and can obscure relevant anatomy and  
34 diagnostic information (7); and  
35
- 36 Whereas, Non-diagnostic or obscured images may need to be repeated increasing patient dose  
37 when shields are used (7); and  
38
- 39 Whereas, The gonad surface shield is ineffective at reducing internal scatter (7); and

1 Whereas, Studies have shown that gonad shields are incorrectly placed for females in 91% of  
2 radiographs and for males in 66% of radiographs, rendering them ineffective (8,9); and  
3

4 Whereas, On January 12th, 2021 the National Council on Radiation Protection and  
5 Measurements (NCRP) issued a statement that the risks of utilizing gonad shields far outweigh  
6 the negligible benefits to reproductive organs and therefore they should not be routinely used  
7 (10); and  
8

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

12 RESOLVED, That our American Medical Association oppose mandatory use of gonad shields in  
13 medical imaging considering the risks far outweigh the benefits (New HOD Policy); and be it  
14 further  
15

16 RESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the  
17 code of federal regulations to oppose the routine use of gonad shields in medical imaging  
18 (Directive to Take Action); and be it further  
19

20 RESOLVED, That our AMA, in conjunction with state medical societies, support model state and  
21 national legislation to oppose or repeal mandatory use of gonad shields in medical imaging.  
22 (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&rqn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=c6fd98dfc8955d41420798f3e5357c66&mc=true&node=se21.8.1000_150&rqn=div8)
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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

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

9  
10 Whereas, Adjusted for inflation in practice costs, Medicare physician payment declined 22%  
11 from 2001 to 2020, or by 1.3% per year on average; and

12  
13 Whereas, Medicare physician payments have remained restricted by a budget-neutral financing  
14 system in which the Centers for Medicare & Medicaid Services routinely overestimates the  
15 utilization and volume of new services, yet budget neutrality adjustments are permanently  
16 established in the fee schedule; and

17  
18 Whereas, Physician and nonphysician practitioner services represent a modest portion of the  
19 overall growth in health care costs; and

20  
21 Whereas, Potential penalties under the Merit-Based Incentive Payment System (MIPS), which  
22 apply to MPFS services, will increase to 9% in 2022; and

23  
24 Whereas, The alternative payment model pathway for physicians under MACRA has yet to be  
25 realized, leaving the majority of practices stuck in the MIPS portion of the MACRA program; and

26  
27 Whereas, Medicare patients suffer as physicians adjust to unpredictable and excessive  
28 reductions to payment that inhibit their ability to ensure beneficiaries have access to the care  
29 they need; and

30  
31 Whereas, physician practices are amid the COVID-19 public health emergency, requiring  
32 continued infection control protocols that, while necessary, have increased the costs of  
33 providing care; therefore be it

34  
35 RESOLVED, That our American Medical Association continue to advocate for legislation that  
36 prevents Medicare cuts from taking place prior to Jan. 1, 2022 (Directive to Take Action); and be  
37 it further

38  
39 RESOLVED, That our AMA seek annual and full Medicare Economic Index updates for  
40 Medicare Part B physician payments (Directive to Take Action); and be it further

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

3  
4 RESOLVED, That our AMA advocate for payment policies that allow the Centers for Medicare &  
5 Medicaid Services to retroactively adjust overestimates of volume of services by instituting a  
6 three-year look-back period to correct Medicare conversion factor estimations. (Directive to  
7 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

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- 1 Whereas, On March 17, 2020, the Secretary of the U.S. Department of Health and Human  
2 Services declared a public health emergency caused by COVID-19; and  
3
- 4 Whereas, This action triggered the Secretary’s authority to issue certain directives relating to  
5 public health under the Public Readiness and Emergency Preparedness Act (PREP Act), 42  
6 U.S.C. §247d-6d; and  
7
- 8 Whereas, The PREP Act gives broad immunity to certain covered persons from lawsuits and  
9 liability under federal and state law in regard to claims for loss caused by, arising out of, relating  
10 to, or resulting from the administration to or use by an individual of a covered countermeasure to  
11 diseases, threats and conditions, except in the case of willful misconduct; and  
12
- 13 Whereas, Effective Sept. 9, 2021, the secretary released the Ninth Amendment to Declaration  
14 Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures  
15 Against COVID-19, (herein after referred to as “the declaration”), expanding liability protection  
16 and authority for certain covered persons authorized to prescribe, dispense, and administer  
17 COVID-19 therapeutics that are covered countermeasures under section IV of the declaration;  
18 and  
19
- 20 Whereas, The declaration specifically expands the scope of authority for state-licensed  
21 pharmacists to order and administer, and certain pharmacy technicians and pharmacy interns to  
22 administer, COVID-19 therapeutics subcutaneously, intramuscularly, or orally as authorized,  
23 approved, or licensed by the U.S. Food and Drug Administration; and  
24
- 25 Whereas, The declaration states that it preempts state law that would otherwise prohibit these  
26 individuals from independently prescribing, dispensing, or administering COVID-19 therapeutics  
27 or other covered countermeasures; and  
28
- 29 Whereas, It is a longstanding principle in the U.S. that the practice of medicine is regulated by  
30 the state and that states determine and enforce the scope of practice for physicians and health  
31 care providers practicing in their respective states; and  
32
- 33 Whereas, State scope-of-practice laws serve an important role in protecting public health,  
34 including safeguarding patients from improper care provided by individuals acting outside the  
35 scope of their practice under state licensure, which is based on education, training, and  
36 experience requirements that vary significantly by licensure type as well as by each state for the  
37 same type of licensure; and

1 Whereas, Many states uphold physician-led, team-based care with proper physician delegation  
2 and supervision of medical acts performed by nonphysicians to protect patient safety; and  
3

4 Whereas, The declaration places public health in jeopardy by attempting to override these state  
5 guardrails and protocols meant to protect against such variables in physician and health care  
6 provider education, training, and experience; and  
7

8 Whereas, The declaration threatens to erode physician-led, team-based care and interfere with  
9 continuity of care in the patient's primary medical home; and  
10

11 Whereas, For more than 30 years, the American Medical Association's state and federal  
12 advocacy has safeguarded the practice of medicine by opposing attempts to inappropriately  
13 expand nonphysicians' scope of practice; therefore be it  
14

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

20 RESOLVED, That our AMA specifically oppose expansion under the declaration of the scope of  
21 authority for state-licensed pharmacists to order and administer, and certain pharmacy  
22 technicians and pharmacy interns to administer, COVID-19 therapeutics subcutaneously,  
23 intramuscularly, or orally as authorized, approved, or licensed by the U.S. Food and Drug  
24 Administration (New HOD Policy); and be it further  
25

26 RESOLVED, That our AMA also specifically oppose the declaration as it purports to preempt  
27 state law that otherwise would prohibit these individuals from independently prescribing,  
28 dispensing, or administering COVID-19 therapeutics or other covered countermeasures (New  
29 HOD Policy); and be it further  
30

31 RESOLVED, That our AMA release a statement in opposition to the declaration and ask that it  
32 be rescinded (Directive to Take Action); and be it further  
33

34 RESOLVED, That our AMA continue to advocate for legislation that prevents the federal  
35 government from preempting state scope-of-licensure laws for physicians and health care  
36 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

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

3  
4 Whereas, Patients and physicians continue to find value in the use of telemedicine when the  
5 condition is appropriate for this delivery type; and

6  
7 Whereas, Patients will now expect telemedicine visits when appropriate, since telemedicine is  
8 about convenience for the patient, and removing telehealth services from the covered code list  
9 will prove disruptive to practices and patients alike; and

10  
11 Whereas, The Centers for Medicare & Medicaid Services proposes to retain 135 telehealth  
12 services added to the Medicare telehealth services list on a Category 3 basis until the end of  
13 2023; and

14  
15 Whereas, Physicians must have the flexibility to decide whether to see their patients via  
16 telehealth or in person without unnecessary and disconnected pricing incentives; and

17  
18 Whereas, A physician-led and collaborative team-based approach is optimal for patient care  
19 delivery and overall health care outcomes, especially when using telehealth; and

20  
21 Whereas, Physician payment is determined using the resource-based relative value scale,  
22 which aligns payments based on the cost and resources used to provide services using  
23 physician work, practice expense, and medical liability expense; and

24  
25 Whereas, Augmenting a physician's practice with telemedicine incurs additional expenses  
26 different from those of delivering only in-person care, and offering telemedicine adds expenses  
27 such as software, hardware, workflow adjustments, physician and staff training, and patient  
28 education; therefore be it

29  
30 RESOLVED, That our American Medical Association advocate for Congress to require  
31 Employee Retirement Income Security Act (ERISA) self-funded employer-sponsored plans,  
32 state-regulated plans, Medicare, Medicaid, and TRICARE to pay physicians appropriately for a  
33 covered service provided as a telemedicine service to an enrolled patient by a contracted  
34 physician at least the same as the contracted rate that would have been paid if the service were  
35 provided in an in-person setting (Directive to Take Action); and be it further

36  
37 RESOLVED, That our AMA support state medical board licensure requirements in the state  
38 where the patient is located, but otherwise the geographic and originating site restrictions  
39 should be eliminated to allow patients to receive appropriate telehealth services in their homes,  
40 residential facilities, and other locations (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA advocate that the Centers for Medicare & Medicaid Services retain
- 2 on a permanent basis the telehealth services added to the Medicare telehealth services list
- 3 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 evolution 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

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1 Whereas, There are looming Medicare cuts amounting to almost 9.75% on physician practices  
2 on January 1, 2022; and  
3

4 Whereas, The AMA is urging House leaders to extend the 3.75% increase to the Medicare  
5 conversion factor that Congress included in the Consolidated Appropriations Act of 2021 which  
6 provides for continued stability to the physician and provider community as it works toward  
7 broader Medicare payment reform; and  
8

9 Whereas, Physicians, who have given their time, energy, expertise and in some cases their  
10 lives to protect the United States population from the current COVID 19 pandemic deserve to be  
11 recognized not by Medicare reductions but by increases; and  
12

13 Whereas, Our AMA has policy that has not been acted upon in a manner to effect change for  
14 American physicians regarding payment cuts; and  
15

16 Whereas, Our AMA membership of practicing physicians could be improved strengthening our  
17 organization; therefore be it  
18

19 RESOLVED, That our American Medical Association make avoiding the Medicare payment cuts  
20 on physician practices a top priority (Directive to Take Action); and be it further  
21

22 RESOLVED, That our AMA utilize the necessary resources to avoid the pending Medicare  
23 physician payment cuts (Directive to Take Action); and be it further  
24

25 RESOLVED, That our AMA modify policy D-165.941, "Sequestration Budget Cuts," by addition  
26 and deletion to read as follows:  
27

28 **Sequestration Budget Cuts D-165.941**

29 1. Our AMA will urge Congress to develop a fiscally responsible alternative that would  
30 prevent the automatic budget sequestration cuts that would endanger critical  
31 programs related to medical research, public health, workforce, food and drug safety,  
32 and health care for uniformed service members, as well as trigger cuts in Medicare  
33 payments to graduate medical education programs, hospitals, and physicians that will  
34 endanger access to care and training of physicians.

35 2. Our AMA will take all necessary legislative and administrative steps to prevent  
36 extended ~~or~~ and deeper sequester cuts in Medicare payments to physician practices  
37 using the financial means necessary to do so and make this a top priority. (Modify  
38 Current HOD Policy); and be it further

1 RESOLVED, That our AMA reaffirm and take immediate action on policy H-330.932,  
2 "Cuts in Medicare and Medicaid Reimbursement," that:  
3 (1) supports the concept that the Medicare and Medicaid budgets need to expand  
4 adequately to adjust for factors such as cost of living, the growing size of the Medicare  
5 population, and the cost of new technology;(calls for elimination of budget neutrality)  
6 (current policy)  
7 (2) aggressively encourages CMS to affirm the patient's and the physician's  
8 constitutional right to privately contract for medical services; (freedom of choice for  
9 patients), (current policy)  
10 (3) if the reimbursement is not improved, the AMA declares the Medicare  
11 reimbursement unworkable and intolerable, and seek immediate legislation to allow the  
12 physician to balance bill the patient according to their usual and customary fee; (current  
13 policy); and  
14 (4) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid,  
15 Medicare, and other appropriate health care reimbursement programs, in addition to  
16 other needed payment increases. (current policy) (Reaffirm HOD Policy); and be it  
17 further

18  
19 RESOLVED, That our AMA reach out to the physicians of the United States via all possible  
20 means, to include but not be limited to email, US mail, social media, to encourage physicians to  
21 participate in the AMA campaign to improve physician payments (Directive to Take Action); and  
22 be it further

23  
24 RESOLVED, That our AMA have an open and transparent dialogue with Congressional leaders  
25 and the Centers for Medicare and Medicaid Services regarding continued devaluation of the  
26 American physician and communicate such with America's physicians (both member and non-  
27 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; Reaffirmation 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

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1  
2 Whereas, Federal law imposes budget neutrality requirements on revisions to RVUs under the  
3 Medicare Physician Fee Schedule (MPFS) that result in changes in federal expenditures in  
4 excess of \$20 million per year<sup>iii</sup>; and  
5

6 Whereas, Our AMA has calculated that the value of Medicare physician payments declined 22%  
7 relative to practice costs between 2001 and 2020<sup>iii</sup> and government officials project that the real  
8 value of the MPFS will continue to decline under current federal law<sup>ivv</sup>; and  
9

10 Whereas, The US has an aging population<sup>vi</sup> which will drive Medicare enrollment growth<sup>vii</sup> and  
11 increase Medicare spending<sup>viii</sup>; and  
12

13 Whereas, The 2021 MPFS Final Rule would have imposed budget neutrality cuts as high as  
14 10% on certain specialists<sup>ix</sup>, which made it impossible to implement the rule's appropriate and  
15 deserved payment increases for office and outpatient E&M codes without threatening access to  
16 care and endangering the economic viability of other physician practices; and  
17

18 Whereas, Congress provided substantial temporary relief from these cuts<sup>x</sup>, including a 3.75-  
19 percent across-the-board payment increase under the MPFS, this component of the relief will  
20 expire January 1<sup>st</sup>, 2022 unless further Congressional action is taken; and  
21

22 Whereas, Existing budget neutrality requirements make implementing appropriate, significant  
23 RVU revisions for crucial services under the MPFS difficult or impossible to accomplish while  
24 maintaining access to care for beneficiaries who receive treatment from physicians who do not  
25 provide these services; and  
26

27 Whereas, Budget neutrality cuts can create significant, arbitrary distortions in valuations for  
28 Medicare physician services and thereby generate looming access crises on a perennial basis;  
29 and  
30

31 Whereas, Our AMA has taken existing stances against budget neutrality (Objects to the use of  
32 the relative values as a mechanism to preserve budget neutrality (H-400.959 -Refining and  
33 Updating the Physician Work Component of the RBRVS and 400.956-RBRVS development);  
34 therefore be it  
35

36 RESOLVED, That our American Medical Association work towards the elimination of budget  
37 neutrality requirements under federal law (Directive to Take Action); and be it further

1 RESOLVED, That our AMA amend Policy H-385.905, “Merit-based Incentive Payment System  
2 (MIPS) Update,” by addition and deletion to read as follows:  
3

4 **Merit-based Incentive Payment System (MIPS) Update H-385.905**

5 Our AMA ~~will work toward creating and pursuing supports~~ legislation that ensures  
6 Medicare physician payments ~~are~~ is sufficient to safeguard beneficiary access to care,  
7 ~~replaces or supplements budget eliminate budget neutrality requirements within the~~  
8 MPFS and with respect to in-MIPS with incentive payments, or and implements  
9 positive annual Medicare physician payment updates that keep pace with rising  
10 practice costs. (Modify Current HOD Policy); and be it further  
11

12 RESOLVED, That our AMA reaffirm D-400.989, “Equal Pay for Equal Work,” with a special  
13 emphasis on the third bullet point and work to create legislation to eliminate budget neutrality:  
14

15 Our AMA: (1) shall make its first legislative priority to fix the Medicare payment update  
16 problem because this is the most immediate means of increasing Medicare payments  
17 to physicians in rural states and will have the greatest impact; (2) shall seek enactment  
18 of legislation directing the General Accounting Office to develop and recommend to  
19 Congress policy options for reducing any unjustified geographic disparities in Medicare  
20 physician payment rates and improving physician recruitment and retention in  
21 underserved rural areas; and **(3) shall advocate strongly to the current**  
22 **administration and Congress that additional funds must be put into the Medicare**  
23 **physician payment system and that continued budget neutrality is not an option.**  
24 (Reaffirm HOD Policy); and be it further  
25

26 RESOLVED, That our AMA reaffirm and take action on H-400.972, “Physician Payment Reform”  
27

28 **H-400.972, “Physician Payment Reform**

29 It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to  
30 redress the inequities in the implementation of the RBRVS, including, but not limited to,  
31 (a) reduction of allowances for new physicians; (b) the non-payment of EKG  
32 interpretations; (c) defects in the Geographic Practice Cost Indices and area  
33 designations; (d) inappropriate Resource-Based Relative Value Units; (e) the  
34 deteriorating economic condition of physicians' practices disproportionately affected by  
35 the Medicare payment system; (f) the need for RBRVS conversion factor updates that  
36 are not subject to budget neutrality requirements; (g) the inadequacy of payment for  
37 services of assistant surgeons; and (h) the loss of surgical-tray benefit for many  
38 outpatient procedures ( Reaffirmed by Rules & Credentials Cmt., A-96);  
39 (2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the  
40 calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and  
41 equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of  
42 services used to determine RBRVS values and payment levels and to seek adjustments  
43 so that the resulting values and payment levels appropriately pertain to the elderly and  
44 often infirm patients;  
45 (3) evaluate the use of the RBRVS on the calculation of the work component of the  
46 Medicare Payment Schedule and to ascertain that the concept for the work component  
47 continues to be an appropriate part of a resource-based relative value system;  
48 (4) seek to assure that all modifiers, including global descriptors, are well publicized and  
49 include adequate descriptors;  
50 (5) seek the establishment of a reasonable and consistent interpretation of global fees,  
51 dealing specifically with preoperative office visits, concomitant office procedures, and/or  
52 future procedures;

- 1 (6) seek from CMS and/or Congress an additional comment period beginning in the Fall  
2 of 1992;
- 3 (7) seek the elimination of regulations directing patients to points of service;
- 4 (8) support further study of refinements in the practice cost component of the RBRVS to  
5 ensure better reflection of both absolute and relative costs associated with individual  
6 services, physician practices, and medical specialties, considering such issues as data  
7 adequacy, equity, and the degree of disruption likely to be associated with any policy  
8 change;
- 9 (9) take steps to assure that relative value units in the Medicare payment schedule,  
10 such as nursing home visits, are adjusted to account for increased resources needed to  
11 deliver care and comply with federal and state regulatory programs that  
12 disproportionately affect these services and that the Medicare conversion factor be  
13 adjusted and updated to reflect these increased overall costs;
- 14 (10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of  
15 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683  
16 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare  
17 geographic practice costs indices (GPCIs) and work with CMS and the Congress to  
18 assure that GPCIs are updated in as timely a manner as feasible and reflect actual  
19 physician costs, including gross receipt taxes;
- 20 (11) request that CMS refine relative values for particular services on the basis of valid  
21 and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS  
22 Updating Committee (RUC) for assignment of relative work values to new or revised  
23 CPT codes and any other tasks for which the RUC can provide credible  
24 recommendations;
- 25 (12) pursue aggressively recognition and CMS adoption for Medicare payment  
26 schedule conversion factor updates of an index providing the best assurance of  
27 increases in the monetary conversion factor reflective of changes in physician practice  
28 costs, and to this end, to consider seriously the development of a "shadow" Medicare  
29 Economic Index;
- 30 (13) continue to implement and refine the Payment Reform Education Project to provide  
31 member physicians with accurate and timely information on developments in Medicare  
32 physician payment reform; and
- 33 (14) take steps to assure all relative value units contained in the Medicare Fee  
34 Schedule are adjusted as needed to comply with ever-increasing federal and state  
35 regulatory requirements. (created in 1992, reaffirmed 10 times) (Reaffirm HOD Policy)  
36

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

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- <sup>i</sup> 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](https://www.ssa.gov/OP_Home/ssact/title18/1848.htm) see Section 1848(c)(2)(B)(ii)(II) )
- <sup>ii</sup> Payment for Physician Services, Social Security Administration ([https://www.ssa.gov/OP\\_Home/ssact/title18/1848.htm](https://www.ssa.gov/OP_Home/ssact/title18/1848.htm) see Section 1848(c)(2)(B)(ii)(II) )
- <sup>iii</sup> **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](https://www.ama-assn.org/press-center/press-releases/ama-wake-financial-peril-facing-medicare-payment-system) )**
- <sup>iv</sup> 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)
- <sup>v</sup> 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 )
- <sup>vi</sup> 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> )
- <sup>vii</sup> Medicare Payment Advisory Commission Data Book, Ju; 2010 ( [http://www.medpac.gov/docs/default-source/data-book/july2021\\_medpac\\_databook\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/data-book/july2021_medpac_databook_sec.pdf?sfvrsn=0) see chart 2-4 )
- <sup>viii</sup> Medicare Payment Advisory Commission Data Book, Ju; 2010 ( [http://www.medpac.gov/docs/default-source/data-book/july2021\\_medpac\\_databook\\_sec.pdf?sfvrsn=0](http://www.medpac.gov/docs/default-source/data-book/july2021_medpac_databook_sec.pdf?sfvrsn=0) see chart 1-5 )
- <sup>ix</sup> 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 )
- <sup>x</sup> **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](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

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1 Whereas, Adolescents believe that all health care should be confidential and report it as one of  
2 the most important aspects of their health care, yet many express concerns regarding privacy  
3 and worry that their providers will tell parents about their conversations; and  
4

5 Whereas, The Academy of Pediatrics recommends providing confidential and private health  
6 care to adolescents by allowing sufficient opportunities for adolescents to discuss sensitive  
7 issues with physicians without a parent present; and  
8

9 Whereas, The COVID-19 pandemic has not affected adolescents' needs for confidential  
10 services, and the early shift from in-person visits to telehealth visits demonstrated that 85  
11 percent of adolescent primary care visits occurred for sensitive issues including sexual and  
12 reproductive health, eating disorders, and substance use; and  
13

14 Whereas, Recent studies report that only 38 percent of adolescents spent any time alone with a  
15 provider within the last year, yet adolescents who experience portions of their visits  
16 unaccompanied by a parent are more likely to discuss sensitive topics such as sexual and  
17 reproductive health; and  
18

19 Whereas, Only 27 percent of adolescents reported that they had any alone time with their  
20 provider during recent telehealth visits, potentially limiting access to confidential services; and  
21

22 Whereas, A unique challenge of providing confidential care over telehealth includes finding quiet  
23 and private spaces in adolescents' homes that are separate from other household members to  
24 discuss sensitive topics without fear of the conversation being overheard; and  
25

26 Whereas, The American Academy of Pediatrics, Pediatric Health Network, Michigan Medicine,  
27 and other organizations have developed frameworks recommending that physicians continue  
28 providing confidential and private care to adolescents through telehealth; and  
29

30 Whereas, The organizations above provide recommendations unique to telehealth to ensure  
31 private and confidential visits, including asking the parent to leave for part of the visit and  
32 gaining parent buy-in regarding the importance of this privacy; and  
33

34 Whereas, Additional suggestions to provide confidential care to adolescents through telehealth  
35 include asking the adolescent to move to a more private area of the home, providing  
36 suggestions on unique areas that patients may go to ensure privacy, the use of headphones  
37 and chat features, the use of yes or no answers, asking the adolescent for a 360 degree video  
38 view to understand who is in the room, and having the parent and adolescent call from separate  
39 devices to easily facilitate the transition to confidential discussions; and

1 Whereas, AMA Policies H-60.938 and H-60.965 recommend providing confidential care to  
2 adolescent patients, but do not address the unique confidentiality concerns of adolescents and  
3 their parents accessing telehealth, nor the challenges associated with finding private spaces in  
4 an adolescent's home; therefore be it

5  
6 RESOLVED, That our American Medical Association amend Policy H-60.965, "Confidential  
7 Health Services for Adolescents," by addition to read as follows:  
8

9 Confidential Health Services for Adolescents H-60.965

10 Our AMA:

11 (1) reaffirms that confidential care for adolescents is critical to improving their health;

12 (2) encourages physicians to allow emancipated and mature minors to give informed  
13 consent for medical, psychiatric, and surgical care without parental consent and  
14 notification, in conformity with state and federal law;

15 (3) encourages physicians to involve parents in the medical care of the adolescent  
16 patient, when it would be in the best interest of the adolescent. When, in the opinion  
17 of the physician, parental involvement would not be beneficial, parental consent or  
18 notification should not be a barrier to care;

19 (4) urges physicians to discuss their policies about confidentiality with parents and the  
20 adolescent patient, as well as conditions under which confidentiality would be  
21 abrogated. This discussion should include possible arrangements for the adolescent  
22 to have independent access to health care (including financial arrangements);

23 (5) encourages physicians to offer adolescents an opportunity for examination and  
24 counseling apart from parent. The same confidentiality will be preserved between the  
25 adolescent patient and physician as between the parent (or responsible adult) and the  
26 physician;

27 (6) encourages state and county medical societies to become aware of the nature and  
28 effect of laws and regulations regarding confidential health services for adolescents in  
29 their respective jurisdictions. State medical societies should provide this information to  
30 physicians to clarify services that may be legally provided on a confidential basis;

31 (7) urges undergraduate and graduate medical education programs and continuing  
32 education programs to inform physicians about issues surrounding minors' consent  
33 and confidential care, including relevant law and implementation into practice;

34 (8) encourages health care payers to develop a method of listing of services which  
35 preserves confidentiality for adolescents; and

36 (9) encourages medical societies to evaluate laws on consent and confidential care  
37 for adolescents and to help eliminate laws which restrict the availability of confidential  
38 care; and

39 (10) encourages physicians to recognize the unique confidentiality concerns of  
40 adolescents and their parents associated with telehealth visits; and

41 (11) encourages physicians in a telehealth setting to offer a separate examination and  
42 counseling apart from others and to ensure that the adolescent is in a private space.

43 (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.

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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 physicians' fundamental 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

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1 Whereas, Physician Health Programs (PHPs) are designed to allow physicians with potentially  
2 impairing conditions who either come forward or are referred to be given the opportunity for  
3 evaluation, rehabilitation, treatment, and monitoring without disciplinary action in an anonymous,  
4 confidential, and respectful manner; and

5  
6 Whereas, The PHP model is intended to ensure participants receive effective clinical care for  
7 mental, physical, and substance abuse disorders and access to a variety of clinical interventions  
8 and support; and

9  
10 Whereas, Currently, physicians referred to PHPs who are diagnosed with opioid use disorder  
11 (OUD) involving monitoring or sanctions may be subjected to punitive action by their respective  
12 licensing boards; and

13  
14 Whereas, The stigma associated with illness and impairment, particularly impairment resulting  
15 from mental illness, including substance use disorders, can be a powerful obstacle to seeking  
16 treatment, especially in the medical community where the presence of this stigma has been  
17 described in the literature; and

18  
19 Whereas, The US Food and Drug Administration recommends approved medications for the  
20 treatment of opioid use disorder (MOUD) including methadone, buprenorphine, and naltrexone  
21 be available to all patients; and

22  
23 Whereas, MOUD has been proven to help maintain recovery and prevent death in patients with  
24 opioid use disorder (OUD); and

25  
26 Whereas, It is reported that patients who use MOUD remain in therapy longer than those who  
27 do not, and are less likely to use illicit opioids; and

28  
29 Whereas, A 2019 report from the National Academies of Sciences, Engineering, and Medicine  
30 stated that “there is no scientific evidence that justifies withholding medications from OUD  
31 patients in any setting” and that such practices amount to “denying appropriate medical  
32 treatment,” and that such practices amount to “denying appropriate medical treatment”; and

33  
34 Whereas, Clinicians should consider a patient’s preferences, past treatment history, current  
35 state of illness, and treatment setting when deciding between the use of methadone,  
36 buprenorphine, and naltrexone; and

37  
38 Whereas, Additional considerations apply to health professionals who are actively engaged in,  
39 or planning to return to, safety sensitive work; and

1 Whereas, Treatment programs offering the best possible outcomes are critical to ensuring a  
2 pathway to recovery and continuation of clinical practice in a safe and ethical manner with  
3 patient protection at the forefront; and  
4

5 Whereas, The American Society of Addiction *Medicine's Public Policy Statement on Physicians*  
6 *and other Healthcare Professionals with Addiction* includes the recommendation that  
7 "Healthcare professionals should be offered the full range of evidence-based treatments,  
8 including medication for addiction, in whatever setting they receive treatment. Regulatory  
9 agencies (including state licensing boards), professional liability insurers, and credentialing  
10 bodies should not discriminate against the type of treatment an individual receives based on  
11 unjustified assumptions that certain treatments cause impairment;" therefore be it  
12

13 RESOLVED, That our American Medical Association work with stakeholders including the  
14 Federation of State Medical Boards and the Federation of State Physician Health Programs to  
15 develop guidelines supporting the adoption of policies by state-based Physician Health  
16 Programs to support individualized decision-making, inclusive of all treatment options including  
17 counseling and medication for the treatment of opioid use disorder, and considerations for  
18 safety sensitive professionals, to ensure physicians receive effective clinical care to aid in their  
19 recovery and safe and ethical return to clinical practice (Directive to Take Action); and be it  
20 further  
21

22 RESOLVED, That our AMA work with stakeholders including the Federation of State Medical  
23 Boards and the Federation of State Physician Health Programs to develop model legislation  
24 permitting state Boards of Medicine and Osteopathic Medicine to allow for safe-haven or  
25 non-reporting of physicians to a licensing board, and/or accept Physician Health Program  
26 compliance as an alternative to disciplinary action when public safety is not at risk, and  
27 especially for any physicians who voluntarily self-report their physical, mental, and substance  
28 use disorders and engage with a Physician Health Program and who successfully complete the  
29 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

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1 Whereas, Incarceration is a key issue under the domain of Social and Community Context in the  
2 Social Determinants of Health topic area of Healthy People 2020 due to numerous disparities in  
3 inmate mental and physical health compared to the population, as well as the increased rate of  
4 mental health disorders in the children of incarcerated parents; and

5  
6 Whereas, There is a clear link between incarceration and health, with incarcerated individuals  
7 showing higher risk of chronic conditions such as cardiovascular disease, hypertension, and  
8 cancer compared to the general population; a study in March 2013 found that each additional  
9 year an individual spends in prison corresponds with a decline in life expectancy by two years;  
10 and

11  
12 Whereas, Incarcerated populations are particularly vulnerable to the coronavirus disease 2019  
13 (COVID-19) given the demographics of those experiencing incarceration in addition to the  
14 inability to properly "social distance", high population turnover, unsanitary living conditions, poor  
15 ventilation systems, inability or inadequacy to properly test and track COVID-19 cases and  
16 exposure which have led to an estimated 113,664 COVID-19 cases and 887 related deaths  
17 among incarcerated people as of August 2020; and

18  
19 Whereas, Arrests for marijuana possession, regardless of whether the person was later  
20 convicted on these charges, have been shown to negatively impact opportunities such as  
21 finding employment, housing, and obtaining student loans, which can lead to widespread and  
22 multifactorial individual health consequences; furthermore, criminalization of drug use is  
23 associated with increased stigma and discrimination of drug users and that stigma and  
24 discrimination is also a causal factor for decreased mental and physical health; and

25  
26 Whereas, Nationally, African Americans are three times more likely to be arrested for marijuana  
27 possession than Whites, a finding that cannot be explained by differences in use; and

28  
29 Whereas, A 2014 report by the National Research Council found that mandatory minimum  
30 sentences for drug offenders "have few, if any, deterrent effects;" and

31  
32 Whereas, Eighteen states, two territories, and the District of Columbia have legalized the use of  
33 recreational and medicinal marijuana, and in the past four years, 23 states have passed laws  
34 addressing expungement of certain marijuana convictions, pairing these laws with other policies  
35 to its decriminalization or legalization; and

36  
37 Whereas, In 2018, California became the first state to enact legislation ordering its Department  
38 of Justice to conduct a review of criminal records and identify past convictions eligible for  
39 sentence dismissal or re-designation in accordance with the Adult Use of Marijuana Act; the  
40 outcomes of this legislation showed that reductions in criminal penalties for drug possession

1 reduce racial and ethnic disparities in the criminal justice system, allowing for improvements in  
2 health inequalities linked to social determinants of health; and

3  
4 Whereas, Illinois passed a bill in May 2019, to expunge convictions for non-violent crimes of  
5 possession, manufacturing, and distribution of up to 30 grams and possession up to 500 grams,  
6 and Colorado and Massachusetts have approved legislation allowing individuals convicted for  
7 possession to petition to seal criminal records of misdemeanor offenses that are no longer  
8 considered crimes; and

9  
10 Whereas, A recent study examining the impact of this type of expungement found that those  
11 who do obtain expungement have extremely low subsequent crime rates and experience a  
12 significant increase in their wage and employment trajectories and an overall positive impact on  
13 the lives of those affected; however, of those legally eligible for expungement, only 6.5 percent  
14 obtain it within five years of eligibility, findings that support the development of “automatic”  
15 expungement procedures; and

16  
17 Whereas, Those who have received resentencing for past offenses, including decriminalized  
18 marijuana-based charges, have experienced an increase of 22 percent in wages on average  
19 within one year of resentencing as well as lower subsequent crime rates that compare favorably  
20 to the general population; and

21  
22 Whereas, Our AMA has policy (H-95.924) supporting public health-based strategies, rather than  
23 incarceration, in the handling of individuals possessing cannabis for personal use and  
24 encouraging research on the impact of legalization and decriminalization of cannabis in an effort  
25 to promote public health and public safety; and

26  
27 Whereas, Legislation has been considered at the federal level to, among other provisions,  
28 remove marijuana from the list of controlled substances under the Controlled Substances Act  
29 and create an opportunity for individuals with marijuana law convictions to petition for  
30 expungement and resentencing; therefore be it

31  
32 RESOLVED, That our American Medical Association adopt policy supporting the expungement,  
33 destruction, or sealing of criminal records for marijuana offenses that would now be considered  
34 legal (New HOD Policy); and be it further

35  
36 RESOLVED, That our AMA adopt policy supporting the elimination of violations or other  
37 penalties for persons under parole, probation, pre-trial, or other state or local criminal  
38 supervision for a marijuana offense that would now be considered legal. (New HOD Policy)

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

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## 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.

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